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RESEARCH PAPERS

The Distinctiveness of Phobias: A Discriminant Analysis of Fears

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Abstract — The distinctiveness of the fear profiles of three types of phobia was examined. Responses of 80 agoraphobics, 25 social phobics, and 35 specific phobics to Wolpe's Fear Survey Schedule were submitted to a discriminant function analysis. Two highly significant functions emerged, reclassifying three types of phobias with an average accuracy rate of fully 97%, almost perfectly matching the diagnosis made independently in a clinical interview. Agora-, social, and specific phobic fear profiles may now be added to age of onset and sex preponderance as distinctive features.

The current subdivision of phobias into agoraphobia, social, and specific phobias dates back to the work of Marks and Gelder (1966) and Marks (1969). Since then, three strands of evidence have provided support for the original subdivision.

The three phobic types have to a great extent a different age of onset and a particular preponderance between the sexes, and run a fairly typical course. Of these, age of onset has the firmest support as a distinctive feature (Barlow, 1988, p. 331).

Fear surveys among phobics have consistently yielded factors corresponding to the original phobic types (Marks, 1987). These were factors of social

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anxiety and interpersonal sensitivity, agoraphobia, fears concerning injury and death, and fears of small animals (Arrindell, 1980; Hallam & Hafner, 1978).

An additional factor outside the original subdivision, that of fears of aggression and nudity, was reported by Arrindell (1980) and Arrindell et al. (1990, 1984). In their samples, a social anxiety factor accounted for the most variance: 22% out of a total of 40% in Arrindell (1980, p. 233), or 11% out of 40% in Arrindell et al. (1984, p. 228). Given that agoraphobics probably constituted the majority in both samples, this suggests that, far from being restricted to social phobia, social anxieties are also present to varying degrees in other phobias. Factor-analytic studies do not simply reveal distinct types of phobias.

There is other evidence of overlap of fears among types of phobias. Among agoraphobics, 24%–33% met the criteria for an additional diagnosis of social phobia (Barlow, 1988, p. 347), while 36% to 52% fulfilled criteria for specific phobia. Conversely, 17% of the social phobics had a second diagnosis of agoraphobia, while 25% had one of specific phobia. Among specific phobics, 29% met diagnostic criteria for social phobia, but none had a secondary diagnosis of agoraphobia.

Increasingly, evidence points to agoraphobia being a distinct entity (see Marks, 1987, pp. 292–295). Its protean features, however, overlap with other phobias and other conditions, and still leave open the question of the distinctiveness of phobic types.

The distinctiveness of types of phobias has also been challenged on theoretical grounds. Both Tyrer (1984) and Sheehan (1983) take an undifferentiated view of anxiety disorders, and conceive of phobias as a variant of “anxiety neurosis” (Tyrer) or “anxiety disease” (Sheehan). Thus, the question of whether types of phobias can be clearly discriminated is timely.

The purpose of this study was to test the hypothesis that phobic types may be distinguished from each other solely on the basis of their fear profile. We attempted to match diagnosis made at a clinical interview with discrimination on the basis of the FSS scale. Rather than limit ourselves to clinically meaningful fears derived from factor-analytic studies (e.g., Fear Questionnaire, Marks & Mathews, 1979), we chose to approach the question phenomenologically by including a much larger range of fears, relevant and not.

METHOD

Subjects in the present study were 140 phobic outpatients referred to IMM's Unit at the Maudsley Hospital from 1985–1990 for two separate clinical trials (Al-Kubaisy et al., 1992; Marks et al., 1993). In the first trial, 78 patients were diagnosed as having agoraphobia, social, or specific phobias on ICD-9 criteria following an assessment interview by an experienced clinician, and the diagnosis was reviewed by IMM. In case of disagreement, a consensus was arrived at through discussion. In the second trial, 66 patients were diagnosed as having agoraphobia plus panic disorder by use of a structured interview — the SCID (Spitzer & Williams, 1983) — given by an experienced psychiatrist; all these cases also qualified for the diagnosis of agoraphobia on ICD-9. Exclusion criteria were: predominating clinical depression, organic disorder, failed systematic exposure treatment in the previous year, consumption of more than two units of alcohol (the equivalent of two glasses of wine or a pint

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