SOCIO-CULTURAL IMPLICATIONS OF AGORAPHOBIA: AN EVIDENCE FROM KHYBER PUKHTUNKHWA, PAKISTAN

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Signature: _____ Date: _____

Name of Research Student: Sara Ali Khan

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DEDICATION

I dedicate this research to my beloved parents, especially my father, who supports me in every step of my educational life, and my grandparents for their love, support, and encouragement. And friends who helped me and supported me throughout my thesis. They all are the reason behind all of my success. Their prayers, help, and efforts supported me and brought me to this level to complete my thesis. I also want to dedicate this work to Dr. Asim Muneeb Khan (my respectable and honourable supervisor) for his significant contribution, support, and guidance throughout my thesis.

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Sara Ali Khan
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Date:

List of Codes

DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
Hospital A	Mardan Medical Complex
Hospital B	Hayatabad Medical Complex
Hospital C	Pakistan Institute of medical sciences
Hospital D	Benazir Bhutto Hospital
MMC	Mardan Medical Complex
HMC	Hayatabad Medical Complex
PIMS	Pakistan Institute of Medical Sciences

Abstract

Every disorder affects the social life of an individual in its own way. Agoraphobia is a psychological disorder in which an individual fears being in situations where escape might be intricate. Some individuals also fear closed spaces, while others fear open spaces. This study is about the problems that arise in the everyday life of individuals affected by Agoraphobia. The objectives of the study were to i) Find out the changes in the social life of a person affected by Agoraphobia, ii) The complications faced by the family of an affected person during the period of illness, and iii) The relationship fluctuations between pre and post disorder. The data is collected through in-depth interviews, a qualitative form of research. Data is collected from 21 affected individuals, so the study's sample size is 21. Data is collected from Mardan Medical Complex (MMC), Hayatabad Medical Complex (HMC), Benazir Bhutto Hospital Rawalpindi, and Pakistan Institute of Medical Sciences (PIMS) Islamabad. Additionally, patients affected by Agoraphobia are sporadic, so some of the data is collected on a referral basis with the help of doctors, family members, and friends. Data were transcribed and analyzed through thematic analysis techniques by coding and extracting themes from the collected data. Similar codes were summed up under the relevant themes The results of the study are based on the data I collected from mentioned hospitals during my thesis. The findings of this study depict that agoraphobia badly affects the social lives of affected individuals in different ways. Individuals can only perform their daily life activities with the help of others, and they become dependent on others for their outdoor schedule. In the selected population, most people do not understand mental illnesses and their unwanted effects on social life. Arranging social seminars regarding “mental illnesses and their overall impact concerning the agoraphobia on individuals” is recommended. It is required to advocate for a more effective and empathetic support system for those affected by

this condition. It is important to change the concept of people regarding mental health issues spread awareness about the importance of mental health and normalize general counseling with mental health professionals.

Chapter One
Introduction

A phobia is an intense but irrational fear of something specific, usually from an object, person, situation, or a bad experience. Agoraphobia is one of the kinds of phobia that is an anxiety disorder (Wittchen et al., 2010). According to the ancient Greeks, (Carter, 2002) Agoraphobia is the fear of markets or public places, mainly vacant or too congested. Agora is a Greek word that means marketplace, and phobia means fear of something. The term was coined by a psychologist named Carl Friedrich Otto Westphal in 1871 after observing his three patients who were scared of marketplaces. He diagnosed agoraphobic patients for the first time in 1872 (Clum and Knowles, 1991).

Agoraphobia is a fear of being away from a place or object representing safety. It is a fear of leaving home and to spend a night away from home alone. The fear of an individual with Agoraphobia is irrational, but some patients give medical reasons why they cannot leave home alone or face public places (Goldstein & Chambless, 1978). According to the Diagnostic and Statistical Manual of mental disorders (DSM-5), Agoraphobia is an entirely different disorder from a social and straightforward phobia with altogether different symptoms (Asmundson et al., 2014). The person affected by Agoraphobia cannot travel on public transport without the person the patient trusts unthinkingly. Women are more affected by Agoraphobia than males, and it is primarily married in women (Plana-Ripoll et al., 2019).

According to Clum and Knowles (1991), 89% of females are affected by Agoraphobia out of 100%. Symptoms of Agoraphobia are specific and different from the symptoms of another kind of phobia. Symptoms include fear of leaving home, crowds or waiting, enclosed spaces such as movie theatres and elevators, open areas such as parking lots, malls, and using public

transport such as bus, plane, or train (Rachman, 1984). Sweaty palms, increased heart rate, and quick berating are some of the symptoms of Agoraphobia. Once it happens, then it continues throughout life (Segrott et al., 2004).

Hypnotherapy and virtual reality are also techniques to extend phobia. With medication and psychotherapy, a person can escape the trap of Agoraphobia. The associative learning principle, also called classical conditioning, is a theory to overcome and extend the fear of certain things and convert an individual's feelings to a calm state. The person affected by Agoraphobia becomes dependent on others and has a dependent personality (Chambless, 1985). During the 1970s, more effective treatments were developed to treat Agoraphobia, including group or individual sessions. Cognitive, behavioural, and psychophysiological measures were also included. At that time, attention was also given to paper-pencil tests. That was a more practical approach at that time. A person with Agoraphobia cannot make a proper sexual relationship with their spouse and have adjustment issues in their married life. An affected individual does not welcome their spouse with joy, enthusiasm, and happiness, which creates hurdles in their married life (Vidler, 1991).

Due to all these problems, a person's emotional well-being and self-esteem also become low, creating problems. Agoraphobic people become dependent on their spouses and ultimately become helpless. (Fry et al., 1962) claimed that a person chooses a spouse based on similar attributes. It was highlighted from the study that most of the agoraphobic persons married to a person have a similar problem. (Everaerd et al., 1973) claimed in his study that 45% of agoraphobic people complain that they cannot adjust to their families. Hand (1947) reported that two third of individuals with Agoraphobia were not satisfied with their married life before treatment, but after treatment, they became satisfied (Arrindell et al., 1986).

1.1 Types of Phobia:

There are many types of Phobia; each type has its symptoms, onset, diagnostic criteria, and effects on the lives of individuals. Here are some kinds of phobia Acrophobia, which is the fear of heights; Aerophobia is the fear of flying, Algophobia is the fear of pain, Aichmophobia is the fear of needles or pointed objects; Amaxophobia is the fear of riding in a car, Anthrophobia is the fear of flowers, Anthropophobia is the fear of people or society, Aphenphosmphobia is the fear of being touched, Ailurophobia which is fear of cats, Androphobia which is fear of men, and Arachnophobia is the fear of spiders (Soltani et al., 2020). Moreover, Bathophobia is the fear of deep places. Claustrophobia is the fear of enclosed spaces. Cynophobia is the fear of dogs. Entomophobia is the fear of insects. Ereuthophobia is the fear of blushing. Gamophobia is the fear of marriage. Gephyrophobia is the fear of seeing a naked person, Hednonophobia is the fear of pleasure, Hypnophobia is the fear of sleep, Ichthyophobia is the fear of fish, Mysophobia is the fear of dirt, Nostophobia is the fear of returning home, Nyctophobia is the fear of night or darkness, Ophidiophobia is the fear of snakes, Pathophobia is the fear of diseases (Groves et al., 2022).

Moreover, Pediophobia is the fear of children or dolls. Psychrophobia is the fear of the cold. Phobophobia is the fear of phobias, Scopopphobia is the fear of being stared at, Spectrophobia is the fear of mirrors, Tocophobia is the fear of childbirth, Theophobia is the fear of God, Triskaidekaphobia is the fear of the number thirteen, Zoophobia is the fear of the animals and finally Agoraphobia which is the fear of closed spaces and open areas also. Each type of phobia affects the social lives of individuals differently (Dunn, 2022).

1.2 Types of Agoraphobia:

There are two types of Agoraphobia. The first one is Agoraphobia with the symptoms of a panic attack, and the second one is Agoraphobia without the symptoms of a panic attack. Moreover, other kinds of Agoraphobia are Paranoid Agoraphobia, Claustrophobia, Catatonic Agoraphobia, Disorganized Agoraphobia, and Enochlophobia (Antony et al., 1997).

The first type of Agoraphobia is Paranoid Agoraphobia. Paranoia means false beliefs about something. It may be a situation, person, or thing that makes a person uncomfortable, while Agoraphobia is fear irrationally about a specific situation, so both are irrational fears. In Paranoid Agoraphobia, individuals think that they will die in a public area or closed space and no one will be available and free to help them, or during a panic attack, They will be like stupid persons and be embarrassed in front of individuals around them (Hoffart, 1995).

Moreover, Claustrophobia is another type of Agoraphobia in which an individual has just a fear of small places and has an irrational fear to trapped in small and closed spaces, such as cars during a traffic jam and heavy traffic. A claustrophobic individual also feels fear of aeroplanes and trains, elevators, tunnels, subways, crowded rooms, and small rooms. Some people feel fear from one situation in the above situations, but others feel fear from all (Mavissakalian and Hamann, 1986).

Furthermore, another type of Agoraphobia is Disorganized Agoraphobia, in which the sensory nerves do not pass the exact singles to the brain, and miscommunication between the nervous and brain happens because a person feels anxious in a specific situation. For example, a person is going on a bridge, and the wind blows, so they will feel that they will tumble on the ground because of this wind. Due to substantial effects on the brain, the body's organization

system gets disturbed, which becomes disorganised (Schmidt et al., 2014). Another type of Agoraphobia is Catatonic Agoraphobia, in which an individual cannot speak and move in an anxious situation. For example, if a person has a phobia of closed spaces or from a height, they lose the ability to speak in such a situation and cannot move from one place to another (Degonda and Angst, 1993). Furthermore, another kind of Agoraphobia is Enochlophobia, in which a person is afraid of crowded places and cannot move in overcrowded places. That is the main reason a person avoids situations and events like concerts, different public shows, and programs and cannot even go to the market for shopping (Nardi and Balon, 2020).

In the current research, I intended to see the effects on the social, occupational, and personal lives of patients of Agoraphobia and its consequences. This study was also designed to explore the changes in the personality of that specific individual after the disorder. This study also highlighted the impacts on the family of the affected individuals.

1.3 Problem Statement:

Agoraphobia is one of the types of phobia, which is the fear of open or closed places. Individuals affected by Agoraphobia cannot carry out life such as normal activities travelling in private transport, or spending nights out of the home. If a person is a businessman, Agoraphobia affects that individual's business because they cannot travel alone publically and face problems and hurdles when spending a night out of the home. After a person becomes agoraphobic, the social, occupational, and interpersonal life gets affected. Furthermore, my study will try to explore the socioeconomic and demographic characteristics of the respondents, the changes in the social life of a person affected by Agoraphobia, the complications faced by the family of an affected individual, and the personality patterns of an affected individual.

1.4 Research Objectives:

- To study the socioeconomic and demographic characteristics of the respondents.
- To explore the changes in a person's social life affected by Agoraphobia.
- To discover the complications faced by the affected individual's family.
- To identify the personality patterns of the affected individual.

1.5 Research Questions:

- How is the social life of an individual affected by Agoraphobia?
- How does the affected individual's family get intruded from an agoraphobic individual?
- How does Agoraphobia affect a person's overall personality?

1.6 Significance of the Study:

Studying Agoraphobia as a socio-psychological issue is one of the main areas of concern within the social and behavioral science domain. The current research primarily focused on the social and cultural implications of Agoraphobia and how Agoraphobic individuals and their family members experience this disorder. The study is quite important to highlight this disorder and its social and cultural consequences. The study is expected to shed light on the issue and raise awareness concerning understanding and explaining this phenomenon at a broader level. It is asserted that this is a significant area of research within the domain of anthropology.

1.7 Organization of the Study:

This study has been systematized into five chapters. It is summarized for easy understanding for the readers. It is organized into five different chapters, which are:

1. Introductions
2. Literature Review
3. Methodology
4. Analysis and Discussion
5. Conclusion

Chapter One is the study's introduction, which explains and discusses what Agoraphobia is and how it affects the social life of the affected individual in all aspects. This chapter also discusses the disorder's different types. Furthermore, this chapter covered the statement of the problem, the objectives of the study, the research questions, and the significance of the study.

Chapter Two is based on the relevant material from past studies' topics. It comes from different research papers, books, and journals from Pakistan and foreign countries. This chapter is divided into three parts: theoretical review, empirical review, and theoretical framework (Vogele et al., 2010; Davidson, 2001; Segrott, 2004; Holmes, 2006; Trotter, 2004). The theoretical review is based on data from past research. The empirical review contains different case studies related to Agoraphobia such as the case study of Mrs E.L, Adriana, and the case study of 19 years old girl (Aqeel et al., 2016; Fernandez and Faretta, 2007). The theoretical framework is based on the theories linked to the current research topic.

Chapter Three is the study's methodology, covering the research design, population of the study, sampling and sample size, tools and methods of data collection, data analysis, ethical consideration and field experience. This study is qualitative and uses two methods to collect data: the purposive sampling technique and the snowball sampling technique. Data is taken from the four major government hospitals of Pakistan. The hospitals are from Islamabad, Rawalpindi,

Peshawar, and Mardan Districts. Data are collected from 21 respondents. The interview guide was designed to collect data and it was a semi-structured interview guide that covered all aspects of the life of an affected individual. The collected data was then analyzed through the thematic analysis technique.

Chapter Four is an analysis of the data and a discussion about the collected data. This chapter analyzes all the collected data through the thematic analysis technique. In this progress, the researcher made the codes from the collected data and extracted a few meaningful themes. Furthermore, this chapter presents a detailed discussion of all the data.

Chapter Five summarizes the study's conclusion, recommendations, and limitations. It sums up the study. It reviews this research study's key findings, recommendations, limitations, and conclusion. It shows that those individuals who have Agoraphobia face severe issues in their social lives, and it has a profound impact on their personality, social, occupational, and personal lives. Furthermore, it discusses the limitations and recommendations of the study.

Chapter Two
Literature review

The review of this study comes from both theoretical and empirical studies (Holmes, 2006; Davidson, 2001; and Trotter, 2004). Agoraphobia is a mental disorder that affects an individual's social life badly. It is the fear of open places and closed places that affected individuals face problems in certain situations where escape might be difficult or crowdy places. The literature of the study is based on library research, different articles from google scholar, JS Store, and Sci-hub, and also from certain books (Eaton and Keyl, 1990; Compton, 1998).

2.1 Theoretical Review:

Agoraphobia affects the social life of a subject by affecting marital status, occupational life, and family life. Many other disorders are also caused by Agoraphobia, including panic disorder, anxiety, and other phobias. Agoraphobia affects the living style of an individual in the same way. According to the DSM 5, people avoid going to public places because of the fear of panic attacks (Magee, 1999). Theories about Agoraphobia such as “Agoraphobia and Gender” and “Psychoanalytic theory of Agoraphobia” show that traditional women's role increases the risk of Agoraphobia because of less exposure to the external world. 18% of agoraphobic individuals lose their jobs because of absence and low confidence level to face the people around them in job place (Dijkman et al., 1993).

Due to the fear and shame of panic attacks, the individuals become socially isolated and alone, which becomes the aetiology of depression. It causes psychosocial impairment in an individual's daily life and disturbs their life (Ost et al., 1984). Some individuals affected by Agoraphobia have a limited number of fear, while others become so dependent even they cannot

go out of home alone and become housebound. Some individuals avoid most situations from which they are scared, while others avoid one or two. According to Wittchen, in 2010, Agoraphobia occurred mainly in females compared to males. 2.9% is the lifetime prevalence for males and females, 8.3%.

Agoraphobia with a panic disorder is also common and found twice in females compared to males. It is shown from the research that the rate of Agoraphobia is higher in uneducated women who have lower socioeconomic status (Finnerty et al., 2010). Research shows that it is found from the comparative study of individuals affected by social phobia and Agoraphobia that it affects individuals differently who have different incomes, economic statuses, lifestyles, and education. Women with low education and poor financial status become easily affected by Agoraphobia and become housebound, which further affects that specific individual's personality, confidence level, and social life (Hofmann et al., 2014).

Most mental disorders and their onset depend on the quality of life. If the quality of life is good and every person's need is fulfilled, then the chances of occurrence of the disorder become low. Research shows that social phobia, panic disorder, and generalized anxiety are dependent variables affected by the quality of life, an independent variable. Quality of life is a series of happiness. Still, if there is a low quality of life, it will automatically give rise to different psychological conditions that further affect the social life of an affected individual. The theory of Abraham Maslow based on hierarchy states that if the basic needs of an individual are not met, it causes severe issues in the life of individuals, which affect them in different ways (Benson and Dundis, 2003). Agoraphobia affects and influences an individual's subjective well-being, self-realisation, neighbourhood quality, global quality of life, and the relationship of affected individuals with family, friends, spouses, and relatives. This disorder reduces the quality of life

by making a dependent personality of individuals. It also affects the somatic health of an individual, which also negatively affects the social life (Dijkman et al., 1993).

According to Davidson (2001), it was concluded that the patient with Agoraphobia must have some specific symptoms, which may include the symptoms of bipolar disorder such as unrealistic thoughts and beliefs, aggression, fighting with others, isolation, etc. Sometimes, the chances of getting affected by Agoraphobia become twice as when there is a positive family history of psychological illness positive history of grandparents, parents, older siblings, aunts, and uncles. Agoraphobia is a disorder that affects an individual's ability to go to crowded places or leave their home. (Davidson, 2001). Patients who have Agoraphobia cannot afford places that have specific boundaries that open and close for a particular time—for example, elevators, metro buses, etc. There are a variety of objects in particular situations which stimulate agoraphobic anxiety. Agoraphobia is a mixture of many kinds of phobia affecting the individual, such as claustrophobia. Agoraphobia starts with an anxiety attack in a public place if an individual sees any disturbing event, like witnessing an accident. Most individuals with a high level of sensitivity cannot cope with anxiety and die from a heart attack, brain haemorrhage, and even outright insanity, which is also one of the causes of a heart attack. The sufferers include those who experience that kind of situation for the first time (Segrott et al., 2004).

According to Segrott (2004), it is found out that the person in such a situation feels that I am going to die because their heart starts thumping or chocking their throat, they or cannot swallow even saliva, feeling of floating, dizzy, and giddy. The person wants to run from there if this condition happens in the mosque, market, or anywhere. In this situation, an individual forgets their identity; who am I? If a person experiences a particular anxious situation, then next time, they take the step to avoid such a situation and do not go again to that specific location or

any other location which are similar to that definite location in nature (Davidson, 2012). While facing an anxious situation, the heart rate of a person increases and causes severe sweating. Suppose a person faces it for a second time. In that case, the chances of general anxiety will increase, self-confidence will decrease, a person will become dependent on others, and an individual will restrict themselves from many locations where they feel it could be dangerous. Due to this disorder, a person loses their ability to negotiate with others and reduces outgoing activities to places where they initially felt comfortable but are now uncomfortable. Due to these reasons, they become housebound avoid going outside from home alone and become dependent on other family members to go outside (Davidson, 2001).

The disorder's severity depends on the affected individual's coping power; some feel the world is getting smaller. Some individuals feel that I am incapable of controlling my anxiety and even I cannot go close to the door of my home, and some feel that we would not go to the backdoor to throw the garbage. The affected individual may also experience the sensation of being illusory or far away from reality. An individual feels a state of de-realization and de-personalization in which all the thoughts and behaviours of the affected person become unrealistic (Holmes, 2006).

De-personalization is the state in which an individual feels strange for a certain period, cut off from surroundings, feels unrealistic, far away from people, and disembodied. In this state, the whole world looks alien, and delusional geographic creates, issues create many hurdles in the life of the affected person even that they cannot face and negotiate with the external world. Agoraphobics apply certain strategies to control their anxiety. For this purpose, they avoid crowded places and go outside the home when the streets are empty. Affected individuals also feel discomfort when the weather is rainy, cloudy, foggy, or dark and in a storm. That is because

of the disrupted surroundings from the normal condition, and a person cannot manage it because it is natural, so this situation increases the anxiety and panic attack levels in a specific person (Davidson, 2003).

Affected people do not bear it when a situation is not in their hands, and they cannot control it. They cannot travel on public transport because drivers do not stop at passengers' wishes. After all, they have specified stops, but when they are in their private cars, they feel fine because they can control and manage it providing them with ontological security and feelings like home; sufferers describe their cars as an extension of their homes. Arnaud Levy gives the concept of "subjective space", meaning that second skin or envelope, so sufferers search for that subjective space to control their anxiety outside the home. Agoraphobia is a disorder that disturbs an individual's internal and external spaces, and the individual remains confused between the border of these two situations. In this situation, individuals become bound, confused with dislocated self and dependent personality for taking and making decisions (Davidson, 2000).

The study of Trotter (2004) shows that the safe place for an agoraphobic individual is only their home and four walls. They become housebound after getting affected. This type of association of security with home is not universal, and it's unique because there are many secure places everywhere, there is no doubt that a home is a safe place, but the association of only a secure place with home is not a universal experience (Trotter, 2004). Sufferers are always in an emergency to return home; otherwise, they face panic attacks. In the late 20th century, shopping became one of the essential aspects of life for women, Individuals with agoraphobia avoided both shopping and going out in general. Many people encounter challenges when shopping because shopping malls tend to be crowded places, and affected individuals feel fear of such

kinds of crowded places. For normal people, shopping is a pleasure and fun, but for sufferers, it becomes a nightmare. Approximately 3.2 million, of which 2.2% is adults in the United States, is affected by Agoraphobia, and their age range from 18 to 54 (Davidson, 2000).

Moreover, research shows a strong link between difficulties with spatial coordination and Agoraphobia. The non-affected individual can maintain balance in their body by combining the sensation and information from their proprioceptive sense and vestibular system. Still, those individual who are affected cannot maintain balance. Many individuals are affected by this kind of issue and are also affected by Agoraphobia (Hanes and McCollum, 2006). The people with these two disorders are comorbid. They start to rely on just visual and tactile signals. They also become confused due to poor sensation in open and crowded places. They also become disturbed when they see irregular surfaces or areas with slopes. Research shows that those individuals who are affected by Agoraphobia have a chance that they will be weakened in the processing of exchanging audiovisual data (Jacob et al., 1992).

Many individuals use different kinds of drugs and sleeping pills without a doctor's prescription, such as different types of tranquillizers in high doses and sleeping pills like benzodiazepines. It has been found that certain types of medication can be linked to the development of Agoraphobia and can affect an individual. Out of 100% of individuals affected by Agoraphobia, 10% are because of substance use disorder and misuse of drugs. When those individuals quit substances, the symptoms of Agoraphobia may develop within one year (Swinson et al., 1992). Similarly, those people who are addicted to alcohol are associated with panic disorder and also with Agoraphobia. That is because of the disturbance of brain chemicals and chemistry due to the long-term consumption of alcohol. Many other drugs, like tobacco smoking, are also linked to developing and emerging Agoraphobia in an individual, possibly

with panic attacks. Also, an individual might be affected by more than one disorder due to tobacco smoking. Tobacco has nicotine which is linked directly with the symptoms of anxiety, panic attacks, and Agoraphobia and develops these disorders in an individual (Davis et al., 2010).

It also creates breathing problems, which are symptoms of Agoraphobia and the feeling of an Agoraphobic person during a panic attack. Those individuals who take medicine without a doctor's prescription also have issues with panic attacks and Agoraphobia. Agoraphobia, short for panic disorder, affects about 2% of females and 1% of males during 12 months. The topmost age at the beginning is the initial 20 years; the first appearance after age 40 is rare (Kendler et al., 1992).

Research shows that at first, Agoraphobia was placed under the umbrella term of phobia in DSM-3. Still, with the passage of time and advancement, it is considered a different and separate disorder of anxiety and phobia named Agoraphobia. In 1970 different other fears were also identified by Westphal (Boyd and Crump, 1991).

The DSM-III explanation of ‘‘noticeable fear and escaping of being unaccompanied or in public places from which escape might be problematic or the help will not be accessible in case of sudden breakdowns, did not diverge much from that of additional phobic disorders in DSM-3 and the ICD (International classification of diseases) definition of Agoraphobia (Fischer et al., 1988).

The text explanation in DSM-3, nevertheless, previously specified in 1980 that the analysis of Agoraphobia is more narrowly linked to Panic attacks than to phobias. ‘‘Agoraphobia with Panic Attacks’’ must be coded if ‘‘the early phase of the disorder contained repeated panic

attacks,'' thus foremost the individual to develop preventive terror of having such an outbreak and to escape circumstances related to these attacks. Only when there was no history of Panic attacks (or the evidence was missing) was the diagnosis of "Agoraphobia without Panic Attacks'' was complete (Breier et al., 1986).

The revised diagnostic and statistical manual (DSM-3 R) mentioned that Agoraphobia is a classically conditioned response to a stressful situation with a panic attack. Previous studies show that panic attacks and panic disorders are comorbid with Agoraphobia most of the time (Morey, 1998).

Previous studies show that telepsychotherapy is one of the most important therapies professionals use to treat disorders like panic attacks with Agoraphobia and anxiety. One of the patients received 12 sessions of cognitive behavioural therapy with a professional therapist, but it was not so effective. When a therapist starts applying telepsychotherapy to that specific individual, a positive outcome is visible after the initial session, so it is proof from that particular study that telepsychotherapy is more effective than cognitive behavioural therapy, and an individual can be cured more easily with it (Ballardie et al., 1993).

Furthermore, telepsychotherapy was accepted as clinically significant to target the symptoms of Agoraphobia, panic attacks, and anxiety, measure it properly, and improve treatment of all these disorders. Most of the time, telehealth sessions are given through video conferences, subsequently it is more feasible and convenient than other therapies, which are more time-consuming and require more resources. Research studies show that patients are highly satisfied with the treatment of telepsychotherapy, and researchers get a high satisfaction score in telehealth (Bouchard et al., 2000).

Moreover, In the study of Alberta, 100% of patients preferred telepsychotherapy because it is more convenient and easy for an individual who cannot travel to other cities to meet the health care professional. Hence, taking advantage of this kind of therapy becomes easy. Furthermore, in this study, 97% of individuals recommend this therapy to their friends, family members, and the people in their circle. 94% of patients decide to take telehealth services again in the future. A study in Alberta also shows that many individuals are hesitant to use social media for health services due to privacy concerns and trust issues. In this study, a total of 190 sessions were conducted with almost 90 patients, which means that two sessions with each person are too few to treat a psychological illness, but it was still very effective (Roshanaei-Moghaddam et al., 2011).

In a short survey of a rural community Rohland with his fellows found out that every 3rd person out of 200 individuals refused to take services (Rohland et al., 2000). Hence from the study, it is proved that the effectiveness of telehealth is as same as the effectiveness of psychotherapy and cognitive behavioural therapy. Still, telepsychotherapy is more convenient and easy to avail services of this therapy.

EMDR stands for Eye Movement Desensitization and Reprocessing, and researchers suggest in different studies that this is an effective therapy to treat Agoraphobia with panic disorder, anxiety, and panic attacks. This technique was introduced in 1989. After that, many studies based on the treatment of Agoraphobia are compared with this technique to determine whether it is effective in the compassion of cognitive behavioural therapy and other psychotherapies. So from the findings, it was concluded that both cognitive behavioural therapy and eye movement desensitization and reprocessing are equally effective. The plus point of

EMDR is that it is not as lengthy as CBT, has few treatment sessions, and does not require daily homework like CBT (Stickgold, 2002).

Furthermore, EMDR treats every kind of phobia, panic attack, disorder, and anxiety. Many patients need treatment of long-term for a full recovery. Suppose a patient improves from short-term treatment, then it is necessary to consult with their mental health professional regularly. Only 60% out of 100% of patients fully recover from short-term treatment procedures (Rodenburg et al., 2009). Adaptive Information Processing (AIP) is a theory developed to observe the effectiveness of EMDR. The findings showed that EMDR with AIP is the most effective approach for treating various disorders like post-traumatic stress disorder (PTSD), anxiety, and phobia, which are used specifically to treat Agoraphobia and panic disorders. One of the best points of EMDR is that it can find out the etiological cause and event due to which an individual gets affected, and then it helps the individual to come out from that specific condition. The most positive thing is that it explains and discusses every point with the affected individual. Thus, this technique can address and treat the symptoms of Agoraphobia (Shapiro, 2014).

Agoraphobic patients respond differently to their illnesses. Some patients are affected behaviorally, while others are affected psychologically. In his study with his fellows in 1984, Ost shows that he studied 40 patients affected by Agoraphobia continuously in an anxious situation and measured their heartbeat continuously in behavioural tests. The anxiety of the patients was rated on this test. Based on the results of this test, the patients were divided into two groups according to their condition, response, and reaction (Ost et al., 1984).

These are behavioural reactors and psychological reactors. Twelve individual sessions were carried out with all patients, the result of which was highly improved because patients were directed toward the therapy more suitable to the condition of the patients psychologically and

behaviorally. The patients related to behavioural disturbance are assigned to exposure in vivo therapy in which an individual is directly exposed to the object, situation, and activity from which an affected individual is scared (Nimmagadda et al., 2001). Relaxation techniques were applied to the patients who had related psychological disturbances, which consisted of different steps, for example, breathing slowly and deeply with the nose in a relaxed mood, exhalation with the mouth deeply and slowly, counting from 1 to 5 during each breath, it is important to close your eyes before starting this technique, it is deep breathing. After doing this, the patients who were affected behaviorally improved by up to 60%, and those who were effect psychologically improved by up to 70%. It shows that both techniques are equally helpful in treating Agoraphobia with different effects on patients (Perciavalle et al., 2017).

Furthermore, many studies show that females are affected twice as compared as males from Agoraphobia. In addition, it may be different and associated with the age of an affected individual, their economic resources, lifestyle, and whether a person is a drug addict or has a family history of mental disorders (Fava et al., 1995). In the diagnostic and statistical manual of mental disorders, it is clear that the prevalence of Agoraphobia (panic attack) is higher in European countries than in Asian countries. In Pakistan, most people are unaware of mental health and its treatment. In Pakistan, many individuals seek assistance from religious practitioners, traditional healers, and spiritual healers for mental health issues. Few people visit a mental health practitioner before visiting such healers. Most people in Pakistan think that it is not a mental health issue. Rather it is black magic, called Kala Jadu in the local language of Pakistan (Naveed et al., 2015).

Sometimes due to the placebo effect (It is therapy for patients more sensitive to their health. If a patient does not need medicine but insists on it, therapists give them a simple

painkiller or vitamin and tell them that this tablet will relax them and they will feel sleepy after eating. That affects the patient in such a way that they think). The patients get better from treating such traditional healers because of their belief system. But when it doesn't work, people go for a mental health professional (Mursaleen and Ali, 2015). General anxiety disorder affects up to 15% to 25% general population. It can be mild, moderate, and severe, and in this way, it affects the social, occupational, personal, and family life. It can also affect the person physically depending on the severity level of the disorder.

Most of the patients become aware and alert from the symptoms of panic attacks, anxiety, and Agoraphobia, so after that, they feel afraid and scared of these symptoms, due to which the problem becomes worse. Mental health professionals use different therapies and techniques to help the affected person. CBT is mostly used to treat mental health problems, and therapist also gives psycho-education regarding mental health issues. Sometimes they use the method of relaxation and deep berating. Therapists also use self-monitoring and cognitive restructuring to treat mentally affected individuals. Sessions are taken by an individual, which may be group or individual sessions; most patients recover in 10 to 15 sessions and return to normal life (Williams et al., 1989).

The duration of the treatment depends on different factors like the severity of the symptoms and different other diseases and disorders of the patient who get comorbid with their mental disorder, sometimes patients are resistant towards the treatment and may take much time to open up with the therapist who may also affect the effectiveness of the treatment, a therapist's level of skill and competence in using specific therapies is crucial for successful treatment of disorders (Aslam, 2012).

Mental health professionals try to give different instructions for self-help to agoraphobic individuals to help them out of this specific condition. They mostly give self-help instructions and how an individual can expose his/herself to anxious stimuli. A book is given to an affected individual, containing instructions on self-help and coping with these specific situations. Many computer programs are based on the instructions and coping strategies suggested by mental health professionals and effectively treat Agoraphobia (Cox et al., 1993). Agoraphobia is a disorder that affects an individual's whole life, including social, occupational, family, and personal life. If a person feels fear of some specific object irrationally, then the whole family faces this problem, and the friends' circle of the specific person is disturbed. Fear is a rational and common thing in individuals, societies, and communities, and each society explains fear and irrational fear in its own way. Studies show a deep connection between Anthropology and psychology because of the psychological illness and disorder a person's social and family life directly affects. And everyone in each society trusts the fear of specific things and solves it in their own way (Magee, 1999).

2.2 Empirical Review:

A strange case study:

It is the story of 90 years 90-year-old woman named Mrs E.L. who had a severe fear of dying and falling and also had a fear of losing her consciousness. She had been bound in her home for seventeen years. She had an irrational fear that something terrible or wrong would happen. She has not left her bed for many years because of Agoraphobia. She cannot even go outside her room or from her house. Furthermore, she also bounded her husband and did not permit him to go outside of their home because she feared being harmed by something or

someone outside of the home. After twenty years, regular psychotherapies and medications improved her condition, and she could only go outside her room. That was a great success for all the doctors and psychologists who were an important part of her treatment. This case study shows that Agoraphobia is a severe mental illness and can spoil the pleasure of the life of that specific individual. Regular follow-ups and medication can help to treat this condition (Aqeel et al., 2016).

Case Study Two:

This case study is based on the disorder of Agoraphobia, which affects a 19-year-old girl who is mentally and physically healthy and has no family history of mental illness. She was suffering from the irrational fear of being crazy and also from open places with crowds, and it was from six months before diagnosis. The patient went alone to the hospital for help on 16 September 2018. She was also afraid of being alone at home, crossing the road alone, having traffic issues, taking an elevator, riding a bicycle, driving a car, and even phobia of travelling in a plane. On her psychological evaluation, the psychologist evaluated her physical, emotional, behavioural, and cognition levels. It is found that the patient has a poor sleeping pattern because she has difficulties falling asleep and easily waking up. She was feeling nervous and anxious about many things, such as being crazy, being at home alone, being in a crowd and facing it alone, travelling alone, riding a bicycle, from being stuck in the elevator (Davis et al., 2010).

Due to all these problems, the interest of that specific girl has decreased in the colours of life and also in studies, due to which she lost her self-confidence. She does not have sufficient knowledge of her disorder, and due to a lack of psycho-education, she faces many difficulties. Furthermore, the patient's parents were strict with her and imposed expectations on her, so the

disturbances were high. After the consultation with the psychologist, they counselled the patient once a week for 50 minutes. Psychologists gave basic psycho-education about the patient's disorder, set goals for recovery, and discussed all the procedures of counseling and therapies. By following the therapy procedure, the patient recovered quickly, and fear was reduced. Agoraphobia is a disorder in which the level of confidence and self-esteem becomes low, and a person faces severe issues in their daily life due to different things from which they fear (Magee, 1999).

Case Study Three:

It is the story of Adriana. When she was a few months old at that time, her parents gave the responsibility to her grandparents to take care of her because they used to go early for work, and after the job, they used to meet with her daughter. After some years, they reunited because Adriana's parents purchased a home near their workplace.

When Adriana was eight years old, her father was injured in a car accident. After that, he avoided driving a car for two years and gave the responsibility of driving the car to his wife. After that, the mother of Adriana got pregnant with her brother and remained ill. At that specific time, Adriana got stuck in an elevator, and there was no one to help her escape from that place and comfort her. Another traumatic event happened to Adriana when she was nine years old. She was alone at home, and at that time, Thieves broke into their residence to steal their belongings, and wear black masks to hide their faces. She screamed too much then, but no one could help her. After that, she experienced nightmares for years and became phobic about remaining in the home alone.

Before the appearance of the symptoms of panic attacks and Agoraphobia in Adriana, she started cannabis smoking before few months ago. Subsequently smoking marijuana, Adriana experienced extreme dampness, visual instabilities, and a strong agony sensation while driving her car. One month after this episode, she experienced an appendectomy. After Another month, she agonized over her first panic attack in real life while driving her car (Davis et al., 2010).

The symptoms of Agoraphobia completely appeared at the age of 20 in Adriana. The first panic attack was experienced by Adriana when she was driving her car alone. At that time, the symptoms of Agoraphobia appeared for the first time. Adriana's symptoms comprised a feeling of obstruction, the reason for disruption in her oesophagus, tachycardia, perspiring, faint feelings, scratchy hands, leg shakes, visual disabilities, and an irrational fear of fading. She was unable to drive a car alone, unable to face traffic jams, feared being stuck in an elevator or shopping mall, and even could not go shopping alone and became dependent on others for daily life activities. She was unable to live alone at home. She faces many difficulties in managing her daily life activities.

At the age of 32, she presented herself for treatment for the first time. EMDR was used by healthcare professionals at that time to address panic attacks with Agoraphobia. The therapist assessed her in terms of cognitive, behavioural, emotional, and physiological changes for two weeks and advised her for one-year follow-ups. Professional suggestions were given to her to write daily dairy regarding the situations that are fearful for her, the triggers of such situations, duration and intensity of panic attacks, and symptoms. After applying EMDR, the patient's condition becomes good with time physiologically, emotionally, behaviorally, and cognitively. It was concluded that 53% of individuals who experience traumatic events in childhood are affected by Agoraphobia in adulthood (Fernandez and Faretta, 2007).

2.3 Diagnosis of Agoraphobia:

The diagnostic criteria of Agoraphobia are based on the symptoms, fully explained by the Diagnostic and Statistical Manual of mental disorders (DSM-5). To meet the diagnosis criteria of DSM-5, patients must have symptoms of fear for six months or more than six months continuously and also fear of anxiety for two months or more than two months (Park and Kim, 2022).

Agoraphobia can also be diagnosed through in-depth interviews with a healthcare practitioner. For a person who is agoraphobic, face-to-face interviews are very important. A professional can easily diagnose an individual in a face-to-face interview using gestures, postures, behaviour, facial expressions, and way of talking. Some symptoms of Agoraphobia are defined by the Diagnostic and statistical manual of mental disorders (Richter et al., 2021), such as

1. Use of public transport
2. Being in open places like market, parking, grounds, etc
3. Being in closed places like theatres, elevators, metro buses, etc
4. Standing in a line to wait for something or being in a crowd.
5. Being alone outside of the home

The DSM-5 explains the five symptoms of Agoraphobia, and if a person has at least two symptoms out of ten, then they are a patient of Agoraphobia. Furthermore, it is characterised by mild, moderate, and severe based on symptoms present in a person. Each disorder has a specific

code in the Diagnostic and Statistical Manual of mental disorders, so the code of Agoraphobia in this is 300.22(F40.00) (Detre, 2019).

There are some physical symptoms of Agoraphobia, so it can also be diagnosed through some physical examination like blood tests to look for the symptoms of any physical symptoms of Agoraphobia. The diagnosis of Agoraphobia in the DSM-5 is comorbid (in combination with) depression, substance abuse, and suicidal thoughts or ideation (Cosci and Mansueto, 2020).

2.4 Symptoms of Agoraphobia:

Rapid heartbeat, increase in blood pressure, hyperventilating, and feelings of sickness are some other symptoms of Agoraphobia. Symptoms may vary from individual to individual based on the severity of the disorder. For example, a person with mild Agoraphobia may travel alone but up to some distance with no problem. In the case of severe Agoraphobia, the person cannot even get up from their bed (Barzegar et al., 2021).

There are different parts of symptoms of Agoraphobia, which are behavioural, cognitive, and physical. Physical symptoms of Agoraphobia appear when affected individuals face the situation suddenly and are exposed to that specific situation which causes anxiety. The physical symptoms of Agoraphobia rarely occur in the affected individuals because these kinds of individuals show avoidant behaviour and try to avoid such situations which are anxious for them. The physical symptoms are similar to the symptoms of a panic attack. It includes rapid heartbeat, increase in breathing, feeling hot, sweating, pain in the chest, feelings of sickness, difficulty in eating, diarrhoea, stomach problems, feeling faint, trembling, sounds, and ringing in ears like the patients of schizophrenia (Stech et al., 2020).

Another main symptom is Cognitive symptoms, which are an individual's irrational feelings and thoughts about the situation. In this kind of agoraphobia symptom, a patient feels fear regarding anxious situations irrationally; They may avoid panic attacks because they fear appearing foolish in public. I will be embarrassed, so due to this reason, they avoid such situations (Domhardt et al., 2020).

The affected individual feels that the panic attack will be life-threatening, their heart will fail, and they will die because of this disorder, so they think irrationally. The affected individual also thinks they will be unable to escape from the anxious situation in the case of a panic attack, and they will die because of this. They think that they will lose control in front of people in public (Indah and Nurmaily, 2022).

They also think that they will lose their rational and logical thinking. They will shiver and blush in front of people in public places and think that people will stare at them. Some cognitive symptoms are not related to a panic attack. An individual experiencing dependency feels unable to survive without the assistance of others and may live alone at home. Patients also have the feeling of general anxiety (Ebenfeld, 2021).

Some of the symptoms of Agoraphobia are related to a behaviour called behavioural symptoms. An affected person may be in a situation that may cause anxiety and irrational fear, such as crowded areas, public transport, parking lots, etc. They become housebound and are unable to leave home when the disorder is at a severe level. They go with people outside the home when they trust that person, which is when the disorder is minor. They cannot travel far away from home without the help of other individuals. Some affected people try to face and expose anxious situations, but they are uncomfortable and anxious (Fond et al., 2019).

2.5 Causes of Agoraphobia:

The main and most important cause of Agoraphobia is panic attacks. When a person has the illness of panic attacks and feels uncomfortable with this in front of people in public, they start thinking about their condition during a panic attack and feel worried about the symptoms of a panic attack in front of the public. Subsequently, this kind of thinking can lead to the development of agoraphobia. The affected person avoids anxious situations due to these feelings. (Ebenfeld et al., 2020).

Research shows that one-third of individuals with panic attacks also exhibit symptoms of Agoraphobia., but it can occur alone as well. Everyone experiences some fear and stress in a specific situation, and this kind of stress and anxiety is normal to live a healthy and fruitful life. For example, suppose a student has an exam; they must have a little bit of stress and anxiety regarding their exam and result to gain good marks and better results. In that case, they must prepare for the exam and study due to stress and anxiety, which is normal and short-term (Pual et al., 2023).

But if a person thinks negatively about the symptoms of panic attacks every time, they can develop the symptoms of Agoraphobia. This kind of anxiety becomes dangerous for a person and affects their social, occupational/family, and personal life differently (Heiat et al., 2021). Some biological factors may cause Agoraphobia in a person. Fight and flight are the body's normal response to stress and anxiety, during which the body releases the hormone adrenaline, which prepares the body to cope with stress and anxiety. But in some individuals, this process becomes very intense, and the hormone is released in a very large quantity which may lead to Agoraphobia (Kanwar, 2020).

Some psychological factors may develop Agoraphobia in an individual; it may be a stressful, traumatic event or a situation in childhood. It may also happen when the individual was abused by someone physically or sexually in childhood. It may also develop when an individual faces a stressful situation in their present life, such as divorce, loss of job, etc. It may also develop if a person has a history of mental illness or anyone else in the affected family has a history of mental illness, such as anxiety, depression, anorexia nervosa, bulimia nervosa, etc. It may also develop in drug addicts, people with unhappy relationships, and an abusive spouse who does not support and control every step of their spouse have the chance to develop Agoraphobia (Stravynski et al., 2004).

A person can also develop Agoraphobia when they do not have a panic attack history. Several different irrational fears may characterize this kind of phobia. For example, suppose a person leaves their home and becomes the victim of a terrorist attack, being affected by any infection after entering a crowd. In that case, another reason may be that if the individual does something unintentionally wrong in front of other people, it becomes humiliating and embarrassing for that person (Williams, 1987). Some people are very sensitive and fear everything they are exposed to, and they have multiple kinds of phobias, so they also have chances to develop the symptoms of Agoraphobia (Furnham, 1995). Agoraphobia may also be caused due to genetic factors if there is any person in the family with Agoraphobia, such as a father, mother, grandparents, uncle, or aunties, etc. Then the probability of Agoraphobia increases in the upcoming generation. Stressful environmental factors such as the death of a loved one may also cause Agoraphobia, so genetic and environmental factors are the basic and main risk factors of Agoraphobia. Agoraphobia is classified in the DSM-5 as phobia, specified phobia, and social phobia (Tyrrell, 2005).

2.6 Avoidant Behavior of Affected Individual:

The affected individual avoids many things because of their illness, such as they cannot go to the market or shop to buy something, so they prefer online shopping and receive the things of daily life usage at home. When the disorder is mild, the individual may leave home with a close friend or spouse when needed. Still, if the case is moderate, the person cannot go outside from home, and when the case becomes severe, the individual does not even leave their bedroom to go outside (Silverman and Moreno, 2005).

2.7 Treatment of Agoraphobia:

Agoraphobia cannot be cured without treatment. It needs proper treatment and a specific time. Agoraphobia is a treatable illness and can be treated through different therapies, counselling, and medicine. It is easy to recover quickly in the early stage of the disorder, but it takes years to treat when it gets older. Different therapies are used to treat Agoraphobia, such as talk therapy and cognitive behavioural therapy (Nwoke and Ugwuegbulam, 2016). Talk therapy is between a patient and a therapist or mental health professional. In talk therapy, the patient and therapist make goals together, and the therapist explains how a patient can live a healthy life with illness and how to reduce anxiety, stress, panic attacks, and irrational fear. Affected individuals reduce their anxiety by learning practical skills and then overcoming anxiety and phobia (Freeman, 1998).

Talk therapy is one of the most important and effective therapies in psychology and is used to treat most disorders; it helps the individual live a healthy social life. Cognitive behavioural therapy is the type of talk therapy in which a therapist talks about the unhealthy

thinking pattern of an affected individual, the irrational behaviour of the client, and how to change the individual's irrational behaviour and thinking and teach them to live a better life. During this therapy, the therapist will address their worries and encourage them to gradually resume activities they may have avoided due to irrational fears and anxiety. In cognitive behavioural therapy, an individual learns many ways to cope with fear. Individuals may learn the basic triggers that increase anxiety and panic attacks and the triggers that increase irrational fear (Foa et al., 1984).

Individuals may also learn how to tolerate the symptoms of Agoraphobia and cope with it. The therapist also tries to challenge the individual's worries directly by exposing them directly to that specific environment which is fearful for the affected individual to teach them that bad things do not happen in these social environments. Individuals must refrain from letting the situation power over them and face the stressful situation (Katan, 1951). Due to the direct exposure of individuals to these situations, irrational fear gradually reduces with time. Affected individuals remain for a long time in this situation, learn from them, and realize that it is normal and not affecting me. It is exposure therapy and is an important part of Cognitive behavioural therapy (Hofmann et al., 2010).

2.8 Medicines Used to Treat Agoraphobia:

Some medicine is used to treat the irrational fear of something and Agoraphobia. Some antidepressants used to treat Agoraphobia which are selective serotonin reuptake inhibitors (SSRIs), another is fluoxetine (Prozac), and sertraline (Zoloft) (Beck, 2011). These medicines are not only used to treat Agoraphobia but also to treat depression and other mental illnesses. Another medicine which is called benzodiazepines, is also used to treat and reduce the level of

anxiety. It is sedative and can reduce the level of anxiety. It is a short-term medicine used to treat anxiety symptoms on the spot and relieve it shortly (Butler et al., 2006).

The affected individual uses self-help to help them cope with stressful events and be normal. A person must have confidence in themselves to face their fear. Some steps should be followed by the affected person, such as, at the time of the panic attack, staying where the patient is, focusing on the whole situation which is anxious for that person, slow breathing and deep breathing is necessary during this condition, affected individual should have to face and challenge their fear, the patient should use creative visualization technique to overcome with anxiety, it is a technique in which a person thinks about their favourite place which is relaxing for them during stressful situation and should avoid anxious situation in such a way. The patient must write the negative thoughts and ideas that come into their mind daily, think about them, and share them with a mental health professional. Also, they have to write about the effects on their social, occupational, family, and personal life and how their spouse and kids are affected due to their disorder, and they must be outspoken in telling everything in front of a mental health professional (Linehan, 1987).

Patients should have to change their lives to live healthy, such as regular exercise to avoid stress and anxiety. Patients must take a healthy and balanced diet to maintain overall health. For individuals who struggle with drug addiction, it's crucial to discontinue drug use and avoid consuming stimulants such as coffee or tea. Getting seven to eight hours of uninterrupted sleep each night is also essential for recovery. Physical activity is important, but the patient must avoid intense exercise because it also triggers anxiety. A healthy diet is necessary, but patients must avoid sweets (Hollon, 2013).

Furthermore, proper yoga and meditation are also important for overcoming anxiety. In every religion, there are different practices and rituals. According to the religion of the specific person, they must do religious practices and make a strong connection with God to normalize the anxiety. As a Muslim, a person must pray five times daily and live according to their religion. It is one of the important methods to overcome anxiety (Seligman and Ollendick, 2011).

Strong and proper connection is required with family and friends. If a person cannot visit in person to meet with friends and relatives, they must maintain a good relationship with the individuals in their circle and related people. Also, as a patient must maintain salts, minerals, fats, and vitamins in their diet to be strong, vitamin D is a very important vitamin that reduces an individual's stress level (Stewart and Chambless, 2009). The living style of the person affected by Agoraphobia has a specific pattern. They live in their specific shell and do not go outside of that shell without any specific reason, their home is the most important place and a comfort zone for them, and they love to live in it for their whole life (Wood et al., 2006).

Individuals affected by Agoraphobia may also have a separation anxiety disorder for the people with whom they are attached. Individuals who are affected by this fear may be hesitant to leave the company of a specific person. If the child of an affected person goes to the hostel for their higher studies, the affected individual does not take this kind of decision and has trouble doing so. Another example is if the daughter of the affected person is getting married, they will also be in fear and stress, due to which the important decisions of life are disturbed and social life is affected badly (Walkup et al., 2008). Affected people may also fear waiting outside from home for a long time to wait for the door to open and become the victim of a panic attack. That is called macrophobia. The onset of panic attacks in Agoraphobia is sudden and lasts 10 to 15 minutes. Agoraphobia is the behavioural outcome of persistent panic attacks in adverse form.

During the initial phase of a panic attack, there may not be any distinct signs of Agoraphobia. However, as the panic attacks become more persistent, symptoms of Agoraphobia may start to manifest. (Kendall and Southam-Gerow, 1996).

Research has indicated that individuals with Agoraphobia may experience apprehension towards unfamiliar environments and new locations, leading them to avoid such places. (Angel and Thoits, 1987). Likewise, an individual must change their life according to their symptoms, which may be mild, moderate, and severe, to make their life easier and to cope with this disorder.

2.9 How a Person Learns to Cope with Agoraphobia:

The therapist teaches different techniques and explains the usage and applications of these techniques. An individual must apply these techniques daily to cope with Agoraphobia. The affected person needs to care for themself, and the affected person's family has a great role in the recovery of the individual. If the family takes good care of the affected person, the affected individual recovers quickly. The patient must use the medicine at the specific time prescribed by the mental health professional (Bhugra et al., 2021).

The most important practice for the affected individual is that they should not avoid a situation that is stressful for them and face a situation that is anxious for them and which sparks phobia. If a person does all these things, it will be better and helpful for the affected individual to enjoy things and feel less fear compared to the previous time. The chances of a panic attack will decrease, and a person will be on the way to recovery after this (Benedict and Jacks, 1954).

Agoraphobia is a disorder in which a person becomes isolated and feels anxious. Still, it is based on the affected individual's control of anxiety symptoms and managing their daily life

activities to have a good and healthy lifestyle and overcome the effects of the disorder on their social, occupational, family, and personal life (Good and Good, 1982).

Furthermore, the affected person needs to make an appointment with a healthcare professional. Individuals need to communicate clearly and explain their problems without hesitation to lead a healthy and satisfying life in the future. Individuals must be open and honest in their conversations with the healthcare professional, leading to a healthy life (Langdon and Wiik, 2010). Some general situations and medical illnesses also cause different disorders of anxiety-like Agoraphobia because the main cause of this disorder is overthinking about any stressful and anxious event; all medical illnesses are unpleasant conditions for everyone and those individuals affected by it who are more sensitive and overthink in every situation (Den Boer, 2000).

Some medical disorders that cause Agoraphobia are hyperthyroidism, heart attack or heart failure, chronic obstructive pulmonary disease (COPD), Pheochromocytoma, and arrhythmia. Various medical illnesses affect the body in distinct ways physically. Due to physical illnesses, the patient cannot tolerate and take mental stress, which further converts into mental health issues like Agoraphobia (Dominique and Margraf, 2008). Affected persons have major distress in social situations, such as issues in the place of their job or any occupation. Due to these problems, their occupational life also gets disturbed. Some individuals struggle to manage their responsibilities as they rely too heavily on others to make decisions and handle their tasks. Hence, it adversely affects their finance, due to which they and their family face financial issues (Barrera and Norton, 2009).

It also leads to other abnormal conditions such as depression, alcohol use, a person becoming a drug addict, suicidal ideation, and abnormal behaviour. These conditions adversely affect the patient and their family life, social life, occupational life, and personal life of an affected individual. Individuals experiencing panic attacks often feel overwhelmed and distressed. In some instances, they may even feel that death is preferable to a life filled with stress and anxiety. (Massion et al., 2002). In addition to the social issues caused by Agoraphobia, this condition also affects the brain because the activity in the basal ganglia, which is part of the brain, increases. It tends to become more active in response to stressful and anxious situations, due to which the brain is also affected. Many individuals with Agoraphobia may become confined to their homes without realizing that it is caused by chemical imbalances in their brains rather than a personal fault. If the patient comes to know proper psycho-education from a mental health professional, then it can help in the fast recovery of the individual (Sioni et al., 2017).

Agoraphobia also has the symptoms of various personality disorders like avoidant personality disorder and dependent personality disorder, making an affected person housebound. A dependent personality disorder is a severe and irresistible requirement to be favoured, often accompanied by suspicions of being alone, reckless, or unacceptable to others. Sometimes children become dependent on their parents for every life decision. The main cause here in dependent personality disorder symptoms of Agoraphobia is the treatment of parents with children. If parents allow their children to make their own decisions, guide them in making the right choices, and educate them on distinguishing between right and wrong. In that case, the personality of children develops very strongly. An avoidant personality disorder is a mental disorder in which an individual is extremely fearful of being judged by others, and they must feel shame in front of a crowd. For this reason, that specific person avoids social events like the

wedding ceremony of close friends or family, and they avoid going out with friends for parties, trips, and tours, so both Agoraphobia and Avoidant personality disorder have similar symptoms. They are comorbid with each other and affect the whole life of an affected person (McEwen and Stellar,1993).

Agoraphobia affects not only individuals but also their social and family lives. It can have a significant impact on an individual's marital status, as the non-affected spouse must constantly compromise with the affected partner, so it becomes challenging for an ineffective individual. For example, if a couple is newly married, the husband is affected by Agoraphobia while his wife is ineffective, and she demands to go outside for ice cream. Her husband avoids her because of his illness, but he cannot explain his condition clearly in front of his wife, which can create an issue between the two partners. Relationships can become strained when such conditions arise. These conditions have the potential to cause dysfunction within the relationship., sometimes resulting in divorce and partner separation (Stults-Kolehmainen and Sinha, 2014).

Some psychosocial factors lead to the development of Agoraphobia, such as poor upbringing of children by their parents. For example, if both parents are working and no one is available at home to take care of the children, parents hand over their children to a caregiver who cannot care for their children. Hence, children's personality develops very weakly; they need support in every step of life and spend life in an anxious and confused manner. (Mogg et al., 1990). Individuals become unable to work in this disorder and become financially dependent on their family members or partners. The attachment of the affected person with their family and spouse becomes insecure attachment. Someone who is affected by this condition experiences

constant anxiety at the thought of being separated from their loved ones. They worry that one day their loved ones will leave, leaving them alone. (Keinan, 2002).

Many children experience the loss of their parents during childhood and are subsequently raised by others. This can be a challenging upbringing, often resulting in a pervasive sense of fear and anxiety throughout their lives. These children require support and understanding to help them navigate life's challenges. However, if they have everything in their adulthood, their personality will still be full of anxiety symptoms (Raposa et al., 2016).

Agoraphobia can disrupt the intimate relationship between a couple, leading to communication breakdown and dependence on one partner. This can have a ripple effect on the individual's social circle. There is a lack of closeness between the two partners, and they lack in completing the needs of each other. The intimacy between two partners was not sustained due to changes in one person's behaviour. They also do not share things or communicate clearly, weakening the relationship between the affected and non-effected partners (Van Eck et al., 1998).

Agoraphobic individuals resist many things in life that might be pleasurable with the non-affected partner. For example, the husband is affected by Agoraphobia, and his wife wants to go shopping with him. If he resists, the wife will complain about his behaviour which will also be depressing for her husband. So two illnesses become comorbid with each other, which are depression and Agoraphobia, which leads to more severe consequences (Dhabhar, 2014).

Agoraphobia also affects the relationship between children and parents. If there is a strong bond between mother and child, then the child would be able to share everything without any hesitation with their mother, but if the mother or father is Agoraphobic and remains

anxious, depressed, stressed and is unable to take care and give a quality time to children then the personality of children will be not as strong as compared to the children who have a strong bond with their parents (Sandi and Haller, 2015).

To live a healthy life, there are several basic needs that humans require. If a parent fails to provide these necessities promptly, it may lead to future issues. During a child's early stage of development, they learn important socialization skills that will aid them in interacting effectively with society in the future. These points are leadership qualities that a child learns from their parents in an early stage of life. Recognition that parents give to their child, and the need for safety and safe boundaries which parents give to a child in the form of a home. Every child's needs are required in childhood, but if they miss them for some reason, it will lead to severe issues and mental illnesses in the future, affecting their whole social life (Weinraub and Wolf, 1983).

Communication grace and clash-resolving schemes involve phases such as assertiveness, evasion, resourcefulness, hostility, or similarity, practised by partners. Communication difficulties are most often caused by imprecise understandings of the companion's behaviour, mostly related to feelings of danger, uncertainty, non-acceptance, inadequate recognition, or apparent injustice in the connection and dysfunctional communication among spouses with or without panic disorder/agoraphobia can be influenced by, to a variable degree. Communication can be pretentious by dependence on a partner (problems talking about one's needs, refusing unacceptable needs, having a personal, open discussion), problems with familiarity, over-expressed feelings; or the need to control the partner (sorrow, influence, blaming, fault) (Cohen et al., 2004). Mature communication skills (fear of refusal leads to a lack of appearance of one's needs) (Crnic et al., 1983).

The reputation of understanding partner connections in affected individuals with panic disorder or agoraphobia is reinforced by many research studies that show that interferences are prominent in the development of communication. For example, the removal of communication anticipation expands treatment results as well. On the other hand, except more adaptive communicative patterns grow in a relationship, the consequences of psychotherapy are not fitting on its own (Mitsonis et al., 2009)

Some studies show that, in the marital relationship of an affected individual, both partners are unsatisfied with each other and do not care about the needs of each other. It is because of the affected person's illness, which is not understandable by a non-affected partner. However some research studies from the UK show that Anxiety and panic attacks do not affect an individual, and they remain happy with each other (DuBois et al., 1994).

2.10 Theoretical Framework:

Jerry Fodor, in 1974 gave the theory of ‘’Gender Role Stereotyping in Agoraphobia’’ According to it, sex role vary from culture to culture, and the development of sex role play an important role in the development of agoraphobia. In a specific culture, people expect from the individual belonging to that specific culture. Most women get affected after marriage because the environment suddenly changes for them. The expectations become high for them, and they also expect, but when it does not meet, it causes a certain problem in an individual's life. Further, these social issues become psychological conditions affecting the individual’s social life.

Some stereotypes are attached to women after marriage, and women become helpless, fearful, dependent, and nonassertive. Females also look forward to such a male with extreme male sex roles. According to the theory of Jerry Fodor, if the development of serotype fails in

one or both partners, then the chances of agoraphobia in females become high. According to Fodor, Agoraphobia may be constructed, which extends the sex role stereotype. Interpersonal issues in a family play a significant role in the onset of agoraphobia.

The theory of Maslow's hierarchy proposed in 1943 states that if the needs of an individual are not met on time, then it will cause further problems in social life, such as the basic need for water, food, and shelter, the need for affiliation, self-esteem, security need, and self-actualization. The same is the case with women affected by agoraphobia after marriage. Suppose their needs are not met on time and in-laws neglect them. In that case, it will cause further problems and become a psychological condition of agoraphobia because of anxiety and panic attacks.

The first theory applied to this study is “Gender role stereotyping theory,” which is applied in such a way that in the selected population of the study, certain gender stereotypes are attached to both the sex. From childhood, it is taught to children how you will be perfume in the future in this society. The socialization of the children is carried out through specific cultural and religious norms and values of the society. Expectations are put on an individual. The study of Jerry Fodor and the collected data show that if individuals lack at certain points in their lives and do not fulfill societal norms and values, there is a high chance of getting affected by Agoraphobia. In this society, after marriage, new families expect certain things from the married couple, especially from the bride. If she fails to do whatever her family wants, people start negative talks about her, and she does not bear it. Because of overthinking, certain mental disorders, like Agoraphobia. The same is the case for males. If males do not fulfill society's criteria, he develops Agoraphobia.

Another theory that is applied to this study is Maslow's hierarchy theory of needs. In our society, if an individual thinks of change from others, they are not supported, and people impose many restrictions on them. Because of the pressure of society, individuals get frustrated but do not overcome their frustration and overthink. The basic need is not provided to that individual, like peace of mind and freedom. Because of overthinking and pressure on an individual's mind, they get affected by mental disorders such as Agoraphobia.

Chapter 3

Methodology

In the previous chapter, a review of relevant literature was conducted and presented. The current chapter summarizes the methodological steps and processes adopted in this research study. The method of the study is based on a qualitative research design in nature, in which I collected the data in the form of non-numeric data, and data collected is about the behaviour, thinking, social patterns, and experiences of the individual and personality attributes of individuals. It is the inquiry within a naturalistic setting. Data is purely primary. I chose the qualitative research technique because of my interest in this topic and the expertise of my supervisor.

Moreover, this chapter explains about research design, population of the study, sampling and sample size, tools and methods of data collection, data analysis, ethical consideration, and field experience.

3.1 Research Design:

The design of the present study was purely qualitative. The qualitative research method is suitable for the topic because, in the present research topic, I explored how a person's social life is affected by a psychological disorder such as Agoraphobia and how their lives get changed. The data extracted from the Qualitative research method can give a detailed explanation of every aspect of the topic, so it is a valid technique and suits more with the topic (Ravitch & Carl, 2016).

3.2 Population of the Study:

Initially, I decided to collect data from Mardan Medical Complex (MMC), the largest hospital in the district of Mardan. However, when I went to the field, I faced certain problems regarding data collection because the patients affected by Agoraphobia were rare cases, and mostly these patients do not go outside from home to check themselves in the hospital due to severe irrational fear. Then after this situation, I decided to widen the range of my population, so I added three more government and largest hospitals in Pakistan. I did seven interviews from Mardan Medical Complex (MMC), five interviews from Hayatabad Medical Complex (HMC), which is situated in Peshawar, three interviews from Pakistan Institute of Medical Sciences (PIMS), which is located in sector G8 of the capital territory Islamabad, and five interviews from Benazir Bhutto hospital located at Chandni chowk, Murree Road, Rawalpindi. A screening test was developed to identify the individuals affected by Agoraphobia. Some data are also collected on a reference basis from different villages of Mardan city. After deciding on the population, the respondents were interviewed in-depth through an interview guide. Thematic analysis technique was used after data collection to analyze data.

3.3 Sampling and Sample Size:

In research, two main types of sampling techniques are used, which are probability sampling technique and non-probability sampling technique. In qualitative research, different methods of non-probability sampling techniques are used for selecting sample size (Bird, 2009). I used two different techniques of sampling in this research study. One is the purposive sampling technique in which I interviewed only those who meet my research's purpose. I selected those individuals with the help of a screening test and different doctors' help. In my research, I utilized

the snowball sampling technique to determine the appropriate sample size because this kind of data is very rare and cannot be collected easily, so I used the reference of different people to approach such patients and then went to their homes to interview them. In qualitative research, a researcher stops data collection when they get the saturation point, so initially, I did not select the sample size of my research, but I collected 21 interviews. I acquired the saturation point; hence the sample size becomes 21.

3.4 Tools and Methods of Data Collection:

3.4.1 Tools of Data Collection:

For the collection of data, the interview guide was formulated. The interview guide had 36 questions that completely covered all aspects of the life of an affected individual. There were five sections of the interview guide which were (i) general characteristics of the respondent, (ii) effects on the social life of an Agoraphobic individual, (iii) changes in personality due to Agoraphobia, (iv)How family life suffered due to Agoraphobia and the last one was (v) coping strategies. Mock interviews were conducted to test the tool, which helped me take interviews and add probing questions to understand the respondent's condition. (see Appendix)

3.4.2 Method of Data Collection:

I found the process of collecting data to be quite challenging due to the scarcity of patients at the hospital and the different rules, regulations, and cultures of hospitals. A formal permission letter was taken from the Department of Humanities and Social Sciences, Bahria University Islamabad, for data collection. In the beginning, I approached the heads of psychiatry departments of the selected hospitals. Initially, I introduced myself to them and showed them a

permission letter from the university side. Then they allowed me to sit in OPD to observe patients and select specific patients based on my purpose. For 3 to 4 months, I continuously visited these selected hospitals for data collection. When I got Agoraphobic patients, I formally took their consent to give me an interview and talk to me. I considered all the ethics in data collection. The data were collected in face-to-face, in-depth interviews, mostly in the hospitals and also at the homes of the respondents. I recorded some of the interviews with the respondents' consent. Some of the respondents declined to have their voices recorded, so I omitted those recordings, but I was taking notes continuously when they were speaking. Throughout the data collection process, I kept the different characteristics of qualitative research in mind, such as trustworthiness, self-control, the capability to know the respondents' sentiments, escape preconceptions, maturity, accuracy, and carefulness (Bian, 1997). Data were collected continuously from March 2023 to May 2023.

3.5 Data Analysis:

I utilized the thematic analysis technique to analyze the data. All the major six steps of thematic data analysis were utilized, such as becoming familiar with data, Generating initial codes, searching for themes, reviewing themes, defining themes, and writing up. The thematic analysis technique is important and helps develop and identify qualitative data themes. This technique is proposed by Braun and Clarke (2006) to identify important themes in the study, and with the help of these themes, the person can easily analyze data. After reading the data carefully, I highlighted the important points repeated in the data. After completing my data collection, I transcribed all the data word by word in MS Word. When I completed the transcription phase, I arranged the data into rows and columns and made a complete table to understand and read the data easily. I carefully reviewed my data multiple times and used the

thematic analysis technique to extract themes from it. Then I labelled the parts of data with descriptive tags, which is coding. I used MS Word and used a highlighter to highlight similar data. After highlighting the common data, I collected similar codes for a theme. This way, I found similarities and differences in data and interesting facts related to my topic. In this process, I found the key ingredients of my research for each theme. I handled everything manually using MS Word since I don't possess any software to automatically analyze qualitative data.

3.6 Ethical Consideration:

During the process of collecting data, I prioritized ethical considerations for the research. I took measures to ensure the privacy and confidentiality of the respondents. Before beginning the interview, I requested their permission to proceed with the interview. The interview guide was designed so that the respondent felt comfortable and free to give the answers. The survey did not include certain questions, which caused the respondents to feel upset. Throughout the data collection process, I made sure to prioritize the comfort zone of the patients. I assured them that my data would be confidential and would use it for research. A few respondents did not answer the questions accurately as they claimed not to comprehend them, while some terminated the interview midway due to pressing engagements.

3.7 Field Experience:

Working as a clinical psychologist made me develop a rapport with different people. It strengthened my sense of observation. My experience made me a good listener and observer. My memory has also been enhanced because of the practice with patients and remembering their stories. This fieldwork was a new experience in my life, which is itself a story. All the heads of

departments of the psychiatry department of hospitals were very active and conscious about the sensitivity of the patients, so initially, they were reluctant to permit me to take data, but once I assured them that I would take care of the patients' sentiments. I will take consent from the patients if patients decline to participate in an interview. I will not put pressure on them. It's important to ensure their satisfaction and allow them to voluntarily provide data by ensuring them to do so they were satisfied and allowed me to conduct interviews.

Another difficult task was to find out the patients affected by Agoraphobia. After going to the field, I discovered this is a very rare case, and patients with Agoraphobia are reluctant to go to the hospital. According to the head of the department of Benazir Bhutto Hospital, only one or two patients were diagnosed as Agoraphobic in three months. I was disappointed after listening to it. Some friends suggested that I should change my topic, but I committed myself to follow through and find the patients. Following that, I expanded the size of my population, and through persistent effort and the encouragement of my supervisor throughout the data collection process, I completed it.

I obtained formal permission from the hospital to begin collecting data. Initially, I observed the flow of patients from the OPD. During this time, I acted as a silent observer in the field. Later on, I consulted with some psychologists who were interning at the hospital. They aided me in identifying specific patients. Following that, I began conducting formal interviews with patients. During my data collection process, I prioritized the confidentiality, sensitivity, and privacy of the participants. I established a strong connection with the participants in my thesis research, as they trusted me and willingly provided me with all the pertinent information. Through my fieldwork, I came to understand the importance of effective communication and a positive demeanour, which facilitated the collection of valuable data from the respondents.

Collecting data for my thesis was a time-consuming process, as the information I needed was scarce in hospitals. To gather the necessary data, I relied on referrals from my psychologist friends who work in various psychological settings and rehabilitation centers in Mardan, Peshawar, Rawalpindi, and Islamabad. I received assistance in approaching these patients. They provided me with their contact information, which I used to visit them and gather data. This method also enabled me to obtain relevant data.

I gathered all the data, conducted interviews, captured images, and recorded conversations by myself. As a result, the data collection process takes longer. Interviews typically ranged from twenty minutes to an hour, with some lasting even longer. As a clinical psychologist with experience in a clinic and recent fieldwork, I was able to empathize with patients and gather valuable data from their perspectives. As a psychologist at a clinic, I have developed a probing technique for gathering case histories from patients. I tailored my approach based on the education level of each respondent, asking questions in English for those who were educated and in Urdu or Pushto for those who were not. This experience has given me confidence in my ability to communicate effectively with a variety of individuals. Overall my field experience was very good. The hospital from Peshawar welcomed me warmly and helped me a lot during data collection at every stage. Some doctors shared their contacts with me to help me further, which was the best and a novel experience of my life.

Chapter Four:
Analysis and Discussion

The previous chapter was about the study's methodology, tools, and techniques used in the study, the data collection process with explanation, population and sample size, ethical considerations, and many more about the methodology. The main purpose of the study was to find out the social implications of Agoraphobia through different aspects of life by asking different questions like their social, family, and occupational life and also regarding their personality changes due to this disorder. Thus this chapter presents the overall review of the lives of Agoraphobic individuals and their lived experiences. The data collected illustrates how Agoraphobia impacts an individual's social life and other aspects, as well as the experiences of those affected by this condition. Respondents were asked various questions regarding their experiences with Agoraphobia and how it has impacted their lives. To ensure validity, the theories applied to the study and its data are "Gender Role Stereotyping in Agoraphobia," given by Jerry Fodor in 1974, and "The Theory of Maslow Hierarchy" by Abraham Maslow.

The findings of the study are discussed under the four significant themes, which are given below:

4.1 Effects on the social lives of Agoraphobics

4.2 Changes in the Personality of Agoraphobics

4.3 How the Family Life of Agoraphobic gets suffered

4.4 Coping Strategies Used by Agoraphobics

Table 4.1

Socioeconomic and Demographic Profile of the Respondents:

Sr.No	Pseudonyms	Age	Gender	Birthplace	Monthly income	Monthly expenditure	Level of qualification	Marital status	Occupation
1	Saima	33	F	Mardan	50,000	45,000	10	Married	Housewife
2	Noor ul Ain	41	M	Rawalpindi	varied	varied	10	married	plumber
3	Khalida	44	F	Charsadda	45,000	More then 45,000	illiterate	Widow	Maid at hospital
4	Laal Pari	61	F	Katlang	10K given by the son	10k	illiterate	Widow	housewife
5	Naila	36	F	Takht-bhai	Nil	Brother can handle	8	single	homemaker
6	Kiran	30	F	Sawabi	8 lac	7 lac	16	Married	student
7	Sabeeha	28	F	Dargai Malakand	120,000	80,000	16	single	student
8	Palwasha	28	F	Peshawar	2 lac	1.7 lac	12	married	housewife
9	Kalsoom	55	F	Punjab	3 lac	2.5 lac	10	married	housewife
10	Jahangir Khan	28	M	Mardan	50k	40k	18	single	Accounts officer
11	Majid	35	M	Islamabad	50k	40k	16	married	teacher
12	sameera	26	F	Islamabad	50k	varies	16	single	student
13	Zubaida	36	F	Mardan	60k	55k	16	married	Finance officer

14	Sanan tahir	32	M	Mardan	50k	45k	16	single	Cash officer
15	shaukat	32	M	Islamabad	50k	35k	16	married	businessman
16	Ali	29	M	Islamabad	35k	varies	16	single	Visa consultant
17	saba	32	F	Islamabad	60k	varies	16	married	student
18	Fatima	20	F	Islamabad	N/A	N/A	12	single	student
19	Shabana	35	F	Mardan	45k	varies	16	married	teacher
20	Mumtaz	36	M	Haripur	55k	varies	16	single	Nurse
21	Ihsan	28	M	Islamabad	25k	varies	12	single	Office boy

The socioeconomic and demographic profile of the respondents plays an important role in the analysis and understanding of the data. Eight different socioeconomic and demographic variables are used in the current study, "Socio-Cultral Implications of Agoraphobia: An Evidence from Khyber Pukhtunkhwa, Pakistan." Table number 4.1 explains the socioeconomic and demographic status of the 21 respondents, which contains their name, age, gender, place of birth, monthly income, monthly expenditure, level of qualification, occupation, and marital status. Moreover, I have recognized and characterized overhead stated socioeconomic and demographic variables of my respondents into numerous distinct tables demonstrating frequency distribution to understand and explain background variables concerning the data collected from the Agoraphobic individuals representing several age groups.

Table 4.2

Age of the Respondents:

Sr.no	Age	Frequency	Percentage
i.	20-25	1	4.7
ii.	26-30	7	33
iii.	31-35	6	28.4
iv.	36-40	3	14
v.	41-45	2	9.5
vi.	46-50	0	0
vii.	51-60	1	4.7
viii.	61-70	1	4.7
	Total	21	100

Source: Socioeconomic and Demographic Profile of the Respondents

Age is a significant demographic variable. In my research, I discovered that Agoraphobia impacts the lives of survey participants of various ages in distinct ways. Younger respondents are affected differently than older respondents because their experience, exposure to stimuli, responsibilities, and family structure are different. In the above table, 4.2 ages of the respondents are divided into eight groups which have five years of intervals. It demonstrates that the least age limit of my respondent was 20 years, whereas the maximum age limit of my respondent was noted as 61 years. Data shows that patients' strength is high in the age range from 26-30 and has the highest percentage, 28.5.

Table 4.3

Educational Level of the Respondents:

Sr.no	Education	Frequency	Percentage
i.	Illiterate	2	9.5
ii.	Under Matric	1	4.7
iii.	Matriculation	3	14.6
iv.	Intermediate	2	9.5
v.	Graduation	12	57
vi.	Masters	1	4.7
	Total	21	100

Source: Socioeconomic and Demographic Profile of the Respondents

Table 4.3 shows the respondent's educational level, which I categorized into groups based on collected data like illiterate, under matric, matriculation, intermediate, graduation, and master. According to the data, most patients are graduated and have 16 years of education. Graduated individuals have the highest percentage of 57. Education is an important key to data analysis because there is a huge difference between the perception of educated and illiterate people, and they see things differently. Furthermore, their social lives become affected differently because of Agoraphobia.

Table 4.4

Marital Status of the Respondents:

Sr.no	Marital status	frequency	Percentage
i.	Single	9	42.8
ii.	Married	10	47.7
iii.	Widowed	2	9.5
	Total	21	100

Source: Socioeconomic and Demographic Profile of the Respondents

Table 4.4 shows the marital status of the respondents. Of twenty-one respondents, ten were married, with a high percentage of 47.6. Two women were widowed with a percentage of 9.5, and the remaining 42.8 percent were single. I categorize the data on marital status into three categories: single, married, and widowed. Marriage is an important part of life that completely changes an individual's lifestyle according to the norms of patrilineal society. When women get married, they typically leave their parents' homes and move into their husband's home. This migration can have a significant impact on their lives.

Table 4.5

Occupation of the Respondents:

Sr.no	Occupation	Frequency	Percentage
i.	Student	5	23.8
ii.	Housewives	5	23.8
iii.	Officers	4	19.1
iv.	Nurse	2	9.5
v.	Labour	2	9.6
vi.	Businessman	1	4.7
vii.	Teacher	2	9.5
	Total	21	100

Source: Socioeconomic and Demographic Profile of the Respondents

Table 4.5 explains the occupations of the respondents. All respondents have different occupations (Agoraphobic individuals), that included students, homemakers, officers in different organizations, teachers, people in business, nurses, and labours. 23.8 percent of my respondents were students, 28.3 percent were housewives, 19.1 percent were officers, 9.5 percent were nurses, 9.6 percent were labourers, 4.7 percent were businessmen, and 9.5 percent were teachers.

Table 4.6

Gender of the Respondents:

Sr.no	Gender	Frequency	Percentage
i.	Male	7	33.3
ii.	Female	14	66.7
	Total	21	100

Source: Socioeconomic and Demographic Profile of the Respondents

Table 4.6 shows the gender of the respondents. It was important to find the percentage of males and females in this study because, previous studies showed that, females become more affected due to agoraphobia as compared to males (Kanwar, 2020; Pual et al., 2023 and Heiat et al., 2021). Hence it is proven from the collected data that most of the study's respondents were female and were 66.6 percent, while the number of males was seven out of twenty-one.

4.1 Effects on the Social Lives of Agoraphobics

Any disorder, disease, illness, or sickness disturbs an individual's social life badly. Agoraphobia is a mental disorder that badly affects an individual's life and targets all aspects of an individual's life (Goldstein and Chambless, 1978). Thirteen questions were asked of respondents about the effects on their social lives due to Agoraphobia. Due to this disorder, a person might be unable to perform social activities, attend social gatherings, and go outdoor activities. They have a cluster of abnormal thoughts and behaviour (Choi et al., 2005). One of my respondents responded, *"Whenever I am in a closed room, I feel that the walls of the room are coming towards me and my side. And the walls are above my chest. Whenever I go outside from*

home, I feel that this thing will happen to me and there will be no one to help me out from this condition, and I will die. And after me, what will happen to my children? Who will take care of them? Such type of ideas comes to my mind every time." (Personal communication in Hospital A, 15-3-2023). Personal communication means that it is the conversation between the researcher and respondent only in a hospital. A, B, C, and D showed different hospitals (see List of Codes). The numbers after that showed the specific date on which the interview was conducted (Aziz et al., 2020).

Another respondent shared a similar response regarding the enclosed space. (Public transport) *"Once, while travelling in a taxi, I encountered a problem where the door mirror was closed, and I couldn't seem to open it. I held the hand of the driver to help me out in this situation."* (Personal communication in Hospital B, 20-3-2023).

Agoraphobia, a mental disorder that affects an individual's social life, also has physical impacts and different symptoms on an individual (Carter et al., 1995). It has been proven from the feedback I got from my respondents. One of the individuals I surveyed replied., "*Yeah, I feel that my heart is getting outside of my body, but when someone puts a hand on my heart, they feel it is normal. But sometimes I think it is a disease of the stomach or kidneys. But in such conditions, my color becomes yellow, like the egg yolk. I have been clenching my teeth lately, and it's causing some discomfort."*.(Personal communication in Hospital A, 23-3-2023).

A similar response was also given by another respondent which is *"Once upon a time, I was on the way home from someone's death, and I told the conductor of the flying coach that you could not set someone in the back seat from me, so he said that if I paid for all these seats so I will not set anyone. After some time flying coach stopped and picked up two persons more, and*

at that time, I became out of my mind, and I felt that my breath was stopping. I told the conductor to stop the vehicle; otherwise, I would jump". (Personal communication in Hospital A, 3-3-2023).

Agoraphobic individuals also become faint and feel shaky during panic attacks. They have trouble breathing, their heart rate increases, and their body begins to experience intense sweating (Magee, 1999). Explaining this, one of my respondents said, "*Yes, I feel faint, and my body starts shaking. I also have trouble breathing, and my heart rate increases because of my severe fear of different situations. And a very weird sound and a severe headache start in my head during such a situation". After a panic attack for up to 24 hours, I feel severe pain in my feet and hands.* (Personal communication in Hospital C, 2-4-2023).

Agoraphobic individuals are afraid of crowded areas (Onuh, 2019). Data shows that they mostly avoid crowded areas. If they face such a place, then they feel severe fear. One of my respondents explained this by saying, "*First of all, I do not visit crowded areas, and I avoid such places, but if I face such conditions unwantedly, then I try to escape from such situations, and I try to go outside of the crowd to safe place."* (Personal communication in Hospital A, 12-4-2023).

Traffic jam is a fearful stimulus for Agoraphobic individuals (Hoffart, 1995). The response of one of my respondents about traffic jams is, "*It's a big problem for me to face traffic jams. On 14 August, I became the victim of a severe panic attack because of traffic jams and extreme noise"*. (Personal communication in Hospital A, 15-4-2023).

An agoraphobic individual tries to escape traveling alone and far away from home. They prefer such places with which they are familiar. They try to avoid visiting such places, which is

new for them (Rachman, 1984). One respondent answered, "*I can travel alone easily to the places I have been before. I can travel to my home village, Peshawar, but if I'm going alone to a place I have never been before, I have slight panic attacks, and just thinking it activates my hyperventilation"*. (Personal communication in Hospital D, 25-4-2023).

There is no specific age for the onset of agoraphobia. It may develop in childhood, early adulthood, and adulthood, usually before the age of 36 but can also affect individuals in older age (Stech et al., 2020). One of my respondents responds about the onset of her agoraphobia which is *"Before my illness, there were also problems, such as my husband's death at a young age. After that, the head surgery my son happened soon, and when he became young, he became addicted and died at the age of 22 so there were a lot of problems at that time. I was also busy solving my problems, and the same is true now. I am the only breadwinner of my family because of this. I am very stressed. Because of all these situations, my illness has become more severe".* (Personal communication in Hospital C, 5-4-2023).

The activities of affected individuals changed after mental disorders, which changed their whole social lives. An agoraphobic individual tries to manage and adjust to the environment subsequently for this purpose individuals change their activities and follow the steps that are best suitable for them (Ebenfeld et al., 2020). One of my respondents explained his activities to me: "*Before my illness, I engaged in a wide range of activities such as socializing with friends, exploring new places, and participating in outdoor hobbies. After the onset of my illness, I have had to make adjustments and prioritize activities that align with my comfort level and manage my Agoraphobia".* (Personal communication in Hospital C, 7-4-2023). It proves that Agoraphobia badly affects an individual's activities and completely changes them. It affects an individual's social life badly and makes them dependent on others for all outdoor activities.

Many of my respondents were from the business side or a job with outdoor activities. Individuals with this disorder experience disruptions in their entire lifestyle, which can also impact their income. Due to agoraphobia, their financial status may decrease. (Mavissakalian and Hamann, 1987). Questions related to suicidal ideation and thoughts were also asked of respondents. Most of the individuals respond that they do not have such thoughts and that it is forbidden and sinful in our religion Islam and we are afraid of Allah.

Based on the feedback from my survey participants and previous data, it is concluded that Agoraphobia affects an individual's life badly in all aspects of life. Individuals become dependent on all their activities. An agoraphobic individual feels fear of facing the external world. It affects the occupational life of an individual in such a way that they cannot go far away from their comfort zone for official activities like meetings etc. They cannot face crowds because of the severe fear of being stuck and have the same feelings in closed places like elevators. These stimuli, in combination, disturb the whole life of an individual.

4.2 Changes in the Personality of Agoraphobics

Based on previous studies and collected data, it has been observed that Agoraphobia can cause changes in the personality traits of individuals who experience it. Six different questions were asked of respondents about their personalities. Overall collected data shows that the personalities of most individuals become introverted extroverts or Ambivert (Mavissakalian, 1990).

Data indicates that individuals with this disorder may experience a reduction in their social circle. This is because they may withdraw from outdoor activities and social gatherings, leading to a breakdown in their connections with friends and, ultimately, the loss of those

friendships (Furnham, 1995). One of the people I surveyed responded, "*At times, my illness may contribute to feelings of isolation or being alone. Agoraphobia can limit my ability to participate in certain social activities or engage in spontaneous outings, which may result in occasional feelings of loneliness"* (Personal communication in Hospital C, 19-4-2023).

One of my survey respondents provided the following similar response on this matter, "*Before my illness, I used to engage in various activities such as socializing, exploring new places, and pursuing hobbies. However, since developing Agoraphobia, my activities have become more limited, and I focus more on managing my condition and seeking treatment. Agoraphobia has had some effects on my occupational life. It can be challenging to attend work-related events or travel for business purposes. However, I strive to communicate my needs to my employer and find alternative ways to contribute effectively"* (Personal communication in Hospital A, 15-4-2023).

Based on the data, it appears that individuals who suffer from Agoraphobia had different personalities before the onset of the disorder (Silverman and Moreno, 2005). They were outgoing and enjoyed spending time with their loved ones, engaging in outdoor activities and social events such as dinners and parties. However, after developing Agoraphobia, their preferences, and behaviour drastically changed. They became limited to their comfort zone and preferred to only spend time with their closest family and friends. One individual responded, "*I have mixed feelings about parties and dining out. While I enjoy socializing, the prospect of crowded or unfamiliar places can trigger anxiety. I may prefer smaller gatherings or familiar venues"* (Personal communication in Hospital A, 17-4-2023). They have a confused personality and are unsure about their decisions and feelings.

The lives of affected individuals change as well as disturb them to such an extent that, they beat themselves and start shouting at the time of panic attacks due to which they cause harm to themselves as well as upset their families mentally (Freeman, 1998). One of my respondents responded, *"Yes, my family and personal life were disturbed due to my illness because I created issues with small things and beat myself and screamed, which disturbed my family. At that time, I didn't feel that what I was doing, but after some time, I felt it was not good".* (Personal communication in Hospital D, 1-4-2023).

Individuals' hobbies may become limited to their comfort zone. They tend to engage only in activities that are easy for them to do within their comfort zone (Foa et al., 1984). A respondent replied., "*I engage in hobbies that can be enjoyed within the comfort of my home. That may include reading, painting, listening to music, or pursuing creative activities. During my free time, I prioritize self-care, relaxation, and engaging in activities that bring me joy and peace"* (Personal communication in Hospital D, 11-4-2023).

Due to the changes in the sleeping pattern of individuals due to Agoraphobia, individuals become grumpy from a cool personality (Brown et al., 2011). One of my respondents responded, "*My sleeping patterns can vary, but I generally aim for a consistent sleep routine. If the light is switched off at night, I may experience discomfort or anxiety due to a fear of the dark. Using a nightlight or having a dim light source can help alleviate these concerns"* (Personal communication in Hospital C, 26-4-2023).

4.3 How the Family Life of Agoraphobic gets suffered

The main problems come in the family and social lives of affected individuals because of this disorder. Due to the negative effects on Agoraphobic individuals, their families also become affected. Five different questions were asked of each individual regarding their affected social life and its effects on their families (Choi et al., 2005).

Families often face various issues and challenges due to negative behaviour exhibited by their ill loved ones. Failure to compromise with the patient only worsens their condition and makes their social life even more challenging (Beck, 2011). Based on the data collected, respondents provided different explanations regarding their families' attitudes toward their illnesses. Here are some of the responses gathered from the data. "*My family also becomes afraid when I get panicky. They prayed for me then and tried to relax me, but sometimes my husband got angry with me during my panic attacks and my worries about the kids. They also sometimes take me to the hospital when I tell them about my condition. Most of the time, I do not share and keep quiet"* (Personal communication in Hospital A, 22-4-2023).

Collected data showed that most of the respondents are neglected by their families at the time of panic attacks and families do not understand the situation of the affected individual (Butler et al., 2006). One of my respondents responded, *"My family does not understand me. They think I am acting crazy".* (Personal communication in Hospital A, 21-4-2023*). "Family support and understanding are crucial when dealing with agoraphobia. My family plays a significant role in providing emotional support and encouragement and helping me navigate daily challenges associated with the illness. Their thoughts about my situation may vary, but overall, they recognize the impact of agoraphobia on my life and work together to find ways to support my well-being"*. (Personal communication in Hospital A, 23-4-2023)

Psychological problems cannot be understood easily by a common person, and it is difficult to understand, so different families respond differently to disorders. There are also some myths in every society; through those myths, family treats and deals with the affected individuals (Linehan, 1987). Some uneducated families do not consult with a doctor or any other professional individual and take the patient to a religious practitioner or someone of their trust to treat the individual. And in all these situations, the affected individual's condition worsens (Edwards et al., 2010). *"First of all, everybody was thinking that it is Jinn and she is acting, but now, after visiting the doctor, they understand that she is ill"* (Personal communication in Hospital A,12-3-2023). Another respondent also gave the same response, *"The problem is with me, not with my family, so how will they understand me? And I also never told all of them about my condition and when I got a panic attack"* (Personal communication in Hospital C, 23-3-2023). "*At that time, if they become aware of my situation, then they give me water and talk to me and try to relax me."* (Personal communication in Hospital C, 22-3-2023).

If a family and the people of a closed circle of individual do not understand the individual the condition of the individual gets worse but if the family support the during a panic attack and try to relax the patient then the patient also tries to calm his/her self and participate actively in daily life activities because of the courage and support system of the family (Hollon, 2013). The response of one of my respondents is *"My family is aware of my agoraphobia and understands the signs and symptoms of a panic attack. They respond with patience, support, and reassurance during such times. They may provide a calming presence, offer grounding techniques, or encourage me to practice relaxation exercises until the panic subsides".* (Personal communication in Hospital C, 24-3-2023).

Families often take trips to various places during vacations and weekends, enjoying each other's company and having a good time. Still, Agoraphobic individuals cannot go outside with their families because of severe fear of crowds and other fearful stimuli. Because of these situations, some family trips and tours end up being canceled, making the relationship between the affected individual and the family fragile (Wood et al., 2006). Some respondents shed light on that, "*Celebrating weekends and vacations outside the home can be challenging due to Agoraphobia. While there may be certain limitations on engaging in activities beyond my comfort zone, my family and I strive to find alternative ways to spend quality time together within familiar and comfortable environments, such as organizing indoor activities, movie nights, or pursuing hobbies collectively"* (Personal communication in Hospital C, 22-4-2023). A similar response was given by another respondent, *"Due to my Agoraphobia, celebrating weekends and summer vacations outside the home can be difficult. However, my family and I find alternative ways to spend quality time together, such as planning activities within familiar environments or creating a cozy and enjoyable atmosphere at home"* (Personal communication in Hospital D, 12-5-2023).

Furthermore, because of the effects of disorder on individuals, the family and personal lives of individuals also change (Walkup et al., 2008). Some respondents have provided their responses, "*Yes because now I depend on others for taking different decisions and steps in my life. If I want to go somewhere and need someone from my family to accompany me, I cannot go alone. Furthermore, my family life is also disturbed if my family plans to go outside for dinner. Consequently, I cannot go with them because of my illness and situation. Many of the plans end up being canceled because of me, which can cause some disruption."* (Personal communication in Hospital A, 15-3-2023). One of my respondents responded about the changes in their family

and personal life, *"Yes, Agoraphobia has had a significant impact on both my personal and family life. It has necessitated adjustments and accommodations to ensure my comfort and mental well-being. While it can limit certain activities and opportunities, my family and I have learned to adapt and find alternative ways to support each other and maintain fulfilling relationships"* (Personal communication in Hospital D, 2-4-2023). A similar response was given by another respondent, *"It changed my personal life and personality. Now fear become a part of my personality which remains every time with me. But it cannot affect my family life".* (Personal communication in Hospital D, 3-4-2023). Every family shows different responses to this disorder. Some of the responses of my respondents are, "*At that time, my family gave me water and took me to a safe place and tried to make me calm by talking to me about different things, and they prayed for me*" (Personal communication in Hospital A, 3-32023).

Agoraphobic individuals mostly remain private and do not share their situation with anyone but in some cases, some individuals can share because of the acute level of the disorder (Angle and Thoits, 1987). One of my respondents responded, *"I mostly kept my situation just with myself, but sometimes if they know about my panic attack they give me the courage and try taking me to the doctor. After some time, I improve."* (Personal communication in Hospital D, 15-3-2023). One of my respondents says, *"During a panic attack, my family is understanding and supportive. They know the signs and symptoms and have learned techniques to help me manage and cope. They provide reassurance, create a calm environment, and assist me in implementing relaxation techniques that I have learned to alleviate the intensity of the panic attack"* (Personal communication in Hospital A, 1-3-2023).

It is concluded from the above discussion that if an individual's family is supportive and takes care of the affected individuals and their feelings, then the coping power of the patient

increases, and the patient tries to stay positive. But if families deal with the patient negatively and apply different cultural stigmas on the individual and do not try to understand the condition and feelings of an individual, their condition deteriorates.

4.4 Coping Strategies Used by Agoraphobics

Collected data shows that affected individuals use different coping strategies to face and cope with fearful stimuli. Some individuals use religious practices to cope with the disorder, like prayer, etc, while others go to a doctor, and some patients take help from an individual of their trust or close family members (Benedict and Jacks, 1954). Some responses are, "*Sometimes I take medicine which the doctor prescribed to me, and I start praying Ayat-ul-Qursi"* (Personal communication in Hospital A, 2-3-2023).

Collected data showed that some of the affected individuals can take medicine without any problem while many agoraphobic individuals face issues when they take medicine. Here are some responses of affected individuals, *"I cannot use medicine because due to medicine, all negative thoughts fix in me, but simply sometimes I use laxitunel to avoid all thoughts and to sleep. After that, I also remember these anxious things, but they stop disturbing me for some time. A psychologist suggests deep breathing and walking, so I do it at home".* (Personal communication in Hospital B, 07-3-2023). The response of another respondent is, *"I am taking medicines prescribed by doctor Mehboob currently, and I am using the strategy of deep breathing and exercise also.* Individuals try different methods and techniques to cope with stressful situations such as, *"By praying and changing my mind and thinking about good things"* (Hospital A, 2-3-2023)." *I think positive and try to avoid all negative things"* (Personal communication in Hospital B, 9-3-2023).

Some individuals cannot speak about their issues with someone and have the fear in their mind that others will make fun of them. They do not talk clearly about their issues, which worsen with time (Langdon and Wiik, 2010). Some of the responses of my respondents are, *"Mostly, I do not talk and share about my panic attack with anyone, and neither have I taken help from someone. I kept it just to myself*" (Personal communication in Hospital A, 2-3-2023). "*I don't talk clearly with other people regarding my illness because I think they would make fun of me"* (Personal communication in Hospital A, 2-3-2023). "*No, I cannot do so because I think people will laugh at me. In these situations, my teeth tend to get stuck as well. I visited a doctor for this in our village; he was not taking me seriously and laughed at me. After that, my condition becomes worse"* (Personal communication in Hospital B, 9-3-2023). Some similar responses from respondents are, *"I do not talk to people about my illness as I believe that revealing it won't make things easier for me because, in our society, people either make fun of such situations or don't believe them. So I feel hesitation and avoid sharing"* (Personal communication in Hospital C, 7-3-2023). The average time an individual takes to become normal again is 15-20 minutes. Most of the individuals give similar answers regarding the time back to normal. "*At least it takes 15 to 20 minutes to relax"* (Personal communication in Hospital C, 7-3-2023).

It is concluded from this chapter that Agoraphobia adversely affects the social, occupational, family and personal lives of individuals, it also changes the personality patterns of individual, an individual cannot spend a happy and healthy life when agoraphobia affect him/her and become dependent on others for many daily life activities. An individual cannot leave his/her comfort zone which affects his/her occupational life and a person becomes financially unstable because he/she cannot give quality time to his/her job or business. Family life also gets disturbed

because of a similar issue, a person cannot attend family functions, cannot go outside with family for dinner or to spend time outside because of the fear of crowds and to stuck in a closed place.

Chapter Five
Summary of the Findings, Discussion and Conclusion

This study was an attempt to find out the Social Implications of Agoraphobia and how Agoraphobia affects the social lives of individuals and their families as a whole. Initially, the study population was limited to KP. However, after realizing that this was an uncommon case, I expanded the population over time. The study was further interested in finding out the changes in the social life of a person affected by agoraphobia, The complications faced by the family of an affected person during the period of illness, and the relationship fluctuations between pre and post-disorder. This study aimed to identify the primary challenges experienced by individuals with Agoraphobia in their social lives and the impact on their personalities, personal lives, and families. The study's outcomes support many of the prior studies such as those (Dijkman et al., 1993; Benson and Dundis, 2003; Segrott, 2004; Holmes, 2006; Davidson, 2000; Jacob et al., 1992; Kendler et al., 1992 and Ballardie et al., 1993) cited in the literature review. The study results revealed that most people in Pakistani society do not understand and are not aware of mental health issues, so they do not consider mental illnesses. It makes the survival of affected individuals harder. Results of the data show us that affected individuals face many hurdles in their social lives, such as they cannot spending a night out from home, Their occupational lives being impacted, and clashes between the family and the affected individual occurring when the affected individual refuses to go with family for dinner, to celebrate vacations and weekends outside of the home, they do not leave their comfort zone, and it becomes their weakness.

Furthermore, the occupational lives of affected individuals are also disturbed because they cannot work when there is a huge client flow in the office, they cannot attend business meetings outside of the city, their activities become limited to their comfort zone, and they become dependent on others for their decisions and many more things. Individuals become

bound to their comfort zone, and because of this boundedness, Agoraphobic individuals often experience a loss of social connections, leading to a smaller and more limited circle of friends. It becomes hard for individuals to attend family functions, so they skip them, which causes many problems for them. The personality pattern of an individual also changes. Results show that many Agoraphobic individuals, before becoming Agoraphobic have extroverted personalities. However, when individuals are faced with challenges or difficulties, they often retreat to their comfort zone, leading to introverted behaviours and limitations in their personalities. Without treatment and counselling, it becomes difficult for an individual to face situations which is fearful for them and to survive.

5.1 Limitations of the Study:

Most of the Agoraphobic individuals who have severe issues and are at a severe stage of the disorder cannot visit the hospital because of the fear of going outside so most of the cases do not go to the hospital, so I was a big challenge to find out the affected individuals and collect data. Due to limited resources, time, and rare cases, the data is collected only from twenty-one individuals. The study could have more advantageous outcomes if the sample were huge. It was hard to visit affected individuals' homes, but I faced all these hurdles and completed the data collection stage. I collected data from four hospitals in Rawalpindi, Islamabad, Peshawar, and Mardan. It was a huge problem to cover all the hospitals quickly. Time management was a big problem.

5.2 Recommendations:

The first and most important recommendation of the study is to arrange mental health seminars for the common people in society and tell them about the common mental health disorders which are found in society and also give them lectures through videos and pictures on how these disorders affect the social lives of individuals and how individuals react in these situations. Society needs to learn how to care for those who are affected, how to control the individual during a panic attack and understand the feelings of an affected individual. Group therapies are important for patients who can cope with these situations and help them to try to understand how to live healthy lives with this disorder and remain calm during panic attacks.

Furthermore, in our society, psychologists and mental health practitioners are scarce. Firstly people do not understand their problems, but if they understand their problems, there is no one to understand and support them. People in this society call different names to individuals when they visit a psychologist, psychiatrist, or mental health practitioner. Awareness is important to develop in this society.

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Appendix
Bahria University Islamabad Campus
Department of Humanities and Social Science

Research topic:

Socio-Cultural Implications of Agoraphobia: An Evidence from Khyber Pukhtunkhwa, Pakistan.

Interview Guide

Section A: General Characteristics of the Respondent.

1. Age of the respondent (In years) _____
2. Gender _____
3. Place of birth _____
4. Monthly income _____
5. Monthly expenditure_____
6. Level of qualification _____
7. Marital status of the respondent _____

Section B: Effects on the social life of Agoraphobic Individual

Please explain your stance/response regarding the followings:

Situation: Thoughts, behavior, and feelings you may have in the following situations:

   a. Crowd
   b. Public Transport
   c. Public Places
   d. Traveling Alone
   e. Away from Home
   f. Spending a Night Out
   g. Open and Closed Places

8. Do you feel sudden fear or frightened in these situations, and what is your response?
9. How do you feel anxious, worried, or nervous in these situations?

10. Have you thought about panic attacks, uncomfortable physical sensations, or getting lost in fear in these situations? Please explain.
11. Please explain whether you feel faint or shaky, have trouble breathing, have a faster heartbeat, and sweat from your body in these situations.
12. How do you feel when you see a crowded area?
13. How do you feel when you are alone in a closed area?
14. Do you feel comfortable using public transport?
15. What is your response to traffic jams?
16. Explain your feelings about rain and fog.
17. How far can you travel alone from home?
18. Tell me about your activities before illness and after illness.
19. Do you have any effects on your occupational life?
20. Do you have suicidal ideation or thoughts about suicide?

Section C: Changes in Personality Due to Agoraphobia

21. Do you think you can avoid such situations?
22. Are you feeling alone because of your illness?
23. Tell me something about your sleeping patterns, and what if a light is switched off at night?
24. Do you like parties and having dinner outside?
25. How many friends do you have, and what is your attachment to them?
26. Tell me something about your hobbies and what you do when you are at home and you have free time.

Section D: How Family Life Gets Suffered Due to Agoraphobia

27. How your family deals with you, and what are their thoughts about your situation and illness?
28. Do you celebrate weekends and summer vacations with your family outside your home?
29. Do you think this illness altered your personal and family life?
30. What is the response of your family at the time of your panic attack?
31. Does your family face any financial problems due to your illness?

Section E: Coping Strategies

32. What strategy or medicine do you use to cope with these situations?

33. How do you control yourself at the time of a panic attack?
34. From whom do you take help at that time, and how?
35. How much time does it take for you to relax after these situations?
36. Do you talk to the people at that time about your illness without hesitation?

******************Thank You For Your Time******************