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with a student nurse from another school, in itself a broadening experience.

Whether or not evaluative studies of this kind are feasible, I hope Dr. Korson will con-
tinue his program and that other psychiatric hospitals, encouraged by his innovation, will seek their own ways of improving the affiliate experience of their student nurses.

Different Ages of Onset in Varieties of Phobia

BY I. M. MARKS, M.D., D.P.M., AND M. G. GELDER, D.M., M.R.C.P., D.P.M.

In the course of treating a large series of adults with phobias, observations were made about the ages of onset which do not seem to have been reported previously in adults. As our observations appear to have an important bearing on the origin of phobias, they are reported here.

The Patients

These were all adults presenting at a psychiatric hospital with phobia as a main complaint. Patients were classified into four groups according to the kind of object they feared.

I. Patients with specific animal phobias (n = 18, 17 female, one male) all had phobias of animals or insects, e.g., birds, feathers, dogs, or cats, which were usually the only complaint, although in a small minority the phobia was associated with other disturbances, such as depression, aggressive behavior, or other fears.

II. Patients with specific situational phobias (n = 12, nine female, three male) had phobias of particular situations (without reference to animate objects) e.g., heights, darkness, or thunderstorms. In these patients the phobia was often the only complaint, as in the first group, but was associated occasionally with other fears.

III. Patients with social anxieties (n = 25, 15 female, ten male) had phobias of social situations, expressed variably as shyness, fears of blushing in public, of eating meals in restaurants, of meeting men or women, of going to dances or parties, or of shaking when the center of attention. Sometimes the distinction from the fourth group was rather arbitrary, e.g., a patient who feared walking on the street for fear of seeming ridiculous to other people was included in this group. Where the fear of walking in the street was not obviously related to the presence of people, the patient was included in the agoraphobic group. A minority of these patients also had other psychiatric symptoms such as agoraphobia and serious depression.

IV. Patients with agoraphobias (n = 84, 73 females, 11 males) had fears of open or closed spaces, of being alone or in crowds, of traveling on buses or trains, or walking in the street. They were not uncommonly associated with specific situational or social phobias of minor intensity. These were by far the most common and most handicapping phobias and the most difficult to treat. They were associated with many other psychiatric symptoms—general anxiety, depression, and obsessions were frequently pronounced.

Age at Onset and Age at Treatment

Specific animal phobias (animals and insects) stand out clearly from other types of phobia in that most started by the age of five and none started in adult life, even though these patients only presented for treatment as adults (see Table 1).

By contrast, specific situational phobias showed a wide spread of onset age—some started before five, most began in adult life. Social anxieties started mostly after

The authors are with the Maudsley Hospital, Denmark Hill, London, S.E. 5, England, where Dr. Marks is Senior Registrar and Dr. Gelder is Senior Lecturer, Institute of Psychiatry.

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TABLE 1

<table>
<thead>
<tr>
<th>TYPE OF PHOBIA</th>
<th>N</th>
<th>AGE AT ONSET MEAN</th>
<th>SD*</th>
<th>AGE AT TREATMENT MEAN</th>
<th>SD</th>
<th>SYMPTOM DURATION MEAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Specific animate</td>
<td>18</td>
<td>4.4</td>
<td>2.8</td>
<td>29.8</td>
<td>7.5</td>
<td>25.4</td>
</tr>
<tr>
<td>II. Specific situational</td>
<td>12</td>
<td>22.7</td>
<td>16.0</td>
<td>36.3</td>
<td>9.2</td>
<td>8.6</td>
</tr>
<tr>
<td>III. Social anxieties</td>
<td>25</td>
<td>18.9</td>
<td>8.3</td>
<td>26.8</td>
<td>6.5</td>
<td>7.9</td>
</tr>
<tr>
<td>IV. Agoraphobia</td>
<td>84</td>
<td>23.9</td>
<td>9.7</td>
<td>32.3</td>
<td>10.3</td>
<td>8.4</td>
</tr>
</tbody>
</table>

* SD = Standard deviation.

Analysis of variance was done on reciprocals of the observations on onset age. Specific animal phobias (I) differ from all the others regarding age of onset (p < .001) but not regarding age at treatment. Specific situational phobias also differ from the other three varieties but much less obviously than the animal phobias, as the t-values show.

Patients with specific situational phobias came for treatment later than those with social anxieties (p < .001), and the latter presented for treatment earlier than agoraphobic patients (p < .05). The t-values show clearly that the onset age of specific animal phobias is the outstanding feature in all the data.

Discussion

The main finding is that only one of 18 adults presenting for treatment of phobias of animate objects had developed them after the age of eight. This was not true of other groups of phobias examined, which were far more likely to start after the age of ten.

The accuracy of our data may be ques-
been earlier than stated, as a common story was “I’ve had it as long as I can remember—at least since the age of five.” It may also be questioned why these patients came for treatment in adult life when their phobias had been present for so long. There were several reasons: some were brought suddenly into contact with the object of their phobias as the result of some change in their mode of living (e.g., a woman who feared spiders came for treatment when she moved from a town flat to a spider-infested cottage in the country). Others came because they had read of new treatments for fears; a few came initially with another complaint (e.g., depression) and then also asked for help with their phobias.

Can findings about the development of fears in children throw light on our observations? Fears of dogs and snakes are known to be common in young boys and girls but diminish by the age of six (3). Fears of animals fall sharply between nine and 11 (1) and remain at a very low level thereafter. Before age 11 these fears are common—our patients are probably the small residue who did not lose their fear.

Why did this minority fail to lose their fear? The incidence drops sharply at ages 13 to 14 but the drop is greater for boys than for girls, thus leaving more girls than boys with fears after this age (4). Many changes take place during adolescence and we can but speculate which of the many possibilities, from social learning to physiological mechanisms, causes the reduction of such fears at this period.

Why do new phobias of animate objects rarely appear after the age of five? Since both children and adults are exposed fairly frequently to animals and insects, some process other than exposure seems likely. One of these might be a process akin to imprinting, for which there is some evidence in humans (6). Several factors differentiate the phenomenon we describe from those usually described as imprinting: imprinting is of positive attractive behavior, not avoidance; imprinted responses are very hard to modify, whereas our specific animal phobias respond to behavior therapy (2, 5); and imprinted responses start in a more narrowly circumscribed period than are found in these phobias. The phenomenon does suggest, however, that there is a facilitatory period in humans during which avoidance responses can be acquired to a limited class of objects much more readily than at other ages.

This idea is supported further by the fact that in a patient of ours with several varieties of fear, the specific animal phobia began in early childhood, while the agoraphobia started much later.

The concept of a facilitatory period implies that maturation partly determines which environmental stimuli produce fear responses at different ages. Current descriptions of the origin of phobias emphasize learning, as in behaviorist writings, or emotional conflict, as in psychoanalytic formulations. Though both play their part, overemphasis tends to ignore the contribution of maturational factors which our data suggest are important for at least one variety of phobia—the animal phobias.

Both behaviorist and psychoanalytic views favor unitary explanations of phobias, and attempts to subdivide the phobias have proved fruitless. Our clinical data suggest that there is heuristic value in classifying phobias of animate objects separate from the other varieties of phobia, since they differ in certain important ways: they have a very different age of onset, a relatively continuous course, are associated with few other psychiatric symptoms (5), and respond better to behavior therapy (2, 5). The psychiatrist also sees far fewer of them than of the other varieties (5).

Summary

One hundred and thirty-nine adult phobic patients presenting for treatment were subdivided into four groups with phobias of: I) animals and insects; II) specific situations (e.g., heights, thunder); III) social situations; and IV) agoraphobia.

All four groups first sought treatment at comparable ages in adult life. However, the onset age of phobias differed between groups: hardly any phobias of animals and insects had started after age five, while most phobias of the other varieties started after age ten. This suggests a facilitatory period in early childhood for the acquisition of certain fears.

This different onset age of animal pho-
bias was accompanied by other differentiating features: circumscribed symptoms, continuous course, and a better response to behavior therapy despite longer duration of symptoms.

REFERENCES

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Differential Effects of Abrupt Versus Gradual Withdrawal of Chlorpromazine in Hospitalized Chronic Schizophrenic Patients

BY LAWRENCE M. GREENBERG, M.D., AND S. ROTH, M.S.W.

In many mental hospitals, there are increasing numbers of chronically ill, schizophrenic patients who have been receiving large dosages of chlorpromazine over long periods of time. It is generally accepted that chlorpromazine is of significant value in the treatment of such patients, enabling them to achieve improved levels of social functioning(10). However, to avoid the many side effects of chlorpromazine, such as drowsiness, photosensitivity, hepatic dysfunction, blood dyscrasias, and extrapyramidal symptoms(1, 2, 9), it is desirable to discontinue or at least reduce the medication without increasing the morbidity rate. In addition, the considerable costs of medication and staff time for both administration and periodic examinations cannot be minimized(5).

Many studies(5, 8, 17, 18, 24) of abrupt withdrawal of chlorpromazine with or without the use of placebo substitution are cited as presenting evidence that chlorpromazine is necessary for maintenance of clinical improvement in such patients. The adequacy of studies using abrupt withdrawal are questionable, however, to demonstrate this need for medication; an abrupt withdrawal of medication may result in a higher relapse rate than would be obtained with gradual decrease of medication.

If one assumes that chlorpromazine and similar medications are useful clinically to enable the patient to reintegrate ego defenses by acting as a "protective buffer" to internal and/or external stimuli, it would follow that a gradual reduction of such a "protective barrier" would be preferable to a possible abrupt overwhelming of the ego with stimulation (see also 14, 23).

Ray and associates(15), Rothstein and associates(17), and Winkelmann(23) substituted placebo for active medication over periods of four weeks, two weeks, and one


This study was conducted while the authors were with St. Elizabeths Hospital, Washington, D. C. Dr. Greenberg is now a Fellow with the Department of Child Psychiatry, Children's Hospital, Washington, D. C. Mrs. Roth is a social worker at Hillcrest Children's Center, Washington, D. C.

Placebo tablets were supplied by Smith, Kline and French Laboratories.

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