Chapter 12

Specific Phobia

NEVILLE J. KING
PETER MURIS
THOMAS H. OLLENDICK

Children display a variety of fears during the normal course of development (Gullone, 2000; Ollendick, Hagopian, & King, 1997), Typically, children evince fear reactions to stimuli such as strangers, separation, loud noises, darkness, water, imaginary creatures, and small animals such as snakes and spiders, as well as other circumscribed or specific events or objects (King, Hamilton, & Ollendick, 1988). For the most part, these fears appear to result from day-to-day experiences of growing children and to reflect the children's emerging cognitive and representational abilities (Muris & Merckelbach, 2001). Such fears are short-lived, are adaptive, and do not cause distress. On the other hand, some children exhibit fear reactions that persist, are maladaptive and cause much distress for the child. Extreme fears of this nature are known as "phobias" (Barrios & Hartmann, 1997; Ollendick, King, & Muris, 2002; Ollendick, King, & Yule, 1994).

SYMPTOM PICTURE

Common examples of childhood phobias include excessive fears of animals, heights, water, thunderstorms, darkness, and medical or dental procedures. Following the tripartite model originally developed by Lang (1968, 1977), childhood fears and phobias can be conceptualized in

terms of three response systems: cognitive, physiological, and overt-behavioral (Barrios & Hartmann, 1997; King, Ollendick & Murphy, 1997; Silverman & Ginsburg, 1995). In relation to the cognitive system, common responses include thoughts of being scared ("I feel afraid"), negative self-statements about coping ("I do not know what to do"), and the expectation that confrontation with a fear stimulus will result in personal harm or negative outcomes ("the dog will bite"). In terms of the physiological system, increased heart rate is frequently reported, as well as sweating, dryness of the mouth, upset stomach, and changes in respiration (Beidel, 1989). In relation to the overt-behavioral response system, phobic children frequently avoid or escape from what is feared. When escape or avoidance behavior is not possible, inappropriate fear-related behavior may be evident, such as tantrums, freezing or rigid posture, thumb sucking, clinging to parents, or crying. Severe phobias frequently manifest themselves in all three response systems, although the interrelationship between the response systems is complex (King, Hamilton & Ollendick, 1988; Silverman & Rabian, 1994).

In recognition of their seriousness and persistence, phobias are included in the two most widely accepted mental health diagnostic classification systems (American Psychiatric Association, 1994; World Health Organization, 1992). For example, the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) specifies the following criteria for "specific" phobia: (1) marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation; (2) exposure to the phobic stimulus almost invariably provokes an immediate anxiety response or panic attack; (3) the person recognizes that the fear is excessive or unreasonable; (4) the phobic situation(s) is avoided or else endured with intense anxiety; (5) the phobia causes significant interference to functioning, or there is marked distress about having the phobia; (6) in individuals under 18 years, the duration is at least 6 months, and (7) the anxiety or phobic avoidance are not better accounted for by another disorder, such as obsessive–compulsive disorder or separation anxiety disorder. Five subtypes of specific phobia are differentiated: animal type (fear cued by snakes, spiders, dogs, or bees/insects), natural environment type (fear cued by storms, heights, or water), blood–injection–injury type (fear cued by seeing blood or an injury or by receiving an injection), situational type (fear cued by specific situations such as tunnels, bridges, elevators, flying, public transportation), and a miscellaneous "other" type (fear cued by stimuli such as costumed characters and loud noises).

The DSM-IV (American Psychiatric Association, 1994) recognizes that children may not view their fears as excessive or unreasonable, and, further, that children's fears may be expressed in "childhood" ways such as crying, tantrums, freezing, or clinging. These are important acknowledgments, as

these criteria recognize the developmental nature of children and the developmental course of their fears (Ollendick & King, 1991a; King, Muris & Ollendick, in press). In addition, the DSM-IV specifies parameters for the duration of specific phobias in children (i.e., 6 months). In previous editions of the DSM, duration was not specified.

Consistent with our own clinical impressions, emerging evidence suggests that children with specific phobias frequently have comorbid internalizing or externalizing disorders (Last, Perrin, Hersen & Kazdin, 1992; Silverman et al, 1999). In a study of 80 clinic-referred children with specific phobias, Last and colleagues (1992) found that 75% of the children had a lifetime history of additional anxiety disorders (most commonly separation anxiety disorder), 32.5% had a lifetime history of any depressive disorder, and 22.5% had a lifetime history of any disruptive behavior disorder. Similarly, Silverman and colleagues (1999) reported that of 104 children referred to a phobia outpatient treatment program, a majority (72%) of had at least one comorbid diagnosis: 19% had an additional specific phobia, 16% had separation anxiety disorder, 14% had overanxious disorder, and 6% were diagnosed with attention-deficit/hyperactivity disorder. The remaining 17% of the 72% who had a comorbid diagnosis were distributed over eight additional diagnostic categories. Thus, contrary to simplistic views or assumptions commonly held about children with phobias, these findings suggest that such children have a complex and varied diagnostic profile involving marked comorbidity. An important caveat here is that this conclusion is based on studies with clinic-referred children. Although further investigation is necessary, it appears that community samples probably have greater diagnostic "purity" and less comorbidity (Costello & Angold, 1995).

EPIDEMIOLOGY AND NATURAL HISTORY

Findings on the prevalence of specific phobia in children vary considerably and reflect differences in the sample selected (community vs. clinic-referred), the source assessed (child, parent or both), the assessment method used (structured or unstructured, rating scales) and whether an impairment criterion was part of the definition of a case (Silverman & Rabian, 1994). In their recent review of epidemiological studies, Costello and Angold (1995) concluded that

> OAD/GAD (overanxious disorder/generalized anxiety disorder), separation anxiety, and simple (i.e., specific) phobia are nearly always the most commonly diagnosed anxiety disorders, occurring in around 5% of children, while social phobia, agoraphobia, panic disorder, avoidant disorder,