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The Classification of Phobic Disorders

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History of term 'phobia'

The term 'phobia' derives from the Greek word 'phobos' meaning panic-fear and terror, and from the deity of the same name who provoked fear and panic in one's enemies. Although morbid fears have been described by doctors from Hippocrates onwards, the word phobia has only been used on its own since the beginning of the 19th century, and it gradually gained acceptance during that century in the same sense as today, viz. an intense fear which is out of proportion to the apparent stimulus. Such fear cannot be explained or reasoned away and leads to avoidance of the feared situation where possible.

Systematic descriptions of phobic disorders appear with increasing frequency in the psychiatric literature from 1870 onwards. In 1871 Westphal gave his classic description of agoraphobia. Maudsley, in the 1879 edition of *Pathology of Mind*, quoted Westphal's description with approval as a separate syndrome; but in the 1895 edition he included all phobias under the heading of melancholia, and castigated the current trend of allotting a special big-sounding name to each variety of phobic situation, since many phobias were often found together or successively in the same case. In 1895 also, Freud distinguished between common phobias of those things everyone fears to some extent, like death, illness and snakes, and specific phobias of circumstances which inspire no fear in the normal man, e.g. agoraphobia. In 1913 Kraepelin included in his textbook a brief chapter on irrepressible ideas and irresistible fears.

Phobias only achieved a separate diagnostic label in the APA classification as late as 1952, and appear in the ICD in 1955. Even by 1959 only 3 out of 9 classifications used in different countries listed phobic disorder as a diagnosis on its own. Subdivision of the phobic disorders themselves has only begun in the last five years. The Camberwell Psychiatric Register now lists monosymptomatic phobias separately from other phobias.

Two recent developments have led to increased knowledge about the phobic disorders. The first is the introduction of techniques like desensitization and implosion, which led to greater interest in the natural history of phobias. The second development is the spread of psychophysiological measures in the study of neurotic disorders. As a result of this work we can now tentatively distinguish certain groups of phobias which have clinical correlates. Although these groupings will have to be modified in future as knowledge advances, they form a helpful frame of reference at the present time.

Special problems in the classification of phobias:

In the delineation of these groups two problems had to be overcome. First, phobias can occur of almost any situation; second, phobias may be found in association with almost any other psychiatric symptom. These difficulties are not unique to phobias and are found in other areas of psychiatry, for example in classifying delusions.

The problems are not insuperable. To take the first one: since a phobia can develop of virtually any object or situation, it seems to follow that a classification dependent upon the feared situation will result in an endless terminology. Such a classification was prominent until early this century, and innumerable Greek prefixes were attached to the word phobia to describe each of the situations which was feared. In fact certain phobias do tend to occur together and to have particular correlates. These clusters naturally overlap, but are useful for purposes of description, aetiology and prognosis. The object of the phobia is therefore of some importance.

The second problem is that phobias can occur either on their own or as part of a whole range of psychiatric disorders. Phobias include such contrasting states as the ephemeral fears of

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darkness children go through, the multiple crippling fears of a housebound housewife, and the vague phobias found in some personality disorders. It is not surprising that some writers describe phobias as limited symptoms or 'habits' which themselves constitute the disorder without any underlying cause, while for other writers phobias are but the visible aspect of deeper pathology. Each view is correct in different cases, and we only find the varying significance of phobias difficult to formulate if we assume a unitary origin for all phobias instead of recognizing that multiple factors play a role in their genesis.

Phobic symptoms and phobic states:

Clinical observation reveals that phobias may be a minor complaint in many disorders. Phobias may occur as part of a depressive illness, waxing and waning at the same time as the more prominent depressive symptoms. Next, phobias may be a feature of obsessive neuroses, diffuse anxiety states, personality disorders and even schizophrenia. In all these conditions treatment of the phobia depends upon management of the major condition in which the phobia occurs. This paper will exclude such conditions.

When phobias occur as the patient's dominant symptom we call the condition a phobic state or disorder (or phobic reaction in the APA terminology). These phobic states are found in about 3 per cent of psychiatric outpatients (Hare, 1965, Errera and Coleman, 1963, Frazier and Carr, 1967), although there are many people with phobias who do not come to psychiatrists and may never seek any medical aid at all. Phobic states assume many forms from an isolated fear in an otherwise healthy person to diffuse extensive fears occurring together with other psychiatric problems. The present paper concerns patterns emerging within this range of phobic states in adults and is not applicable to children, in whom phobias are more volatile. The emergent groups are necessarily incomplete and overlapping, and will have to be modified as we fill in the large gaps in our knowledge about them.

The main trends of phobias in adults

Table I shows the main groups of fears found in adult life. The commonest are normal minor fears which are present in most people. Fears sufficiently intense to be called phobias, however, occur in only a small proportion of adults. In a student population, for example, most students felt slightly squeamish in the presence of non-poisonous snakes, but only 20 per cent reported intense fear, and only 1–2 per cent actively avoided a snake to a degree which might get labelled a phobia (Lang, 1966).

Phobic states can conveniently be divided into Class I, phobias of stimuli *external* to the patient and Class II, phobias of stimuli *internal* to the patient. The commonest phobias seen by psychiatrists are Class I, and these can broadly be divided into four groups as seen in Table I. Examples are fears of going into public places, of going into the open, of drinking in public, of birds, thunderstorms, heights, and so on. These situations will be avoided when the fear becomes intense. The last two groups (Class II) concern phobias of stimuli internal to the patient, and these cannot be avoided. Examples

TABLE I

The main fears in adults

Class I: Phobias of external stimuli:	% of Maudsley phobics	Related disorders
1. Agoraphobia	60	Anxiety states, 'neurotic' depression
2. Social phobias	8	Sensitive personalities, conditioned autonomic disorders
3. Animal phobias	3	—
4. Miscellaneous specific phobias	?14	—
Class II: Phobias of internal stimuli:		
5. Illness phobias	?15	Hypochondriasis
6. Obsessive phobias		Classified separately under obsessive-compulsive neurosis

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are palpitations thought to indicate heart disease, vague pains thought to indicate cancer, or obsessive impulses to kill one's child. Of course, the distinction between internal and external stimuli breaks down in certain cases, as in agoraphobia which is accompanied by a fear of dying, or in an obsessive phobia of killing one's child which leads a patient to hide any knives at home far from temptation.

The frequency of each type of phobia at the Maudsley Hospital is shown in Table I. A survey of phobics in Burlington, Vermont (Agras *et al.*, 1969) also found that the commonest phobics to see psychiatrists were agoraphobics, and the next commonest were illness phobics.

Recent experimental work on phobias has largely concentrated on Class I, phobias of stimuli outside the patient, so that there is little new to say about Class II phobias. Each type of fear will be briefly described. Fuller details of each group have been described elsewhere in the author's book *Fears and Phobias* (*1969*).

A. *Normal fears*

Most children and adults have minor fears of one kind or another. In children these include fears of parents leaving them, of noise, strangers, animals and unusual situations. In adults such fears include mild fears of heights, lifts, darkness, aeroplanes, spiders, mice, snakes and taking examinations, as well as superstitions such as fears of houses said to be haunted by ghosts, of passing under ladders in the street, and other taboos which are quite elaborate in some pre-industrial societies. These minor fears do not lead to total avoidance of objects, are within the cultural norm, and only interest psychiatrists in the way they aid our understanding of severe phobias.

B. *Abnormal fears* (phobias)

Class I. Phobias of external stimuli. We will first describe the most clear-cut varieties and then pass on to less well-defined groups. Clinical data are largely from adult patients at the Maudsley Hospital. (Marks and Gelder, 1965, 1966, Gelder and Marks, 1966, 1968, Gelder, Marks and Wolff, 1967, Marks, Birley and Gelder, 1966.) Psychophysiological data come mainly from Kelly (1966), Lader (1966) Lader *et al.* (1967), Martin *et al.* (1969) and Kelly and Martin (1969).

Animal phobias:

The animal phobias are the most clear-cut variety. They are also the rarest kind seen in hospital practice—only 24 have presented at the Maudsley Hospital in the last decade, i.e. about 3 per cent of all the phobics who came. The vast majority of animal phobias occur in women (Marks and Gelder, 1966). Though patients present for treatment in adult life, their phobias will generally have started in early childhood before the age of 8 (Figure 1), and have persisted fairly continuously thereafter. Before puberty animal phobias are found quite commonly in boys and in girls (MacFarlane, Allen and Honzik, 1954), so we presume that this group of adults is the residuum of the earlier and larger group. It is noteworthy that before puberty animal phobias are found in both sexes, while the few animal phobias which remain after puberty are usually found in women. These women usually have a monosymptomatic phobia of a single animal species with little generalization despite persistence of the phobia over decades. There is no tension or panic in the absence of the phobic object. Occasionally other symptoms may be present, but these are generally few. This is paralleled by a low score on the Cornell and Neuroticism questionnaire. (Table II).

The psychophysiological features are of particular interest (Table II). Patients with animal phobias acquire eyeblink conditioned responses more rapidly and extinguish them more slowly than do normal subjects (Martin, Marks and Gelder, 1969). Their skin resistance shows a normal number of spontaneous fluctuations and habituates normally to successive auditory stimuli (Lader, Gelder and Marks, 1967). In the few subjects whose forearm blood flow has been tested this too has been normal. These skin resistance and blood flow measures are correlates of ratings of anxiety (Lader and Wing, 1966; Kelly, 1966), so that the physiological measures confirm clinical observations about the absence of diffuse anxiety. Although animal phobias have usually been present for decades by the time they are treated in adult

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life, they show a good and persistent improvement with desensitization (Table III), even though treatment may need to be protracted.

The agoraphobic syndrome

The agoraphobic syndrome is very different. It is the commonest and also the most distressing variety seen by psychiatrists. It formed roughly 60 per cent of all phobias seen at the Maudsley and was also the most frequent variety found in Vermont. The term agoraphobia is not an altogether happy one to describe this syndrome, since these patients have fears not only of going into public spaces but also of shopping, crowds, travelling and closed spaces, to name but a few of their troublesome fears. However, fear of going out is probably the most frequent symptom from which others develop, so the name has stuck since Westphal's lucid description. Many other different names have been given to this condition, e.g. phobic-anxiety-depersonalization syndrome, phobic anxiety state, locomotor anxiety, topophobia, kenophobia, platzangst. Each name highlights some aspect of the condition, but none is all embracing.

Most agoraphobics are women, and the

TABLE II

Summary of clinical and psychophysiologic data

(Reproduced with permission of Heinemann Medical Books from '*Fears and Phobias*' by Marks, 1969)

	Anxiety states	Agoraphobias	Social phobias	Animal phobias	Normals
% women	50	75	50	95	50
Onset age	25	24	19	*4	—
Treatment age	36	32	27	30	—
Overt anxiety (0–6 scale) ..	2·6	2·0	2·0	*0·4	0
Modified Cornell	—	34	21	*13	10
Neuroticism	**37	30	29	*21	20
Extroversion	**14	19	19	24	25
G.S.R: spontan. flucs. ..	36	32	33	*12	6
G.S.R: habituat. rate ..	29	39	39	*68	64
Resting forearm blood flow ..	**4·8	2·9	?2·6	?2·2	2·0
Eyeblink C.R. acquisition ..	11	15	19	**21	14

n varies from 18 to 84 in different cells
* = differs significantly from other psychiatric groups
** = differs significantly from all groups
*** = differs significantly from all groups except social phobias
Data are composite of several studies, some unpublished. Main sources are:
Clinical variables: patients from Marks and Gelder, 1966; Lader, 1966; Kelly, 1966.
Questionnaire scores: Gelder *et al.*, 1967; Kelly 1966.
Psycho-physiological data:
G.S.R.: Lader *et al.*, 1967 and Lader, 1966.
Forearm blood flow: Kelly, 1966.
Eyeblink conditioning: Martin *et al.*, 1969.

TABLE III

Improvement of 4 kinds of phobia after desensitization

(Maximum possible change = 3·5)

	Agoraphobias	Social phobias	Animal phobias	Mixed specific phobias
n = ...	31	11	13	9
Mean improvement	0·9*	1·4	1·6	1·6

* Significantly less than the other three groups
'Improvement' refers to change in main phobia on the 5 point scales described by Marks and Gelder (1965) and Gelder and Marks (1966). Data are from patients in 1 retrospective and 3 prospective trials (Marks and Gelder, 1965; Gelder and Marks, 1966; Gelder *et al.*, 1967; Marks *et al.*, 1968).

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majority develop their symptoms after puberty, usually between age 15 and 35 (Figure 1). The syndrome is rare in childhood (Rutter *et al.*, 1968). Multiple phobias occur which centre round going out alone but generalize rapidly to many other situations. Numerous other neurotic symptoms are commonly present including panic attacks and tension even at rest, dizziness, frequent depression, depersonalization and obsessions. Once the syndrome has persisted more than a year it runs a fluctuating course with partial remissions and relapse over a long period. The diffuse symptomatology is reflected by high scores on Cornell and Neuroticism questionnaires (Table II).

Unlike the animal phobics, agoraphobics acquire and extinguish eyeblink conditioned responses at a normal rate (Martin, Marks and Gelder, 1969). Their skin resistance is abnormal in that it shows significantly increased spontaneous fluctuations and significantly slowed habituation to repeated auditory stimuli (Lader, Gelder and Marks, 1967). The forearm blood flow is only slightly increased. These findings agree with the clinical features of diffuse anxiety so often seen in agoraphobics. Agoraphobics do not respond particularly well to desensitization (Table III) since they have a tendency to relapse repeatedly. Prognosis is poorer where patients have multiple panic attacks or obsessions. Alleviation of the diffuse anxiety is followed by gradual improvement in the phobias. This occurred, for example, in a group of severe agoraphobics whose anxiety was relieved by modified leucotomy (Marks, Birley and Gelder, 1966). In these cases anxiety fell maximally after operation, while phobias continued to improve up to three years after operation. Agoraphobics with diffuse anxiety may require large amounts of sedative drugs, and their management is much more difficult than that of more localized types of phobias.

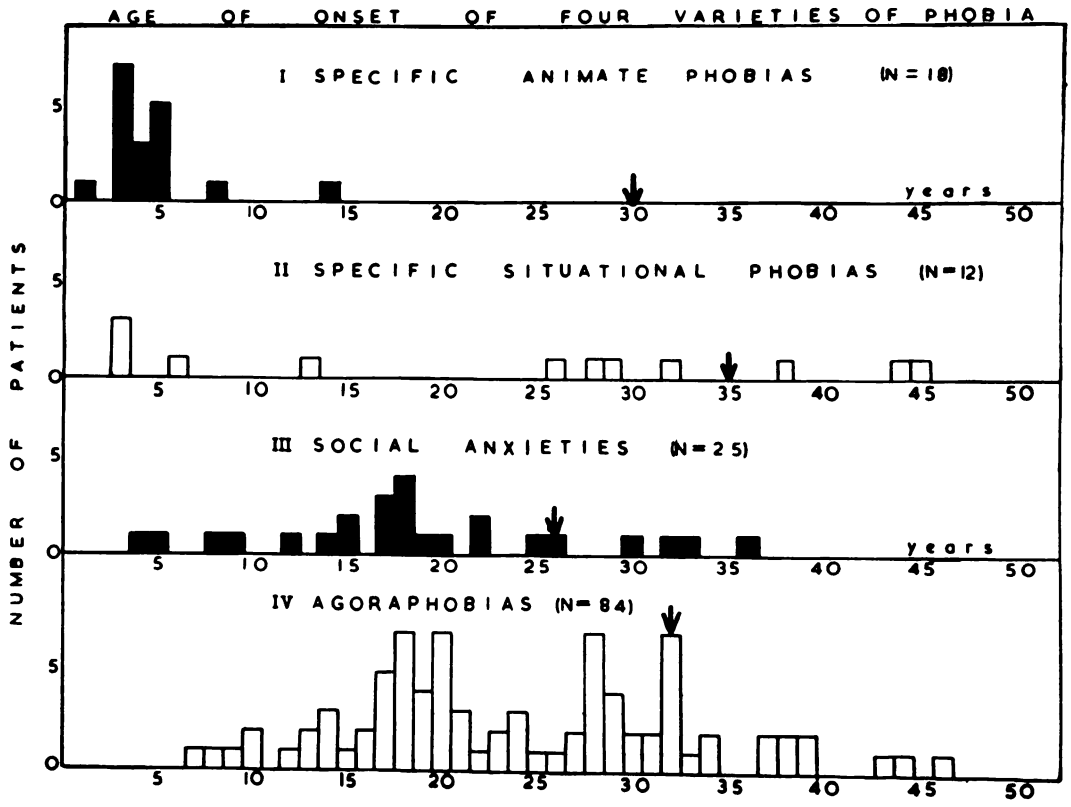


FIG. 1.

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Clinical evidence for the distinction of agoraphobia from other phobias was noted by Snaith (1968). He found that agoraphobics are more anxious, have a more remitting course and a different distribution of phobias from patients with other phobias. The clinical features of agoraphobia are similar in widespread reports from Europe, America and Australia. Evidence for the unity of the syndrome also comes from statistical enquiries. Roth *et al.* (1965) managed to delineate a group of agoraphobic patients by factor analysis of the clinical features of 275 neurotic patients. Their resultant agoraphobic factor is seen in Table IV. Their own label for this factor was phobic-anxiety-depersonalization. Further evidence was obtained from a factor analysis of answers to the Tavistock Phobic Inventory given by a group of 72 phobics at the Maudsley Hospital (Marks, 1967). An agoraphobic factor emerged which concerned the usual complaints made by these patients, and correlated well with the clinical diagnosis made independently (Table V). Finally, similar features were found to characterize 1,200 agoraphobics throughout Britain who completed a detailed questionnaire. Analysis of the replies yielded factors closely like that elicited by Marks, 1967; see also Marks and Herst, 1969.

TABLE IV

Agoraphobic factor based on clinical data from 275 neurotic patients (*Roth* et al. *1965*)

Loading	
·80	Situational phobias (agoraphobic)
·76	Panic attacks
·70	Depersonalization and derealization
·56	Temporal lobe features
·48	Marked precipitant
·44	Sudden onset
·40	Dizzy attacks

There is little doubt from clinical and statistical evidence that agoraphobia is a coherent clinical syndrome with a well-defined cluster of features which persist together over a long period of time. However, the more diffuse varieties of agoraphobia merge imperceptibly with anxiety states, affective disorders and even obsessive neuroses. In such cases more than one diagnostic label may be appropriate. During periods of depression agoraphobic patients are indistinguishable from affective disorders and pre-existing phobias become intensified. As the depression remits with antidepressant treatment the phobias improve to their previous level.

Anxious agoraphobics closely resemble patients with anxiety states. However, anxiety states do not occur much more in women (Hare, 1965). Their age of onset and clinical features are similar, except that anxiety states have more diffuse (free-floating) anxiety and fewer phobias. Anxiety states have higher neuroticism scores and are more introverted. The skin resistance and blood flow measures indicate a higher level of diffuse anxiety. The eyeblink acquisition rate is marginally lower. In fact many agoraphobics appear to be anxiety states with superimposed phobias, and in cases where the anxiety and phobias are equally prominent allocation into one or other diagnostic group is purely arbitrary. We do not know why some cases with marked anxiety develop phobias rapidly which then dominate the clinical picture, while other cases with

TABLE V

Agoraphobic factor based on questionnaire replies of 72 phobic patients (*Marks, 1967*)
(loadings are mean of analyses on test and retest)

Loading	Item
·73	(Diagnosis of agoraphobia)
·70	I sometimes have a fear of fainting in public
·59	I feel nervous when I have to go on a train journey
·51	I am nervous when I am left alone
·51	I am uneasy when I am in a crowded place
·48	I am uneasy when alone in a large open space
·36	The thought of a surgical operation would terrify me
·26	It generally makes me uneasy to cross a bridge or street.

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similar anxiety never show phobias. At our present stage of knowledge it is useful where possible to distinguish between the two conditions as the presence of agoraphobia produces a distinctive disability which requires different treatment.

Contrast of animal agoraphobias

If ever we are tempted to think that all phobic states are a unity which reflect the same disorder and aetiology, we can quickly dispel this illusion simply by looking at the startling contrast between animal phobias and agoraphobia. These two conditions differ radically in onset, course, symptomatology, response to treatment and psychophysiological measures.

One might argue that the phobic situation is not of any importance, and that animal phobia and agoraphobias are but two ends of a continuum of phobias which are specific at one end and diffuse at the other. If this were true we should then find many animal phobias which are diffuse and many agoraphobias which are specific; we should not find that the phobic situation predicts the specificity of the disturbance.

In fact we do not find diffuse animal phobias in adults—the majority of animal phobias are discrete disturbances, and more extensive symptoms are found only in those few cases where the animal phobia happens to be associated with another disturbance such as agoraphobia or a personality disorder. The phobic object predicts the specificity of the disturbance. The same applies in agoraphobia. Most agoraphobics have extensive symptoms, and it is exceptional to find a discrete fear of open spaces without other fears, except in the early stages of the disorder before there has been time for generalization. The other exception is 'burnt-out' agoraphobia, where after years of disability extensive symptoms gradually clear up to leave a few localized fears. The argument against a continuum is further strengthened by the fact that knowledge of the phobic situation is such a good predictor of physiological measures.

Social phobias

Psychiatrists see a wide variety of social phobias in the form of fears of eating, drinking, shaking, blushing, speaking, writing or vomiting in the presence of other people. These differ from the fears of crowds found in agoraphobics in that the latter are more apprehensive about a mass of people together than of the individuals who make up the crowd. Not a few agoraphobics also have mild social phobias.

Social phobias form roughly 8 per cent of phobic disorders in the Maudsley Hospital, and occur in men and women. Social phobias usually start after puberty, with a peak in the late teens. Their age of onset overlaps with that of agoraphobia.

This group is less coherent than the animal phobics or agoraphobics, and has characteristics intermediate to them. Social phobics have rather more phobias and other symptoms than animal phobics, but fewer than agoraphobics. Psychophysiological measures are seen in Table II. They acquire eyeblink conditioned responses quite rapidly (Martin *et al.*, 1969). Skin resistance is indistinguishable from that of the agoraphobics (Lader *et al.*, 1967). In the few patients who have had their forearm blood flow measured, this has been at the same level as in agoraphobics.

Social phobics resemble agoraphobics except for their sex incidence, fewer symptoms and lower Cornell scores. The more diffuse examples may have minor agoraphobic symptoms, but many are very specific phobias. We need to know more about social phobics before definitely classifying them on their own.

The groups seen together (Table II)

It is useful here to summarize the data for animal phobias, agoraphobias and social phobias. In preponderance of women the agoraphobics and animal phobias stand out. In onset age the animal phobias are distinctive. Treatment age does not distinguish the different groups of phobias. Overt anxiety is most prominent in anxiety states, least obvious in the animal phobics. Cornell and Neuroticism scores are normal only in the animal phobics. Anxiety states are significantly more neurotic and introverted than any other group. Skin resistance and forearm blood flow are again normal in the animal phobics and most abnormal in anxiety states. Eyeblink conditioned response

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acquisition is significantly more rapid and extinction more slow in animal phobics. Response to treatment is poorest in agoraphobia and best in specific phobias.

Miscellaneous specific phobias

The final group of phobias of external stimuli is a group of monosymptomatic phobias which start at any time in life and persist fairly continuously. The phobic situations vary from one case to another but are fairly specific for a given case. The situations include heights, wind, darkness, thunderstorms, running water and so on. Although agoraphobics frequently have fears of closed spaces such as lifts, tubes or aeroplanes, the reverse is not always found, as some patients with claustrophobia tend to have relatively isolated fears without the concomitants found in agoraphobia and these fall within this group. Such patients have limited phobias of travelling in lifts, trains, tubes or aeroplanes, and these may be an occupational hazard, for example in pilots.

Physiological data are not available except that forearm blood flow has been normal in the few patients who have been tested. It is quite possible that this group will turn out to be indistinguishable from animal phobics apart from age of onset and sex incidence. These patients respond quite well to treatment, and many of the successful cases in the literature about desensitization come from this group.

Class II. Phobias of internal stimuli

In these phobias the feared situation is inside the patient, and there is thus no external situation which can be avoided to reduce fear.

Illness phobias

These are intense fears of illness which centre round specific disturbances like cancer, heart disease, venereal disease, death and so on. The phobia consists of endless rumination about the possibility of suffering from any one of a host of diseases. The phobia resembles an obsessive thought except that there is no subjective feeling of resistance. Fears of this kind are often a prominent feature of depressive illnesses, in which cases they fluctuate with the depression. However, in a small group of patients these fears of illness occur and persist independent of any other symptom. They could be regarded as an extreme form of hypochondriasis, though in patients with hypochondriasis the fears are diffuse and not of any particular malady. Illness phobias occur in both sexes, the particular illness which is feared depending in part on what is fashionable in the culture. Little systematic work has been done on patients of this kind, as opposed to those with diffuse hypochondriasis. Their course is not clear, and series of patients with this problem have not been treated or investigated systematically. It is thus too early to decide whether this group can be regarded as a separate syndrome.

Obsessive phobias

These are fears about one's own feeling 'which come to consciousness in spite of and contrary to the will of the patient and which he is unable to suppress although he recognizes them as abnormal and not characteristic of himself' (Westphal, 1878).

Examples of such are fears of harming people or babies, fears of swearing or making obscene gestures, fears of contamination which lead to obsessive handwashing. These obsessions could strictly be called phobias; they are disproportionate to demands of the situation, cannot be explained away and are beyond voluntary control. However, they are generally found together with other obsessive-compulsive phenomena, and so are best regarded as obsessive-compulsive disorders and omitted from the main rubric of phobias. Obsessive phobias are bound up with elaborate rituals and magical thinking and are very resistant to treatment (Marks *et al.*, 1969) to which phobias of external situations commonly respond.

Obsessive-compulsive disorders can start at any age and appear with equal frequency in both sexes.

Phobias in children

As in adults any object or situation can be the focus of a phobia in children, but overall patterns are rather different. Phobias of many kinds are more common and more transitory events than in adults. Little is known by which we can classify childhood phobias usefully. Further details appear elsewhere (Rutter, Tizard and Whitmore, 1968, Marks, 1969).

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Discussion

Having looked briefly at the main groups of phobic disorders found in psychiatric practice, the evidence suggests some general thoughts about the aetiology of phobias. Phobias do not occur randomly with respect to all situations, ages, or other psychiatric symptoms. Rather, phobias tend to occur in particular kinds of situations, at certain ages more than at others, and in association with well-defined clusters of other psychiatric symptoms.

One general point is that, although in theory any situation may trigger a phobia, in practice certain classes of stimuli are more likely than others to trigger off phobias, given that these different stimuli are all encountered quite frequently. It is reasonable to expect that phylogenetic mechanisms are at least partly responsible for this prepotency of certain stimuli to produce fear in man, just as they do in other species (Marks, 1969).

Another general point concerns the age incidence. At least in the animal phobias there may be a facilitatory period for the acquisition of such fears in childhood, since adults rarely acquire these fears for the first time in adult life.

The fact that agoraphobia starts after puberty may be linked to the fact that anxiety states also begin in the same age range. Similar mechanisms may be at work. Evidence from the effects of leucotomy indicates that agoraphobia is partly maintained by excessive diffuse anxiety which repeatedly generates fresh fears.

Next, the kind of phobic object is of some importance. Not all phobic situations are equivalent, since by knowing the kind of situation which is feared we can often tell other likely characteristics of the patients.

What do the psychophysiological measures mean? Forearm blood flow and the spontaneous fluctuations and habituation of the galvanic skin resistance correlate with anxiety. The habituation rate also correlates significantly with response to desensitization; that is, patients who habituate rapidly respond better to desensitization.

Little is known about the correlates of eyeblink conditioning and extinction. It is surprising that the phobics who conditioned best were those with fewest symptoms, and that phobic patients with the most symptoms only conditioned at a normal rate. If one assumed that the symptoms were due to rapid conditioning, then rapid conditioners should have many symptoms, and this is precisely the opposite of what we find. We do not yet understand the significance of this rapid conditioning and slow extinction in animal phobics.

Conclusion

In conclusion, the phobic states are a series of related disorders with overlapping features. They range from very simple to very complex disturbances, and multiple factors contribute to their genesis. One way of classifying phobic states has been presented, but the clinical material could have been subdivided differently. The simplest classification would have been to describe two kinds of phobias—monosymptomatic (e.g. animals, other specific situations) and diffuse (agoraphobics and some social phobias). It is true that such a classification is useful in predicting response to treatment. It does not predict symptomatology, onset age or sex incidence. Possibly the best classification would be one which took into account both the nature of the phobic situation and its specificity.

Summary

Phobias can occur in almost any situation and together with practically any other psychiatric symptom. Phobic disorders are a series of related disorders which need to be differentiated from phobic symptoms which are a minor accompaniment of another major psychiatric disturbance.

In adults mild fears are almost ubiquitous but intense phobias are uncommon. Phobic disorders in adults may conveniently be divided into Class I, those of external situations and Class II phobias, those of internal situations which cannot be escaped. Amongst phobias of external situations the agoraphobic syndrome is the commonest and most distressing phobic disorder in psychiatric practice. This is a cluster of fears which start in adult life and centre round going out alone, into public places, crowds and vehicles, occurring together in varying combinations, often with other symptoms as well. Animal phobias are rare monosymptomatic fears of a single animal species

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which start in childhood and persist into adult life. Social phobias are less rare, but evidence is lacking that this is a coherent group. Miscellaneous specific phobias are discrete phobias which start at any time of life. Amongst phobias of internal situations the status of illness phobias is unclear, while obsessive phobias are best classified separately with obsessive-compulsive phenomena.

Several groups of phobias of external situations can be differentiated from one another on the basis of clinical, questionnaire and psychophysiological variables.

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REFERENCES

AGRAS, W. S., SYLVESTER, D., and OLIVEAU, D. (1969). 'The epidemiology of common fears and phobias.' *Comprehensive Psychiat.*, **10**, 151–6.

ERRERA, P., and COLEMAN, J. V. (1963). 'A long-term follow-up study of neurotic phobic patients in a psychiatric clinic.' *J. nerv. ment. Dis.*, **136**, 267–71.

FRAZIER, S. H., and CARR, A. C. (1967). 'Phobic reaction.' In: Freedman, A. M. and Kaplan, H. I. (Eds). *Comprehensive Textbook of Psychiatry*. Williams and Wilkins, Baltimore.

FREUD, S. (1895). *Rev. neurol. 3.* (Transl. in *Collected Papers*. Vol. 1. p. 128. London: International Psychoanalytic Press, 1924.)

GELDER, M. G., and MARKS, I. M. (1966). 'Severe agoraphobia: A controlled prospective trial of behaviour therapy.' *Brit. J. Psychiat.*, **112**, 309–19.

—— —— (1968). 'Desensitization and phobias: a cross-over study.' *Brit. J. Psychiat.*, **114**, 323–8.

—— —— and WOLFF, H. H. (1967). 'Desensitization and psychotherapy in the treatment of phobic states: a controlled enquiry.' *Brit. J. Psychiat.*, **113**, 53–73.

HARE, E. H. (1965). *Triennial Statistical Report*, 1961–3. Bethlem Royal and Maudsley Hospitals.

KELLY, D. H. W. (1966). 'Measurement of anxiety by forearm blood flow.' *Brit. J. Psychiat.*, **112**, 789–98.

—— and MARTIN, I. (1969). Autonomic reactivity, eyelid conditioning, and their relationship to neuroticism and extraversion. *Behav. Res. Ther.* **7**, 233–44.

LADER, M. H. (1966). 'Predictive value of automatic measures in patients with phobic states.' D.P.M. Dissertation, University of London.

—— and WING, L. (1966). *Physiological Measures, Sedative Drugs and Morbid Anxiety*. Maudsley Monograph No. 14. Oxford University Press, London.

—— GELDER, M. G., and MARKS, I. M. (1967). 'Palmar skin-conductance measures as predictors of response to desensitisation.' *J. psychosom. Res.*, **11**, 283–90.

LANG, P. J. (1966). Fear reduction and fear behaviour. 'Problems in treating a construct.' In *3rd Conference on Research in Psychotherapy*, Chicago, Illinois June, 1966.

MACFARLANE, J. W., ALLEN, L., and HONZIK, M. P. (1954). *A developmental study of the behaviour problems of normal children between 21 months and 14 years*. University of California Press, Berkeley and Los Angeles.

MARKS, I. M. (1967). 'Components and correlates of psychiatric questionnaires.' *Brit. J. med. Psychol.*, **40**, 261–72.

—— (1969). *Fears and Phobias*, Heinemann Medical Books, London.

—— and GELDER, M. G. (1965). 'A controlled retrospective study of behaviour therapy in phobic patients.' *Brit. J. Psychiat.*, **111**, 571–3.

—— —— (1966). 'Different onset ages in varieties of phobia.' *Amer. J. Psychiat.*, **123**, 218–21.

—— and HERST, E. (1970). 'A survey of agoraphobics in Britain.' *Soc. Psychiat.*, **5**, 16–24.

—— BIRLEY, J. L. T., and GELDER, M. G. (1966). 'Modified leucotomy in severe agoraphobia: a controlled serial inquiry.' *Brit. J. Psychiat.*, **112**, 757–69.

—— CROWE, M., DREWE, E., YOUNG, J., and DEWHURST, W. G. (1969). 'Obsessive neurosis in identical twins.' *Brit. J. Psychiat.*, **115**, 991–8.

MARTIN, I., MARKS, I. M., and GELDER, M. G. (1969). 'Conditioned eyelid responses in phobic patients.' *Behav. Res. Ther.*, **7**, 115–24.

MAUDSLEY, H. (1879). *Pathology of Mind* pp. 319, 431, London: Macmillan.

—— (1895). *Pathology of Mind*, p. 228. London: Macmillan.

ROTH, M., GARSIDE, R. S., and GURNEY, C. (1965). 'Clinical statistical enquiries into the classification of anxiety states and depressive disorders.' In: *Proceedings of Leeds Symposium on Behavioural Disorders*. May and Baker.

RUTTER, M., TIZARD, J., and WHITMORE, K. (1968). Chapter 12 in *Education, Health and Behaviour*. London: Longmans.

SNAITH, R. P. (1968). 'A clinical investigation of phobias.' *Brit. J. Psychiat.*, **114**, 673–98.

WESTPHAL, C. (1871). *Archiv f. Psychiatrie*, **3**, 138.

—— (1878). 'Zwangsvorstellungen.' *Arch. Psychiat. Nervenkr.*, **8**, 734–50.

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