



Predictors of specific phobia in young women: A prospective community study

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ABSTRACT

Potential predictors of incidence of specific phobia were investigated within the conceptual framework of the vulnerability–stress model. At two time points separated by approximately 17 months, a community sample of 1261 German women (18–25 years of age) completed a structured interview. A broad range of potential stress- and vulnerability-related predictors was recorded at initial assessment. The strongest predictors of incidence were: high levels of preexisting psychopathology, a lack of coping skills, and a negative cognitive style. Assessing individual differences in stress and vulnerability thus seem to offer additional information about etiology of specific phobia beyond traditional learning theory. Incorporating the role of these risk factors may be useful for identifying individuals who are at increased risk and improving measures of prevention.

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1. Introduction

Specific phobia is an impairing mental disorder in which people display an “extreme and persisting fear of clearly discernible objects or situations” (American Psychiatric Association, 1994). Recent epidemiological studies suggest that approximately 9.4–12.5% of the adult population will experience at least one specific phobia at some point in their lives. Interestingly, women are even more than twice as likely to be affected as men (Depla, ten Have, van Balkom, & de Graaf, 2008; Kessler et al., 2005; Stinson et al., 2007). In a community sample of young women aged 18–25 years from which the present report is derived, we found a lifetime prevalence of specific phobia according to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994)* of 12.8% (Becker et al., 2007).

The dominant model of etiology for specific phobia was formulated by Rachman (1977). He proposed that specific phobia could be acquired through three pathways: direct negative conditioning experiences, learning through observing others, and transmission through verbal information. Although studies have provided support for all three pathways, not all specific phobias can be traced back to one of these methods. Moreover, people do not always develop phobic fear as a result of these learning experiences (King, Eleonora, & Ollendick, 1998). An additional point of concern is that Rachman’s account is purely

environmental and largely ignores the influence of internal cognitive processes involved in specific phobia. These problems with the learning theory approach suggest that a variety of additional factors may need to be considered (Barlow, 2002; Mineka & Zinbarg, 2006; Ollendick, King, & Muris, 2002).

An alternative approach to study etiology of specific phobia would be to explain the disorder within the framework offered by vulnerability–stress models (Ingram & Luxton, 2005; Richters & Weintraub, 1990; Zubin & Spring, 1977). Vulnerability–stress models state that each individual has a particular set of vulnerabilities that when activated by stress lead to the development of the disorder. Such vulnerabilities may be defined as inherited or acquired characteristics that arise from the influence of multiple predictors from biological, psychological, and social domains. These predictors may have a protective value or may be risk factors and both concur in determining the individual’s vulnerability to the disorder (Muris & Merckelbach, 2001; Muris, Merckelbach, de Jong, & Ollendick, 2002).

To identify predictors of the incidence of specific phobias, prospective studies in community samples are needed. To date, very few such studies are available. One study that followed up children from birth to 7 years of age found that low birth weight did not increase risk for specific phobia (Breslau et al., 1996). With regard to protective factors, regular physical activity was found to be associated with a reduced risk for incidence of specific phobia (Ströhle et al., 2007). Other health-behavior-related factors such as smoking (Cuijpers, Smit, ten Have, & de Graaf, 2007) and cannabis use (van Laar, van Dorsselaer, Monshouwer, & de Graaf, 2007) did not predict the incidence of specific phobia. Studies investigating

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the role of psychopathology reveal that panic attacks (Goodwin et al., 2004) and parental depression (Lieb, Isensee, Höfler, Pfister, & Wittchen, 2002) predict the incidence of specific phobia, but that childhood separation anxiety (Brückl et al., 2007) is not associated with developing specific phobia, when using strictly prospective analyses.

Summarizing from these studies, previous research identified very few factors associated with incidence of specific phobia. Results revealed that preexisting psychopathology is a risk factor but also protective factors seem to play a role in the development of specific phobia. However, many other components of the vulnerability–stress model such as stress, coping, and cognitive factors have never been studied as potential predictors of specific phobia.

Ideally, predictors of specific phobia should be studied in a sample during the peak risk phase, which is, based on retrospective age-at-onset reports, scheduled at the time of childhood and adolescence (Burke, Burke, Regier, & Rae, 1990; Kessler et al., 2005). However, one study distinguished between age at onset of fear and specific phobia (i.e., the time when the fear causes enough distress and impairment to meet full diagnostic criteria) and found that there was an average time interval of 9 years between the onset of the fear and the onset of the specific phobia. The typical age at onset for the specific phobia was during early adulthood (Antony, Brown, & Barlow, 1997). Thus, studying predictors of the incidence of the diagnostic threshold in a sample of young adults appears to be promising. Given the large number of women with specific phobia, examining women in this age group is clearly important.

To conclude, our knowledge about predictors of specific phobia is hampered by a paucity of prospective community studies and use of limited sets of predictors. The purpose of this study was to further investigate the etiology of specific phobia, studying predictors of the incidence of specific phobia during early adulthood. Data came from a prospective study in which a community sample of German women completed a diagnostic interview at two time points. A broad range of potential predictors of specific phobia was examined using information from interview and self-report questionnaires at initial assessment. As part of this investigation, we will report incidence rates of specific phobia subtypes in this sample.

2. Method

2.1. Participants

Subjects were 1261 German women who participated in the Dresden Predictor Study (DPS; also referred to as the Dresden Mental Health Study), a prospective epidemiological study of mental disorders. A description of the study as well as details about sampling and representativeness of the sample have already been reported elsewhere (Trumpf, Vriends, Meyer, Becker, Neumer, & Margraf, 2009). Also, initial prevalence and incidence findings of *DSM-IV* disorders for this sample are presented elsewhere (Becker et al., 2000). The current study is restricted to those participants who completed a diagnostic interview at both waves of data collection and a battery of self-report questionnaires at least at baseline.

Participants were drawn randomly from the 1996 population registers of residents in Dresden, former East Germany. All participants had to meet the selection criteria of being female and being aged 18–25 years at the time of initial assessment. At baseline, no reimbursement for participation in the study could be offered. At follow-up, participants received a small gift package funded by sponsorship. A total of 5203 women was located and deemed eligible for the study. Of these, 2138 women (41.1%) did not respond. Reasons for nonresponse were refusal to take part (68.3%), lack of time (24.6%), and failure to appear at the interview (7.2%). Analyses of response bias suggested that women with more

mental problems were less likely to participate in the study (see Trumpf et al., 2009). At baseline assessment between July 1996 and September 1997, a total of 2068 women completed the diagnostic interview and 997 filled out questionnaires only, resulting in a response rate of 58.9%. Of the 2068 participants who took part in the interview, 1881 also filled out questionnaires.

At the follow-up assessment approximately 17 months later ($M = 16.9$ months, $SD = 6.0$, range = 7–30 months), 1435 (76.3%) participants returned for a readministration of the diagnostic interview. Biases that might have emerged due to dropout were examined by comparing dropouts ($n = 446$) with the remaining 1435 participants according to sociodemographic characteristics and mental disorders. Dropout was associated with having a romantic partner, $\chi^2(1) = 14.0$, $p < .001$; a lower educational level, $\chi^2(5) = 46.1$, $p < .001$; being employed full-time, $\chi^2(4) = 10.7$, $p < .05$; and having a lower socioeconomic status, $\chi^2(2) = 25.5$, $p < .001$. Dropouts were more likely to be diagnosed with a current somatoform disorder at baseline, $\chi^2(1) = 4.4$, $p < .05$. However, dropouts did not differ from follow-up participants regarding all other current mental disorder diagnoses.

As our goal was to study incidence of specific phobia, follow-up participants who reported lifetime specific phobia in the diagnostic interview at baseline ($n = 174$) were not included in the present analyses. This provided a sample size of 1261 for the present study. The baseline sociodemographic characteristics of this sample were as follows: Their mean age was 21.3 years old ($SD = 1.9$, range = 18–25). A minority of the participants (2.2%) had completed pre-secondary schooling with the lowest educational level (“Hauptschule” = mandatory basic school, 9 years). About 30% had attended intermediate level school (“Realschule” or “Polytechnische Oberschule” = intermediate type of secondary school that allows qualification for specific university curricula, 10 years) whilst the majority (64.5%) had completed the highest educational level that qualified them for university entry (“Abitur” = secondary school that prepares for entrance to university, 12–13 years). Altogether, 58.3% of the women were still enrolled in professional education, 1.2% had already completed a university degree, 7.6% had completed college, and 16.2% had completed their apprenticeships. Almost half of the participants were working; 17.7% worked part-time, 28.6% full-time. About 30% of participants were classified as belonging to lower socioeconomic status; most participants (62.6%) were classified as belonging to middle socioeconomic status and few participants were classified as high (9.3%). In this context, it should be noted that Dresden is a city with several large universities; and the high density of nonworking young adults with the highest educational level is rather typical for Dresden.

2.2. Diagnostic interview

Diagnostic interviews were conducted with each participant using the “Diagnostisches Interview für Psychische Störungen – Forschungsversion” (F-DIPS; translation: Diagnostic Interview for Mental Disorders – Research Version; Margraf, Schneider, Soeder, Neumer, & Becker, 1996). The F-DIPS is an earlier version of the DIPS (Schneider & Margraf, 2006) and is based on a German translation and extension of the Anxiety Disorders Interview Schedule (ADIS-IV-L; Di Nardo, Brown, & Barlow, 1995). It is a structured interview for the assessment of Axis I mental disorders according to *DSM-IV* criteria. At baseline, the F-DIPS was used to assess lifetime and 7-day disorders; at follow-up, the interval version was applied to assess disorders during the 17-month follow-up and the past 7 days.

F-DIPS interviews at baseline were conducted by a total of 80 interviewers; interviews at follow-up by a total of 72 interviewers. Overall, 16 interviewers were involved in the fieldwork of both investigations. Most of the interviewers were clinical psychology

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