



A population-based study on phobic fears and *DSM-IV* specific phobia in 70-year olds

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ABSTRACT

This population-based study reports on the prevalence and characteristics of specific phobia (SP) and phobic fears in an elderly population. A representative population sample of Swedish 70-year-olds without dementia ($N=558$) was examined using semi-structured interviews. Phobic fears included fear of animals, natural environment, specific situations, blood-injection-injury and 'other'. Mental disorders, including SP, were diagnosed according to *DSM-IV*. Phobic fears (71.0% vs. 37.9%) and SP (13.8% vs. 4.5%) were more common in women than in men. Among those with phobic fears, more than 80% reported onset before age 21. Of those with SP, 35.7% had another *DSM-IV* diagnosis compared to 8.5% of those reporting no fear. Fear of specific situations and 'other' fears were related to SP and other anxiety disorders. SP was related to lower global functioning. We conclude that specific phobia in the elderly should receive attention from health professionals as it is common and associated with a decrease in global functioning.

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1. Introduction

Specific phobia (SP) is common, with prevalence estimates ranging from 1% to 20% (Becker et al., 2007; Depla, ten Have, van Balkom, & de Graaf, 2008; Faravelli et al., 2004; Shen et al., 2006; Stinson et al., 2007). Phobic fears, including also those not fulfilling diagnostic criteria for SP, are considerably more common with prevalence of 11–74% (Costello, 1982; Curtis, Magee, Eaton, Wittchen, & Kessler, 1998; Depla et al., 2008; Iancu et al., 2007; Lindsay, Briggs, & Murphy, 1989). Prevalence of SP (Kessler, Berglund et al., 2005; Stinson et al., 2007) and phobic fears (Liddell, Locker, & Burman, 1991) is reported to decrease with age, and onset seems to be rare in late life (Lindsay, 1991). Among studies focusing on the elderly (≥ 65 years), prevalence estimates vary from 2.1% to 11.5% (Beekman et al., 1998; Chou, 2009; Kirmizioglu, Dogan, Kugu, & Akyuz, 2009; Lindsay et al., 1989; Manela, Katona, & Livingston, 1996; Ritchie et al., 2004). Large variation in reported prevalence between studies may be explained by differences in prevalence period, methodology and demographic factors.

Phobic fears and SP are generally more common in women than in men (Fredrikson, Annas, Fischer, & Wik, 1996). SP is often comor-

bid with anxiety, mood and personality disorders (Stinson et al., 2007). SP had the lowest disability level of all mental disorders studied in the WHO Mental Health Survey (Ormel et al., 2008), but some population studies report that disability is on par with other anxiety disorders (Alonso et al., 2004; Stinson et al., 2007).

We aimed to study prevalence of SP and phobic fears, and their subtypes, in an elderly population sample in relation to psychiatric comorbidity and global functioning. The rationale was that the amount of information available regarding fears and phobias of older adults is limited. Furthermore, there are few population-based studies on prevalence and characteristics of SP and types of phobic fears in the elderly.

2. Methods

2.1. Sample

The study sample was derived from the Prospective Population Study of Women (PPSW) and from the H70 Birth Cohort Study in Gothenburg, Sweden (Bengtsson et al., 1997; Bengtsson et al., 1973; Hellström, 1973; Skoog, 2004). Both samples were obtained from the Swedish Population Register, based on birth date, and included both persons living in private households and in institutions. In 2000, PPSW and H70 merged to become one study, with the recruitment of a new 70-year-old cohort born in 1930. All 70-year-olds born in 1930 on pre-specified dates and living in Gothenburg, Sweden on September 1, 2000 according to the Swedish population register ($N=875$) were invited to a health examination. Five

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persons could not be found, 10 died before they could be examined, 18 could not speak Swedish and 15 had emigrated outside Sweden, leaving an effective sample of 827. Among these, 579 persons (350 women and 229 men) accepted participation in the psychiatric examination (response rate 70.0%). There were no differences between participants and non-participants regarding sex. Non-participants had higher 5-year mortality both among women (9.0% vs. 2.3% $p < 0.001$) and men (23.7% vs. 7.5%, $p < 0.001$). Among men, non-participants were more likely to have received in-patient care in the year preceding the interview (34.3% vs. 22.7%, $p < 0.05$) and to have a psychiatric diagnosis in the Swedish Hospital Discharge Register (17.8% vs. 7.4%, $p < 0.01$). Female non-participants and participants did not differ in these respects (23.6% vs. 21.7%, $p = 0.66$ and 7.9% vs. 5.8%, $p = 0.44$).

2.2. Diagnostic assessments

A semi-structured psychiatric examination was performed by trained psychiatric research nurses or a psychologist. The Comprehensive Psychopathological Rating Scale (CPRS) (Åsberg, Montgomery, Perris, Schalling, & Sedvall, 1978) was used to assess symptoms of SP, obsessive compulsive disorder (OCD) and depression (major depressive disorder, dysthymia, or depression not otherwise specified). The CPRS has been shown to have good applicability and inter-rater reliability in the elderly (Laan, Schimmel, & Heeren, 2005). The Mini-International Neuropsychiatric Interview (MINI) was used to assess symptoms of panic attacks and social phobia. It has been shown to have good agreement with more comprehensive diagnostic instruments (Sheehan et al., 1998). Both instruments rated psychiatric symptoms and signs in the past month. The examination also included tests of memory, language, apraxia, construction, finger agnosia, agraphia, alexia, acalculia, and comprehension of proverbs. Global cognitive function was measured using the Mini-Mental State Examination (Folstein, Folstein, & McHugh, 1975). Interviewers rated the individuals' global functioning during the past month with the Global Assessment of Functioning (GAF) (American Psychiatric Association, 1994).

The question about phobic fears was worded as: there is something called phobias. It is when you are afraid of or perceive irrational dread or anxiety towards some things or objects. [List of examples.] You avoid these if you are able to. Do you have any such troubles? Responses were rated by the interviewer from 0 ('no fear') to 6 ('incapacitating fear'). Ratings 2–3 (vague discomfort mastered without help or by simple precautions) were considered as mild-moderate phobic fears and ratings 4 (certain situations consistently provoke marked discomfort and are avoided) to 6 (incapacitating fear which severely restricts activities) as strong phobic fears. The category Fear includes all those rated 2–6. Inter-rater reliability was investigated among 39 individuals who had dual ratings by psychiatric research nurses or psychiatrists. Inter-rater agreement for the rating of no, mild-moderate or strong phobic fear was Cohen's kappa value of $\kappa = 0.79$ ($p < 0.001$).

Phobic fears were further categorized into fear of animals (e.g., snakes, spiders, and rats), natural environment (e.g., heights, thunderstorms, and water), blood-injection-injury, specific situations (e.g., elevators, flying, enclosed spaces, and bridges) or 'other' (e.g., vomiting, suffocating, and illness). The inter-rater reliabilities for these categorizations were $\kappa = 0.85$ for animals, $\kappa = 0.95$ for natural environment, $\kappa = 1.00$ for blood-injection-injury, $\kappa = 1.00$ for specific situations and $\kappa = 0.48$ for other.

Social or other consequences of fears were rated as none, some (such as being unable to use an elevator or travel by airplane) or severe. Inter-rater reliability for this rating was $\kappa = 0.86$ ($p < 0.001$). Individuals were also asked at which age they had their first fear (information missing for nine individuals).

A diagnosis of specific phobia (SP) according to the DSM-IV (American Psychiatric Association, 1994) was made when the fear was strong (rating 4–6) with at least some social or other consequences. In DSM-IV, a diagnosis of SP can be made in the presence of other mental disorders. SP without psychiatric comorbidity was labelled 'pure' SP. Phobic fears that did not meet the DSM-IV criteria for SP were labelled Non-diagnostic phobic fear.

Social phobia, panic attacks, obsessive compulsive disorder (OCD) and depression (major depressive disorder, dysthymia or depression not otherwise specified) were diagnosed according to the DSM-IV in the following way. First, all symptoms used for DSM-IV diagnoses were defined as present or absent according to the MINI and the CPRS on the basis of the results of the psychiatric examinations. After that, computer algorithms were written to make diagnoses based on the symptom descriptions in DSM-IV.

Dementia was diagnosed according to the DSM-III-R (American Psychiatric Association, 1987) based on information from the psychiatric examination and a key informant interview, as described previously (Skoog, Nilsson, Palmertz, Andreasson, & Svanborg, 1993).

2.3. Statistical analysis

Gender differences in prevalence were tested using a two-sided Fisher's exact test. For gender differences regarding types of phobic fears, odds ratios were calculated with 95% confidence intervals.

Differences in age at onset of fear between men and women and between those with or without SP were tested with the Mann-Whitney *U*-test. For the purpose of this analysis, all those reporting 'a life-long fear' or since age 10 or younger were considered to have onset at age 10. This reduced effects of unreliable recall of age at onset early in life.

To analyze comorbidity, logistic regression analyses were used. In each analysis, a mental disorder was the dependent variable, and sex and Non-diagnostic phobic fear or SP were the independent variables. The reference group in the analyses was those with no fear.

To test the association between fear type and diagnoses of SP and other mental disorders, we used logistic regression analyses. A separate analysis was done for each fear type and each mental disorder, where fear type and sex was independent variables, and mental disorder was dependent variable. The procedure was the same when testing the relationship between number of types of fear and mental disorders. Those with no fear were excluded from these analyses. The effect of gender on number of types of fear was tested with the Proportional Odds Model, a form of ordinal regression analysis (Collett, 2003).

To compare GAF scores between those with SP, Non-diagnostic phobic fear or no disorder, as well as to test the influence of comorbidity on GAF score in those with SP, we first used the Mann-Whitney *U*-test. To further examine the effect of SP and other mental disorders on global functioning, we used the Proportional Odds Model. In this analysis, GAF scores were divided into four categories: ≤ 60 ($N = 39$), 61–70 ($N = 40$), 71–80 ($N = 87$) and ≥ 81 ($N = 391$).

The strength of relationships is presented as odds ratios with 95% confidence intervals. Results were considered statistically significant at $p < 0.05$ or when the lower bound of the confidence interval was > 1.0 .

3. Results

Individuals with missing information on phobic fears ($N = 5$) and those with dementia ($N = 16$) were excluded. Thus, the final sample included 558 persons (334 women and 224 men).

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