

04 - 9.4 Specific Phobia

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9.4 Specific Phobia The term phobia refers to an excessive fear of a specific object, circumstance, or situation. A specific phobia is a strong, persisting fear of an object or situation. The diagnosis of specific phobia requires the development of intense anxiety, even to the point of panic, when exposed to the feared object. Persons with specific phobias may anticipate harm, such as being bitten by a dog, or may panic at the thought of losing control; for instance, if they fear being in an elevator, they may also worry about fainting after the door closes.

EPIDEMIOLOGY Phobias are one of the most common mental disorders in the United States, where approximately 5 to 10 percent of the population is estimated to have these troubling and sometimes disabling disorders. The lifetime prevalence of specific phobia is about 10 percent. Specific phobia is the most common mental disorder among women and the second most common among men, second only to substance-related disorders. The 6-month prevalence of specific phobia is about 5 to 10 per 100 persons (Table 9.4-1). The rates of specific phobias in women (14 to 16 percent) were double those of men (5 to 7 percent), although the ratio is closer to 1 to 1 for the fear of blood, injection, or injury type. (Types of phobias are discussed below in this section.) The peak age of onset for the natural environment type and the blood-injection-injury type is in the range of 5 to 9 years, although onset also occurs at older ages. In contrast, the peak age of onset for the situational type

(except fear of heights) is higher, in the mid-20s, which is closer to the age of onset for agoraphobia. The feared objects and situations in specific phobias

(listed in descending frequency of appearance) are animals, storms, heights, illness, injury, and death. Table 9.4-1 Lifetime Prevalence Rates of Specific Phobia COMORBIDITY Reports of comorbidity in specific phobia range from 50 to 80 percent. Common comorbid disorders with specific phobia include anxiety, mood, and substance-related disorders. ETIOLOGY General Principles of Phobias Behavioral Factors. In 1920, John B. Watson wrote an article called "Conditioned Emotional Reactions," in which he recounted his experiences with Little Albert, an infant with a fear of rats and rabbits. Unlike Sigmund Freud's case of Little Hans, who had phobic symptoms (of horses) in the natural course of his maturation, Little Albert's difficulties were the direct result of the scientific experiments of two psychologists who used techniques that had successfully induced conditioned responses in laboratory animals. Watson's hypothesis invoked the traditional pavlovian stimulus-response model of the conditioned reflex to account for the creation of the phobia: Anxiety is aroused by a naturally frightening stimulus that occurs in contiguity with a second inherently neutral stimulus. As a result of the contiguity, especially when the two stimuli are paired on several successive occasions, the originally neutral stimulus becomes capable of arousing anxiety by itself. The neutral stimulus, therefore, becomes a conditioned stimulus for anxiety production. In the classic stimulus-response theory, the conditioned stimulus gradually loses its

potency to arouse a response if it is not reinforced by periodic repetition of the unconditioned stimulus. In phobias, attenuation of the response to the stimulus does not occur; the symptom may last for years without any apparent external reinforcement. Operant conditioning theory provides a model to explain this phenomenon: Anxiety is a drive that motivates the organism to do whatever it can to obviate a painful affect. In the course of its random behavior, the organism learns that certain actions enable it to avoid the anxiety-provoking stimulus. These avoidance patterns remain stable for long periods as a result of the reinforcement they receive from their capacity to diminish anxiety. This model is readily applicable to phobias in that avoidance of the anxietyprovoking object or situation plays a central part. Such avoidance behavior becomes fixed as a stable symptom because of its effectiveness in protecting the person from the phobic anxiety. Learning theory, which is particularly relevant to phobias, provides simple and intelligible explanations for many aspects of phobic symptoms. Critics contend, however, that learning theory deals mostly with surface mechanisms of symptom formation and is less useful than psychoanalytic theories in clarifying some of the complex underlying psychic processes involved. Psychoanalytic Factors. Sigmund Freud's formulation of phobic neurosis is still the analytic explanation of specific phobia and social phobia. Freud hypothesized that the major function of anxiety is to signal the ego that a forbidden unconscious drive is pushing for conscious expression and to alert the ego to strengthen and marshal its defenses against the threatening instinctual force. Freud viewed the phobia—*anxiety hysteria*, as he continued to call it—as a result of conflicts centered on an unresolved childhood oedipal situation. Because sex drives continue to have a strong incestuous coloring in adults, sexual arousal can kindle an anxiety that is characteristically a fear of castration. When repression fails to be entirely successful, the ego must call on auxiliary defenses. In patients with phobias, the primary defense involved is displacement; that is, the sexual conflict is displaced from the person who evokes the conflict to a seemingly unimportant, irrelevant object or situation, which then has the power to arouse a constellation of affects, one of which is called signal anxiety.

The phobic object or situation may have a direct associative connection with the primary source of the conflict and thus symbolizes it (the defense mechanism of symbolization). Furthermore, the situation or the object is usually one that the person can avoid; with the additional defense mechanism of avoidance, the person can escape suffering serious anxiety. The end result is that the three combined defenses (repression, displacement, and symbolization) may eliminate the anxiety. The anxiety is controlled at the cost of creating a phobic neurosis, however. Freud first discussed the theoretical formulation of phobia formation in his famous case history of Little Hans, a 5-year-old boy who feared horses. Although psychiatrists followed Freud's thought that phobias resulted from castration anxiety, recent psychoanalytic theorists have suggested that other types of anxiety may be involved. In agoraphobia, for example, separation anxiety clearly plays a leading

role, and in erythrophobia (a fear of red that can be manifested as a fear of blushing), the element of shame implies the involvement of superego anxiety. Clinical observations have led to the view that anxiety associated with phobias has a variety of sources and colorings. Phobias illustrate the interaction between a genetic constitutional diathesis and environmental stressors. Longitudinal studies suggest that certain children are constitutionally predisposed to phobias because they are born with a specific temperament known as behavioral inhibition to the unfamiliar, but a chronic environmental stress must act on a child's temperamental disposition to create a fullblown phobia. Stressors, such as the death of a parent, separation from a parent, criticism or humiliation by an older sibling, and violence in the household, may activate the latent diathesis within the child, who then becomes symptomatic. An overview of psychodynamic aspects of phobias is summarized in Table 9.4-2. Table 9.4-2 Psychodynamic Themes in Phobias COUNTERPHOBIC ATTITUDE. Otto Fenichel called attention to the fact that phobic anxiety can be hidden behind attitudes and behavior patterns that represent a denial, either that the dreaded object or situation is dangerous or that the person is afraid of it. Instead of being a passive victim of external circumstances, a person reverses the situation and actively attempts to confront and master whatever is feared. Persons with counterphobic attitudes seek out situations of danger and rush enthusiastically toward them. Devotees of potentially dangerous sports, such as parachute jumping and rock climbing, may be exhibiting counterphobic behavior. Such patterns may be secondary to phobic anxiety or may be normal means of dealing with a realistically dangerous situation. Children's play may exhibit counterphobic elements, as when children play doctor and give a doll the shot they received earlier that day in the pediatrician's office. This pattern of behavior may involve the related defense mechanism of identifying with the aggressor.

Specific Phobia The development of specific phobia may result from the pairing of a specific object or situation with the emotions of fear and panic. Various mechanisms for the pairing have been postulated. In general, a nonspecific tendency to experience fear or anxiety forms the backdrop; when a specific event (e.g., driving) is paired with an emotional experience (e.g., an accident), the person is susceptible to a permanent emotional association between driving or cars and fear or anxiety. The emotional experience itself can be in response to an external incident, as a traffic accident, or to an internal incident, most commonly a panic attack. Although a person may never again experience a panic attack and may not meet the diagnostic criteria for panic disorder, he or she may have a generalized fear of driving, not an expressed fear of having a panic attack while driving. Other mechanisms of association between the phobic object and the phobic emotions include modeling, in which a person observes the reaction in another (e.g., a parent), and information transfer, in which a person is taught or warned about the dangers of specific objects

(e.g., venomous snakes). Genetic Factors. Specific phobia tends to run in families. The blood-injection-injury type has a particularly high familial tendency. Studies have reported that two-thirds to three-fourths of affected probands have at least one first-degree relative with specific phobia of the same type, but the necessary twin and adoption studies have not been conducted to rule out a significant contribution by nongenetic transmission of specific phobia. **DIAGNOSIS** The DSM-5 includes distinctive types of specific phobia: animal type, natural environment type (e.g., storms), blood-injection-injury type (e.g., needles), situational type (e.g., cars, elevators, planes), and other type (for specific phobias that do not fit into the previous four types). The key feature of each type of phobia is that fear symptoms occur only in the presence of a specific object (Table 9.4-3). The blood-injection-injury type is differentiated from the others in that bradycardia and hypotension often follow the initial tachycardia that is common to all phobias. The blood-injection-injury type of specific phobia is particularly likely to affect many members and generations of a family. One type of phobia of recently reported phobia is space phobia, in which persons fear falling when there is no nearby support, such as a wall or a chair. Some data indicate that affected persons may have abnormal right hemisphere function, possibly resulting in visual-spatial impairment. Balance disorders should be ruled out in such patients. Table 9.4-3 DSM-5 Diagnostic Criteria for Specific Phobia

Phobias have traditionally been classified according to specific fear by means of Greek or Latin prefixes, as indicated in Table 9.4-4. Other phobias that are related to changes in the society are the fear of electromagnetic fields, of microwaves, and of society as a

whole (amaxophobia). Table 9.4-4 Phobias Mr. S was a successful lawyer who presented for treatment after his firm, to which he had previously been able to walk from home, moved to a new location that he could only reach by driving. Mr. S reported that he was “terrified” of driving, particularly on highways. Even the thought of getting into a car led him to worry that he would die in a fiery crash. His thoughts were associated with intense fear and numerous somatic symptoms, including a racing heart, nausea, and sweating. Although the thought of driving was terrifying in and of itself, Mr. S became nearly incapacitated when he drove on busy roads, often having to pull over to vomit. (Courtesy of Erin B. McClure-Tone, Ph.D., and Daniel S. Pine, M.D.) **CLINICAL FEATURES** Phobias are characterized by the arousal of severe anxiety when patients are exposed to specific situations or objects or when patients even anticipate exposure to the situations or objects. Exposure to the phobic stimulus or anticipation of it almost invariably results in a panic attack in a person who is susceptible to them. Persons with phobias, by definition, try to avoid the phobic stimulus; some go to great trouble to avoid anxiety-provoking situations. For example, a patient with a phobia may take a bus across the United States, rather than fly, to avoid contact with the object of the patient’s phobia, an airplane. Perhaps as another way to avoid the stress of the phobic stimulus, many patients have substance-related disorders, particularly alcohol use disorders. Moreover, an estimated one-third of patients with social phobia have major depressive disorder. The major finding on the mental status examination is the presence of an irrational and ego-dystonic fear of a specific situation, activity, or object; patients are able to describe how they avoid contact with the phobia. Depression is commonly found on the mental status examination and may be present in as many as one-third of all patients

with phobia. **Differential Diagnosis** Nonpsychiatric medical conditions that can result in the development of a phobia include the use of substances (particularly hallucinogens and

sympathomimetics), CNS tumors, and cerebrovascular diseases. Phobic symptoms in these instances are unlikely in the absence of additional suggestive findings on physical, neurological, and mental status examinations. Schizophrenia is also in the differential diagnosis of specific phobia because patients with schizophrenia can have phobic symptoms as part of their psychoses. Unlike patients with schizophrenia, however, patients with phobia have insight into the irrationality of their fears and lack the bizarre quality and other psychotic symptoms that accompany schizophrenia. In the differential diagnosis of specific phobia, clinicians must consider panic disorder, agoraphobia, and avoidant personality disorder. Differentiation among panic disorder, agoraphobia, social phobia, and specific phobia can be difficult in individual cases. In general, however, patients with specific phobia tend to experience anxiety immediately when presented with the phobic stimulus. Furthermore, the anxiety or panic is limited to the identified situation; patients are not abnormally anxious when they are neither confronted with the phobic stimulus nor caused to anticipate the stimulus. Other diagnoses to consider in the differential diagnosis of specific phobia are hypochondriasis, OCD, and paranoid personality disorder. Whereas hypochondriasis is the fear of having a disease, specific phobia of the illness type is the fear of contracting the disease. Some patients with OCD manifest behavior indistinguishable from that of a patient with specific phobia. For example, whereas patients with OCD may avoid knives because they have compulsive thoughts about killing their children, patients with specific phobia about knives may avoid them for fear of cutting themselves. Patients with paranoid personality disorder have generalized fear that distinguishes them from those with specific phobia.

COURSE AND PROGNOSIS Specific phobia exhibits a bimodal age of onset, with a childhood peak for animal phobia, natural environment phobia, and blood-injection-injury phobia and an early adulthood peak for other phobias, such as situational phobia. Limited prospective epidemiological data are available that chart the natural course of specific phobia. Because patients with isolated specific phobia rarely present for treatment, there is also little research on the course of the disorder in the clinic. The limited information that is available suggests that most specific phobias that begin in childhood and persist into adulthood will continue to persist for many years. The severity of the condition is believed to remain relatively constant, which contrasts with the waxing and waning course seen in other anxiety disorders.

TREATMENT Phobias Behavior Therapy. The most studied and most effective treatment for phobias is probably behavior therapy. The key aspects of successful treatment are (1) the patient's commitment to treatment; (2) clearly identified problems and objectives; and (3) available alternative strategies for coping with the feelings. A variety of behavioral treatment techniques have been used, the most common being systematic desensitization, a method pioneered by Joseph Wolpe. In this method, the patient is exposed serially to a predetermined list of anxiety-provoking stimuli graded in a hierarchy from the least to the most frightening. Through the use of antianxiety drugs, hypnosis, and instruction in muscle relaxation, patients are taught how to induce in themselves both mental and physical repose. After they have mastered the techniques, patients are taught to use them to induce relaxation in the face of each anxiety-provoking stimulus. As they become desensitized to each stimulus in the scale, the patients move up to the next stimulus until, ultimately, what previously produced the most anxiety no longer elicits the painful affect. Other behavioral techniques that have been used more recently involve intensive exposure to the phobic stimulus through either imagery or desensitization in vivo. In imaginal flooding, patients are exposed to the phobic stimulus for as long as they can tolerate the fear until they reach a point at which they can no longer feel it. Flooding (also known as implosion) in vivo requires patients to

experience similar anxiety through exposure to the actual phobic stimulus. Insight-Oriented Psychotherapy. Early in the development of psychoanalysis and the dynamically oriented psychotherapies, theorists believed that these methods were the treatments of choice for phobic neurosis, which was then thought to stem from oedipal-genital conflicts. Soon, however, therapists recognized that, despite progress in uncovering and analyzing unconscious conflicts, patients frequently failed to lose their phobic symptoms. Moreover, by continuing to avoid phobic situations, patients excluded a significant degree of anxiety and its related associations from the analytic process. Both Freud and his pupil Sandor Ferenczi recognized that if progress in analyzing these symptoms was to be made, therapists had to go beyond their analytic roles and actively urge patients with phobia to seek the phobic situation and experience the anxiety and resultant insight. Since then, psychiatrists have generally agreed that a measure of activity on the therapist's part is often required to treat phobic anxiety successfully. The decision to apply the techniques of psychodynamic insight-oriented therapy should be based not on the presence of phobic symptoms alone but on positive indications from the patient's ego structure and life patterns for the use of this method of treatment. Insight-oriented therapy enables patients to understand the origin of the phobia, the phenomenon of secondary gain, and the role of resistance and enables them to seek

healthy ways of dealing with anxiety-provoking stimuli. Virtual Therapy. A number of computer-generated simulations of phobic disorders have been developed. Patients are exposed to or interact with the phobic object or situation on the computer screen. Countless numbers of such programs are available, and others are in continual development. Variable success rates have been reported, but virtual therapy for phobic disorder is on the cutting edge of using computers to treat mental illness. Other Therapeutic Modalities. Hypnosis, supportive therapy, and family therapy may be useful in the treatment of phobic disorders. Hypnosis is used to enhance the therapist's suggestion that the phobic object is not dangerous, and self-hypnosis can be taught to the patient as a method of relaxation when confronted with the phobic object. Supportive psychotherapy and family therapy are often useful in helping the patient actively confront the phobic object during treatment. Not only can family therapy enlist the aid of the family in treating the patient, but it may also help the family understand the nature of the patient's problem. Specific Phobia A common treatment for specific phobia is exposure therapy. In this method, therapists desensitize patients by using a series of gradual, self-paced exposures to the phobic stimuli, and they teach patients various techniques to deal with anxiety, including relaxation, breathing control, and cognitive approaches. The cognitive-behavioral approaches include reinforcing the realization that the phobic situation is, in fact, safe. The key aspects of successful behavior therapy are the patient's commitment to treatment, clearly identified problems and objectives, and alternative strategies for coping with the patient's feelings. In the special situation of blood-injection-injury phobia, some therapists recommend that patients tense their bodies and remain seated during the exposure to help avoid the possibility of fainting from a vasovagal reaction to the phobic stimulation. β -adrenergic receptor antagonists may be useful in the treatment of specific phobia, especially when the phobia is associated with panic attacks. Pharmacotherapy (e.g., benzodiazepines), psychotherapy, or combined therapy directed to the attacks may also be of benefit. REFERENCES Britton JC, Gold AL, Deckersbach T, Rauch SL. Functional MRI study of specific animal phobia using an event-related emotional counting stroop paradigm. *Depress Anxiety*. 2009;26:796. Coelho CM, Purkis H. The origins of specific phobias: Influential theories and current perspectives. *Rev Gen Psychology*. 2009;13:335. Gamble AL, Harvey AG, Rapee RM. Specific phobia. In: Stein DJ, Hollander E, Rothbaum BO, eds. *Textbook of Anxiety Disorders*. 2nd Edition. Arlington, VA: American Psychiatric Publishing; 2009:525. Hamm AO. Specific phobias. *Psychiatr Clin North Am*.

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