



THE ETIOLOGY OF ACROPHOBIA AND ITS RELATIONSHIP TO SEVERITY AND INDIVIDUAL RESPONSE PATTERNS

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Summary—The acquisition of acrophobia in a large clinical sample was investigated. 148 patients from a university-based height phobia clinic and 148 age and sex matched non-phobic controls served as *Ss*. Subjects were assessed with a battery of measures including the *Acrophobia Questionnaire* [Cohen, D. C. (1977), *Behavior Therapy*, 18, 17-23], self-rating of severity [Marks, I. M. & Mathews, A. M. (1979) *Behaviour Research and Therapy*, 17, 263-267] global rating of severity [Michelson, L. (1986), *Behaviour Research and Therapy*, 24, 263-275], origins questionnaire [Menzies, R. G. & Clarke, J. C. (1993a) *Behaviour Research and Therapy*, 31, 355-365], and a height avoidance test. Results obtained question the significance of simple associative-learning events in the acquisition of fear of heights. Only 11.5% of fearful *Ss* were classified as directly conditioned cases. Furthermore, no differences between groups were found in the proportion of *Ss* who knew other height-fearfuls, had experienced relevant associative-learning events, or the ages at which these events had occurred. Finally, no relationships between mode of acquisition and severity or individual response patterns were obtained. In general, the data were consistent with the non-associative, Darwinian accounts of fear acquisition that continue to attract theorists from a variety of backgrounds [e.g. Bowlby, J. (1975) *Attachment and Loss*; Clarke, J. C. & Jackson, J. A. (1983) *Hypnosis and behavior therapy: the treatment of anxiety and phobia*; Marks, I. M. (1987) *Fears, phobias and rituals: panic, anxiety and their disorders*; Menzies, R. G. & Clarke, J. C. (1993a), (1993b) *Behaviour Research and Therapy*, 31, 499-501; Menzies, R. G. & Clarke, J. C. (1995)].

INTRODUCTION

Menzies & Clarke (1993a) recently reported on the acquisition of fear of heights in an undergraduate student sample. Height-fearful ($N = 50$) and non-fearful ($N = 50$) groups were formed on the basis of extreme scores to the heights item on the FSS-III (Wolpe & Lang, 1964). Subjects were assessed with a battery of height-related severity measures and a new origins questionnaire constructed by the authors. Results obtained failed to support the traditional associative-learning accounts of fear acquisition. Only 18% of fearful *Ss* were classified as directly conditioned cases. In addition, no relationships between mode of acquisition and severity or individual response patterns were obtained. In general, the data appeared consistent with various non-associative, evolutionary accounts of fear acquisition which propose that aversive associative conditioning is not necessary for fear onset (cf. Bowlby, 1975; Marks, 1987; Menzies & Clarke, 1993a, 1993b, 1995).

The present study sought to extend this earlier analogue research by examining the origins of height fear in a clinical sample of acrophobics. Many authors have suggested that the low levels of fear typically associated with student fear samples are more likely to be indirectly acquired than directly conditioned (e.g. Rachman, 1977; Ost & Hugdahl, 1985). Hence, until Menzies & Clarke's (1993a) results are replicated with a clinical sample only tentative conclusions can be drawn about the origins of acrophobia.

In addition, the present study attempted to provide a more thorough examination of Rachman's hypothesized relationships between onset type, severity and response patterns, by including a behavioural avoidance test and obtaining physiological data. Rachman (1977) argues that conditioned cases are more likely to involve high behavioural and physiological responses than high verbal-cognitive responses whereas the reverse would be true for indirectly acquired cases. Given

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the absence of physiological data in Menzies & Clarke's (1993a) earlier report, only part of this hypothesis could be tested.

In line with the earlier findings of Menzies & Clarke (1993a), it was expected that many *Ss* would not recall direct or indirect associative-learning events, but would give reports that were more consistent with the non-associative perspective. Specifically, in contrast to the previous findings of Ost and his colleagues (Ost & Hugdahl, 1981, 1983, 1985), it was hypothesized that more acrophobic *Ss* would claim that their fear had *always* been present, or had arisen in a non-associative traumatic event, than would be classified as directly conditioned cases (see further Clarke & Jackson, 1983). Second, in an examination of Rachman's (1977) predictions, it was hypothesized that conditioned cases would be predominantly associated with avoidance and heightened autonomic arousal rather than subjective anxiety, whereas the reverse would be true for indirectly acquired fears. In addition, it was hypothesized that conditioned cases would be more severe than indirectly acquired cases (see further Rachman, 1977). Finally, to further examine the etiological significance of learning events, an exploratory investigation of the differences between phobics and non-fearfuls was undertaken. Groups were compared on the proportion of *Ss* who had experienced traumatic learning events, the age at which these events had occurred, and the proportion of *Ss* who knew other height-fearfuls.

METHOD

Subjects

Phobic group. The sample comprised 148 *Ss* (81 female) with a mean age of 40.3 years who sought treatment at the Height Phobia Clinic at the University of New South Wales. They were selected from 193 initial respondents to newspaper and magazine articles and commercial radio coverage describing the acrophobic condition and a university based treatment programme. Thirty-one of the original 193 respondents were excluded following the initial telephone contact: 20 requested information about the programme, but did not recontact; 11 were clearly suffering from other disorders rather than acrophobia (agoraphobia—6, claustrophobia—2, alcohol dependence—1, pathological gambling—1, major depressive episode—1). Appointments were made for the remaining 162 respondents for a second screening interview and the administration of the phobia items on the Psychiatric Diagnostic Interview (PDI) (Other, Penick & Powell, 1985). After this phase a further 14 respondents had been excluded: seven did not attend the appointment; seven failed to satisfy DSM-III-R criterion D for Simple Phobia, by revealing no marked distress from the disturbances or interference with occupational or social activities or relationships. This was made clear by self-report and their failure to meet the criterion on the social significance questions for Phobic Neurosis on the PDI. This left 148 *Ss* in the phobic group.

All *Ss* in the phobic sample met the DSM-III-R criteria for Simple Phobia (APA, 1987), and reported extreme levels of fear and avoidance of height-related scenes over an extended period. 31% had sought or received previous treatment, with the remaining 69% indicating that they would have if they had been aware that helpful non-pharmacological treatment was available. 23% had used medication or alcohol in the past for acrophobic relief. 92% claimed that their acrophobia had interfered with social activities, friendships or work, with 8% having actually left or turned down jobs because of high work sites. The mean scores for avoidance (15.00) and anxiety (64.63) on the Acrophobia Questionnaire (see Procedure) were either comparable to, or higher than, those obtained in other studies with solicited acrophobic patients (e.g. Cohen, 1977). In sum, it appears that the sample was clinically relevant.

Normal control group. The sample comprised 148 *Ss* (81 female) with a mean age of 40.3 years. These were volunteers from 235 non-academic staff and visitors at the University of New South Wales who were approached for participation in the study. They were matched on age (within 5 years) and sex to the phobic group. *t*-tests revealed the control group means for avoidance (3.98) and anxiety (10.64) on the Acrophobia Questionnaire (see Procedure) to be significantly lower than those obtained in the phobic group [$t(294) = 21.423$, $P < 0.001$; $t(924) = 45.135$, $P < 0.001$ respectively].

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