Mode of Onset of Simple Phobia Subtypes: Further Evidence of Heterogeneity

Joseph A. Himle, David Crystal, George C. Curtis, and Thomas E. Fluent

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Abstract. Previous research has demonstrated heterogeneity of the simple phobia diagnostic category. As a further test of the notion of heterogeneity of the DSM-III-R simple phobia diagnostic category, mode of onset was examined in a sample of simple phobic outpatients. Patients were separated into one of four subtypes: animal or insect, blood and injury, situational, and choking-vomit phobias. Careful study yielded five distinct mode-of-onset categories. Two researchers independently determined the mode of onset for the patients studied: direct trauma, spontaneous, vicarious learning, gradual, and lifelong. Significant mode of onset differences were observed across groups. Situational phobics reported a preponderance of spontaneous onsets as compared to the other groups studied. These results offer further evidence of the heterogeneity of the simple phobia diagnostic category and also support the contention that situational simple phobias are closely related to agoraphobia.

Key Words. Simple phobia, nosology, anxiety.

In DSM-III-R (American Psychiatric Association, 1987), simple phobia is a residual category to which all phobic disorders other than social phobia and agoraphobia are assigned. By their nature, residual categories are prone to heterogeneity. If this should be true of simple phobia, then treating it as a homogeneous category with supposedly similar clinical presentations, patterns of development, and responses to treatment could be quite misleading, both for clinical practice and research.

Increasingly, the literature suggests that the category is in fact heterogeneous. Phobias of miscellaneous situations (e.g., driving, flying, and enclosures) have been found to occur either alone or as part of agoraphobia (Marks, 1970). These phobias have also been reported to have age and manner of onset more like agoraphobia than like other "simple" phobias (Öst, 1987; Himle et al., 1989). Patients in another subgroup, the blood-injury phobias, again have different ages of onset (Öst et al.,...
1984; Himle et al., 1989), a unique psychophysiological response (Connolly et al., 1976; Curtis and Thyer, 1983; Öst et al., 1984), and a unique treatment response (Öst and Sterner, 1987).

Manner of onset or acquisition appears to differentiate several types of simple phobias (Öst, 1987). Öst referred to patients who acquired their phobias as a result of an apparently spontaneous anxiety attack in a situation that consequently became feared or those who had a traumatic encounter with the phobic stimulus as having a "conditioning" onset. He found this manner of onset to be most frequent in patients with agoraphobia (81%) and least likely among animal phobics (45%). He reported that 67% of claustrophobics and 48% of blood phobics had this type of conditioning etiology. Subjects who were not identified as having a conditioning mode of onset were coded as "modeling," "instruction," or "no recall." It is not possible, in Öst's report, to differentiate within the conditioning category those who acquired their phobias by an uncued anxiety episode or by a realistic traumatic event. Munjack (1984) found that 40% of a sample of driving phobics experienced the onset of their phobia as a result of an unexpected anxiety attack while driving. In an additional 20% of the sample, the phobia began after a collision, and in 10%, the fear began after realistic frights while driving which did not involve collisions. McNally and Steketee (1985) referred to sudden onset following a realistic threat with pain as Stimulus-Stimulus (S-S) conditioning, whereas a similar onset without physical pain was classified as Stimulus-Response (S-R) conditioning. In this system, S-R conditioning apparently would also include "spontaneous" anxiety attacks. In 22 animal phobics studied, McNally and Steketee found only 23% to have an etiology by either S-S or S-R conditioning, while 68% had no specific recall of the circumstances surrounding the onset of their fears. In analog animal phobias, Murray and Foote (1979) and Kleinknecht (1982) found factors other than conditioning to predominate in the acquisition of fears, and DiNardo et al. (1988) found no more conditioning experience in analog dog phobics than in nonfearful subjects. Barlow (1988a, pp. 209-210) has designated uncued anxiety attacks as "false alarms," while phobias that begin with realistic trauma are identified as "true alarms."

In view of the heterogeneity in manner of phobia acquisition among subtypes of simple phobia suggested by the literature, further study of mode of onset among different types of simple phobias appears warranted. With improved recognition of the role of panic attacks in the formation of some phobias, it may be especially helpful to separate uncued false alarms (Barlow, 1988a) from onsets precipitated by realistic trauma or threat, true alarms (Barlow, 1988a). Citing similarities in age of onset between agoraphobics and situational simple phobics (e.g., driving, flying, and enclosures), coupled with the apparent familial transmission of situational simple fears, Himle et al. (1989) suggested that situational simple phobias may be more appropriately classified as a mild form of agoraphobia than as simple phobia. As has been commonly found, agoraphobic patients often report uncued panic attacks followed by phobic avoidance (Thyer and Himle, 1985). The apparent association between situational simple phobias and the panic/agoraphobia syndrome suggests that situational phobics might report a larger proportion of spontaneous (false alarm) onset modes than the other phobic groups studied. The present study is
designed to test this hypothesis and to compare further the onset histories among four types of simple phobias derived from the same sample of phobics described earlier (Himle et al., 1989).

**Methods**

Eighty-nine charts of all patients evaluated in the University of Michigan Anxiety Disorders Clinic during 1978-89 who received a sole diagnosis of simple phobia were reviewed. Simple phobia as an official diagnostic entity dates to the publication of *DSM-III* (American Psychiatric Association, 1980). Patients seen before *DSM-III* was adopted (approximately 25%) were included if they received a single *DSM-II* (American Psychiatric Association, 1968) diagnosis of "phobia" or "phobic reaction" with a circumscribed focal phobia other than agoraphobia or what later came to be called "social phobia." Patients were not included if their anxiety or avoidance was accompanied by thought content or ritualistic behavior suggestive of obsessive-compulsive disorder. Patients seen after the publication of *DSM-III* were diagnosed by *DSM-III* or *DSM-III-R* criteria, including the exclusion criteria.

Evaluations were either performed by a faculty psychiatrist or by another clinician experienced in the diagnosis and treatment of anxiety disorders and reviewed by a faculty psychiatrist. All evaluations involved (1) one or more face-to-face interviews; (2) completion by patients of questionnaires providing information relevant to anxiety disorders, affective disorders, psychosis, and a variety of other psychiatric symptoms; and (3) information provided from other sources such as past records. This evaluation procedure would identify most clinically significant psychiatric disorders, including (after 1980) all *DSM-III* defined anxiety, affective, and psychotic disorders. It would not, however, necessarily exclude symptoms that were insufficiently severe to qualify for a diagnosis of a formal psychiatric syndrome (such as limited symptom panic attacks, before *DSM-III-R* in 1987).

Subjects were classified into one of five simple phobia subgroups: animal/insect (*n* = 23), situational (*n* = 41), blood/injury (*n* = 10), and choking/vomit (*n* = 10). Five patients did not clearly fit into one of the other four subgroups, such as those with fears of thunderstorms (*n* = 3), loud noises (*n* = 1), and swinging things (*n* = 1). Due to their diverse nature, these subjects were not included in the data analysis. The situational group included those phobias commonly associated with agoraphobia such as fears of crowded places, driving, airplanes, heights, and bridges (Hallam and Hafner, 1978; Arrindell, 1980). The choking/vomit group comprised patients with fears of swallowing pills or food or with a pervasive fear of vomiting. Subjects were asked on the evaluation questionnaire to describe in a short paragraph the circumstances surrounding the onset of phobia. A careful study of these descriptions yielded five distinct mode-of-onset categories: realistic threat (*n* = 38), vicarious learning (*n* = 9), spontaneous (*n* = 20), lifelong (*n* = 5), and gradual (*n* = 6). The realistic threat category includes phobias resulting from immediate, specifiable threat such as an attack by a dog or experiencing an automobile accident, and also from surprising, sudden contact with the phobic stimulus. The vicarious learning group comprises phobias induced by witnessing a disturbing event or by hearing of such an event from an external source (e.g., the mass media or another person). The spontaneous subtype is characterized by phobias with a sudden, unexpected onset that is not cued by any traumatic encounter or vicarious instructions. The spontaneous onset occurs as follows: The subject enters the to-be-phobic situation without apprehension, and while there experiences the sudden unexplained eruption of intense anxiety (i.e., a panic attack); subsequently the subject avoids that class of situations or endures them with dread. The spontaneous group does not include those patients who met criteria for panic disorder because only patients with a single Axis-I simple phobia were included in the study. The lifelong designation refers to phobias that subjects described in terms such as "having it as far back as I can remember." The gradual classification contains phobias whose onset is unclear or questionable and whose symptoms developed slowly over a period of time. Two researchers, working independently, coded mode of onset described by subjects according to these five categories. The two researchers, one of whom was unaware of the study hypothesis
(T.F.), independently agreed upon manner of onset in 96% of the cases reviewed. Disagreements were resolved by the first author, if possible, and five patients were not included in the study because their mode of onset was of a mixed or unclassifiable nature. The remaining sample of 84 patients consisted of 60 women and 24 men with an average age of 21.8 years and a mean age of onset of 13.9 years.

Results

Significant mode of onset differences were found across groups ($\chi^2 = 37.260, df = 12, p < 0.0002$) (Table 1). Pairwise comparisons between groups revealed that a large portion of the difference in mode of onset lies between the animal/insect group and the situational group ($\chi^2 = 18.20, df = 4, p = 0.0011$). Of 20 patients reporting spontaneous modes of onset, 18 were from the situational group and none was from the animal/insect group which consisted mainly of patients reporting realistic threats (61%). In addition, significant mode-of-onset differences were found between the blood/injury and the situational group ($\chi^2 = 15.008, df = 4, p = 0.0047$). The situational group was mainly represented by patients reporting spontaneous (48.6%) and realistic (35%) mode of onset, while the blood/injury group was almost evenly split between realistic threat (50%) and vicarious-learning modes of onset (40%). The final significant difference in mode of onset was found between the situational group and the choking/vomit phobia group. Again, the situational group had a greater proportion of individuals reporting a spontaneous mode of onset than did the choking/vomit group, which predominantly involved the realistic threat category (67%) ($\chi^2 = 9.6576, df = 4, p = 0.0461$). Mode-of-onset differences approaching significance were also observed between the animal/insect and the blood/injury group ($\chi^2 = 8.6456, df = 4, p = 0.0706$) and between the situational and the blood/injury group ($\chi^2 = 8.6233, df = 4, p = 0.0712$).

<table>
<thead>
<tr>
<th>Table 1. Mode of onset (%)</th>
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<tr>
<td>Phobia</td>
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<tr>
<td>Animal (n = 22)</td>
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<tr>
<td>Situation (n = 37)</td>
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<tr>
<td>Blood/injury (n = 10)</td>
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<td>Choke/vomit (n = 9)</td>
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Note. $\chi^2 = 37.26, p < 0.0002$.

Discussion

In this study, we examined mode of onset among five simple phobia subtypes. We hypothesized that significant differences in mode of onset would be found between these groups. Those data presented here support this hypothesis. The mode of onset among situational phobics in this study closely resembled the manner of onset found among the driving phobics studied by Munjack (1984)—that is, sudden, unexplained eruption of anxiety in the to-be-phobic situation. In contrast, the current study of animal-phobic onset (mainly realistic threat) differed from that of McNally and Steketee (1985), who reported mainly lifelong, unspecified modes of onset, and also
differed from the studies of analog animal phobics (Murray and Foote, 1979; Kleinknecht, 1982), which included few with realistic threats. Comparisons between the present results and those of Öst (1987) are difficult, since he combined realistic threat and onset with a sudden panic attack in the conditioning category. A partially satisfactory comparison can be made by adding together the present realistic threat and spontaneous mode-of-onset categories and then comparing the result with Öst's conditioning category. This comparison suggests that the present results are similar to Öst's (1987) finding of a preponderance of conditioning onsets among claustrophobics, animal, and blood phobics.

The results of this study should be viewed with some caution because of the retrospective nature of the mode-of-onset reports. It is possible that subjects could have forgotten early traumatic confrontations, vicarious experiences, or spontaneous anxiety episodes that may have been associated with their phobias. Prospective studies or corroborating family interviews could help to confirm the accuracy of the present results. In addition, the uncued or spontaneous group may be partly composed of individuals who failed to identify subtle cues that in fact were associated with their phobic onsets. It is also difficult to differentiate some vicarious experiences from personal traumatic encounters (e.g., witnessing someone else being bitten by a dog exposes the witness to an angry, barking dog). In the present study, however, most vicarious experiences involved hearing of a disturbing event instead of actually witnessing the event.

The mode-of-onset differences reported here were mostly due to the many spontaneous onsets among the situational group. The large number of spontaneous onsets among the situational phobics suggests a similarity to the manner of phobic acquisition characteristic of patients suffering from panic disorder with agoraphobia (Thyer and Himle, 1985). This finding, along with the significantly later age of onset and increased familial concordance reported previously (Himle et al., 1989), lends further support to the hypothesized association between situational simple phobia and the panic/agoraphobia syndrome. While there is no suggestion that most situational phobias begin with panic attacks, there is apparently a very significant minority that do. The difference between the experience of these patients and those with panic disorder with agoraphobia is that the attacks did not become frequent and did not occur in situations other than the one which became the focus of avoidance or dread. Since people with panic disorder with agoraphobia typically experience their first panics in situations that later become the focus of phobic avoidance (Lelliott et al., 1989), the situational phobics in this study may be likely candidates to develop agoraphobia in the future. It would also be interesting to discover whether situational phobics, who have a spontaneous onset, often experience this event during a time when they are experiencing anxiety, depression, or significant life events, as has been found among agoraphobics (Uhde et al., 1985; Breier et al., 1986; Fava et al., 1988; Lelliott et al., 1989).

The possibility of an interaction between age of onset and manner of onset needs systematic evaluation. The age of onset of agoraphobia is probably determined mainly by the age of onset of panic attacks (Thyer and Himle, 1985). By the same token, the age of onset of those specific situational phobias, which begin with an
isolated but unexpected panic attack, resembles the usual age of onset for panic disorder with or without agoraphobia (Thyer et al., 1985). Therefore, mode of onset could be a valuable tool in determining diagnosis among individuals troubled by fears of isolated situations.

The present findings also provide further evidence of heterogeneity within the simple phobia diagnostic category. Regardless of the potential association between situational simple phobia and the panic and agoraphobia syndrome, the data on mode of onset in this study add to prior findings of differences in age of onset and sex ratio, clearly illustrating the heterogeneity of simple phobia. Formally subdividing the diagnostic category of simple phobia may encourage research examining the differential effects of given treatments used for specific types of simple phobia. One could hypothesize that those phobias that begin with uncued attacks of anxiety may respond to antipanic medications or psychological panic treatment methods (Barlow, 1988b) when exposure therapy directed at the phobic stimulus has proved unsuccessful. Given the evidence of heterogeneity of the simple phobia diagnostic category, it would seem warranted, at present, to discontinue the use of the general category as a source of comparison in research on anxiety disorders. Further research is needed to determine the best criteria for classifying individuals with isolated specific fears.

References


