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PHOBIAS

It is normal that everyone of us has something which make us scared in our life. However, usually it is not so easy to make a distinction between fear and phobia. It is important to know that fear is the normal response to a genuine danger. For example, a fear of being mugged while walking alone in dark alleys in a big city would not be considered a phobia. *Fear is defining as a basic survival mechanism that allows us to be physically prepared to escape from a real danger*. That is why fear is often called the fight-or-flight response. The body is activated by a rush of adrenalin whenever we perceive danger, so we can respond quickly by escaping from the situation or finding another way to reduce the potential threat (e.g., our hearts race to get blood to the big muscles so we can escape easily). However, the person who is fearful of elevators to the extent that he or she refuses to use elevators, even if it means climbing 15 flights of stairs or moving to a new work location, would likely be suffering from a phobia. Hence, *phobia is defining as an abnormally fearful response to a danger that is imagined or is irrationally exaggerated.* People can develop phobic reactions to animals (e.g., spiders), activities (e.g., flying), or social situations (e.g., eating in public or simply being in a public environment). Phobias affect people of all ages, from all walks of life, and in every part of the world. The main difference between fear and phobia is that a phobia interferences with a person's life or preferred activities, or that is so distressing as to lessen the enjoyment of usual activities. The interference could affect daily activities or major life decisions such as employment. However, being phobic does not necessarily mean that the feared object or situation is completely avoided all the time. For example, a person who is phobic of elevator may continue to use elevators but with a great deal of discomfort or with the aid of certain medications.

- *Symptoms of a phobia:*

- Feelings of panic, dread, horror, or terror.
- Recognition that he fear goes beyond normal boundaries and the actual threat of danger.
- Reactions that are automatic and uncontrollable, practically taking over the person's thoughts.
- Rapid heartbeat, shortness of breath, trembling, and an overwhelming desire to flee the situation – all the physical reactions associated with extreme fear.
- Extreme measures taken to avoid the feared object or situation.

➢ *3 separate systems of experiencing fear and phobia:*

1. **Physical system** which includes a wide range of physical sensations such as dizziness, sweating, palpitations, chest discomfort, breathlessness, feelings of unreality, numbness and tingling and so on.
2. **Behavioral system** which includes the activities designed to reduce fears and phobias, such as escape, avoidance, and relying on various protective behavior.
3. **Mental system** which includes the fearful thoughts and predictions that contribute to fears and phobias, such as "something bad is going to happen".

Categories of phobias

❖ **Specific phobia**

Specific phobia refers to an excessive or extreme fear of a particular object (e.g., an animal) or situation (e.g., being in closed-in spaces), along with awareness that the fear is irrational, unnecessary, or excessive (although children do not always have this awareness). Specific phobias are the most commonly occurring anxiety disorder. According to a large U.S. survey, approximately 12.5% of the general population reports at least one specific phobia during their lives. For many specific phobias types, the proportions differ according to sex, with women reporting more specific phobias that men.

➢ *Official criteria for specific phobia* (DSM-5; American Psychiatric Association, 2013):

1. The individual experiences excessive and persistent fear of a specific object or situation.
2. The individual experiences feelings of anxiety, fear, or panic immediately upon encountering the feared object or situation.
3. The fear is out of proportion to the actual risk posed by the object or situation.
4. The individual tends to avoid the feared object or situation, or if he or she doesn't avoid it, endures encounters with the feared object or situation with intense anxiety or discomfort.
5. The individual's fear, anxiety, or avoidance causes significant distress (i.e., it bothers the person that he or she has the fear) or significant interference in the person's day-to-day life. For example, the fear may make it difficult for the person to perform important tasks at work, meet new friends, attend classes, or interact with others.

6. The fear, anxiety, or avoidance is persistent (usually lasting at least 6 months).
7. The person's fear, panic, and avoidance are not better explained by another disorder. For example, an individual with an extreme and impairing fear of public speaking only, and who is concerned that others will judge him or her negatively, might be considered to have social anxiety disorder, rather than a specific phobia.

- *Types of specific phobias:*

- **Animal phobia** (dogs, cats, mice, birds, snakes, insects, bugs, spiders, and others).
- **Natural-environment phobia** (heights, darkness, water, storms and so on).
- **Situational phobias** (driving a car; traveling by train, bus or plane; closed-in or claustrophobic situations, such as elevators, small windowless rooms, tunnels, crowded places and so on).
- **Blood-injection-injury phobias** (seeing blood, watching surgery, getting injections, or related situations).
- **Other types** (all other types of phobias of circumscribes objects or situations e.g., phobias of vomiting, choking, certain music, novel foods, clowns, balloons, snow, and so on).

According to the researchers having one specific phobia does not exclude you from having another specific phobia. In fact, it is not uncommon for people to experience several different phobias at one time. Also, there is some evidence to suggest that having one phobia increases the chances of having another phobia, particularly from within the same general type as the first phobia (such as phobias of spiders and snakes, which are both from the "animal" type).

- *Causes of specific phobias:*

1. *Direct learning experience*

Specific phobias can sometimes begin following a traumatic experience in the feared situation. For example, if a person experiences loud barking in the presence of dogs on a number of occasions, he or she might eventually come to expect aggressive barking every time a dog is encountered. In such cases, just seeing a dog would eventually produce fear. Other examples of fears developing from traumatic conditioning include: fear of closed-in places after being trapped inside a closet as a child or fear of heights developing after a fall.

2. *Observational learning experience*

According to the researchers we are able to learn not only through our own experiences, but also by watching others. For example, a child who observes his or her mother or father acting afraid of thunder and lightning might develop the same fear. Similarly seeing someone else hurt in a car accident might cause you become fearful of driving. Especially observation of people who are important to us, such as our parents can impact developmental of our fears or phobias.

3. *Informational learning experience*

There is an opportunity that people who were warned or told to be extremely cautious about a specific object or situation might cause developmental of phobia. For example, parents sometimes instill fears of dogs in children by repeatedly warning their children of the dangers of big dogs. Similarly, hearing news reports about plane crashes can contribute to fears or phobias of flying. It can explain how phobias develop when an individual has never had direct personal contact with the feared object or situation. For example, the person who hears about a parent's frightening childhood experiences with snakes may develop a fear of snakes even though he or she live in a large metropolitan area and has never seen a snake.

4. *Stress*

Some people are more vulnerable to developing fears and phobias because of the stress. It is well known fact that stress tends to lead people to feel the effect of negative experiences (e.g., physical illness, family conflicts) more strongly. As a result, people are more likely to feel afraid in situations that would not usually worry them, simply because they are "stressed out". For example, being attacked by a dog might lead to a phobia in someone who is already stressed by family conflict, whereas it might not lead to phobia in someone whose life has generally pretty good over the last few months.

5. *Biological and genetic factors*

Researchers claim that people who suffer from phobias have a problem with the regulation of serotonin levels in their brains. Seeing that serotonin is a hormone which is responsible for mood moderating it is known that when serotonin level is too high or too low it can cause anxiety which is related to phobias. Consequently, phobias are often treated with a class of antidepressants known as selective serotonin reuptake inhibitors (SSRIs). Also, there is evidence that fears run in families, so that the person who is afraid of animals is more likely to have a parent who is afraid of animals.

➢ *Why do specific phobias persist?*

There two main maintenance factors for specific phobias: avoidance behavior and fearful beliefs.

- *Avoidance behavior*

It is a natural coping technique. Avoidance can range from being very obvious to very subtle. For example, you could avoid elevators by using stairs – this is an example of obvious avoidance. Alternatively, you might use elevators but endure the situation by imaging yourself somewhere else – this is an example of subtle avoidance. Similarly, you could avoid spiders by never going into attics or places where spiders ten to hang out (obvious avoidance), or by using chemical sprays in your house much more than is recommended (obvious avoidance). Whether avoidance is obvious or subtle, it plays a major role in keeping fear alive. By avoiding, you are in essence conforming the belief that you would be endangered if you allowed yourself to confront whatever it is you fear. In other words, avoidance prevents relearning. Relearning is needed to decrease fear.

- *Beliefs*

Phobic beliefs are characterized by a sense of danger, threat, or the view that "something bad will happen". The threat is attached to the particular object or situation, to one's own reactions to the object or situation, or both. For example, a fear of high bridges may persist because of the belief that the construction is generally poor and that the bridges is likely to collapse (situation is viewed as threatening). Similarly, the fear of small, enclosed places might persist because of the belief that doors will jam or that if you become fearful in an enclosed place you will suffocate, faint, or lose control.

➢ *Treatment of specific phobia:*

1. *Cognitive therapy*

Cognitive therapy, either alone or in combination with exposure, has been considered as a potential treatment option. CT involves challenging one's beliefs, expectations, or predictors about the likelihood or consequences of harm related to encountering the feared object or situation in order to reduce anxiety and avoidance behavior. For example, an individual who is convinced that an airplane will crash might be encouraged to consider the evidence supporting that belief – in reality, the odds of a commercial flight crashing are about one in the million, and the most dangerous part of any flight is the drive to the airport.

2. *Exposure to Feared Situations (In vivo exposure)*

This technique, also is known as in - vivo exposure, is the treatment of choice for specific phobias. Essentially, it involves confronting a feared situation repeatedly, until the situation no longer triggers fear. For example, someone with a fear of spiders might begin treatment by looking at pictures of spiders, or by standing 30 feet away from a spider in a sealed jar and gradually moving closer and closer to the spider (eventually even touching it). Someone with a fear of storms might be taught to stand near the window or on the front porch during a storm, instead of hiding in the basement. Someone with a fear of elevators would be taught to ride elevators repeatedly until the fear decreases. Exposure works best when it occurs frequently (e.g., several times per week), and lasts long enough for the fear to decrease (up to two hours). Exposure-based treatments for some specific phobias (e.g., animals, blood) have been shown to work in as little as one session.

3. *Interoceptive exposure*

Interoceptive exposure is a form of behavioral therapy in which internal physical sensations (such as feelings of choking, dizziness) are reproduced and the patient is exposed to them in a controlled setting. This is in contrast to exposure to an external stimulus as in *in vivo* exposure. Interoceptive exposure therapy is used in panic disorder, but has also been studied in claustrophobia. Interoceptive exposure appears to be a promising treatment for claustrophobia.

4. *Virtual reality therapy*

In the last few years, virtual reality exposure has gained a great deal of attention in the treatment of height and flying phobia. In virtual reality exposure, a computer program generates a virtual environment that simulates the phobic situation by integrating real-time computer graphics, visual displays, body tracking devices and other sensory input devises.

5. *Applied muscle tension*

Most cases of blood injury phobia have a unique characteristic of a biphasic physiological response to blood, wound and injury stimuli. There is an initial sympathetic response with increased blood pressure and heart rate followed shortly by a parasympathetic response with a drop in blood pressure and heart rate. Taking advantage of this phenomenon, researchers devised an applied muscle tension method for the treatment of blood-injury phobia. Applied tension is a combination of muscle tension and *in vivo exposure*. Subjects first learn to recognize the early signs of decrease blood pressure, and then practice muscle tension alone-tensing and releasing the tension in the body. Then muscle tension

is used in combination with *in vivo exposure* in order to reverse the drop in blood pressure and prevent fainting.

6. *Hypnotherapy*

Hypnotherapy is the application of hypnotic techniques to induce a "trance" or an altered state of consciousness or attention which increases the person's susceptibility to suggestions to experience various changes in sensation, perception, cognition or control over motor behavior.

❖ Social phobia (social anxiety disorder)

Social phobia (also known as social anxiety disorder) is a psychological disorder characterized by an excessive and persistent fear of social or performance situations, in which an individual fears being negatively evaluated by others. People with social phobia fear and avoid the scrutiny of others. The concern in such situations is that the individual will say or do something that will result in embarrassment or humiliation. Individuals with social phobia are typically shy when meeting new people, quiet in groups, and withdrawn in unfamiliar social settings. When they interact with others, they might or might not show overt evidence of discomfort (e.g., blushing, not making eye contact), but invariably experience intense emotional or physical symptoms or both (e.g., fear, heart rating, sweating, trembling, trouble concentrating). They crave the company of others, but shun social situations for fear of being found out as unlikable, stupid, or boring. Accordingly, they avoid speaking in public, expressing opinions, or even fraternizing with peers; in some situations, this can lead to such individuals being mistakenly labelled as snobs. People with social anxiety disorder are typified by low self-esteem and high self-criticism, and as detailed below, often have depressive symptoms.

➢ *Symptoms of social phobia (DSM -4; American Psychiatric Association):*

1. A notable and persistent fear of one or more social or performance situations with exposure to unfamiliar people or possible scrutiny by others.
2. The person fears that he or she will act in a way (or show symptoms of anxiety) that will be humiliating or embarrassing.
3. Exposure to the feared social situation almost invariably provokes anxiety, which can take the form of a panic attack.
4. The person recognizes that the fear is excessive or unreasonable.
5. The feared social or performance situations are avoided or endured with intense anxiety or distress.

6. The condition interferes substantially with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or they have notable distress about having the phobia.
7. The fear or avoidance is not due to the direct physiological effects of a substance or a general medical condition and is not better accounted for by another mental disorder.
8. If a general medical condition or another mental disorder is present, the social or performance fear is unrelated to it (e.g., the fear is not of trembling in Parkinson's disease).
9. Specify the disorder as generalized if fears include most social situations.

➢ *What causes social phobia?*

Social phobia sometimes runs in families, but no one knows for sure why some people have it, while others do not. Researchers have found that several parts of the brain are involved in fear and anxiety. By learning more about fear and anxiety in the brain, scientists may be able to create better treatments. Researchers are also looking for ways in which stress and environmental factors may play role.

➢ *Cognitive behavioral model of social phobia*

Cognitive–behavioral models of social phobia propose biased cognitive processes (i.e., ways of thinking) that contribute to the maintenance of the disorder. These models propose that the anticipation of a social situation (or the situation itself) activates certain assumptions in individuals with social phobia.

1. They believe they will act in a socially unacceptable way, leading to catastrophic social consequences.
2. They review what they expect to happen, which involves recalling past negative events and how they see themselves in those situations (i.e., negative self-image), and thus anticipate poor performance.
3. They attempt to manage these dangers by turning attention inwards towards the self (onto the negative self-image) and also towards any perceived threatening information in the environment.
4. During the social situation, people with social phobia develop a standard by which they believe the audience is evaluating them and compare their perception of their own

performance against this standard. When they do not believe that they measure up, the perceived likelihood of negative evaluation increases, and anxiety increases as well.

5. Physiological arousal may result in observable symptoms such as blushing, muscle tension and trembling. Those with social phobia tend to overestimate the visibility of their anxiety and assume that others will react negatively to these symptoms. The focus on physiological symptoms and the assumed negative consequences may in fact reduce one's social performance.
6. After the event, they make negative interpretations, which reinforce their negative self-image and expectations of poor performance in the future.

➢ *Treatment for social phobia*

1. Interpersonal psychotherapy (IPT)

Interpersonal psychotherapy represents an alternative approach in the treatment of social phobia. The main treatment goal of this approach is to modify interpersonal behavior patterns in the central problem areas of the role transitions, role disputes, and role insecurity/role deficits. Therapist interventions include clarification, exploration, encouragement of emotional expression, communication analysis, encouragement of social activity, and the use of the therapeutic relationship.

❖ BEHAVIORAL TREATMENTS:

1. Exposure therapy

In exposure therapy the therapist and patient generate a graded hierarchy of anxiety-provoking situations, and the patient is then encouraged to enter and remain in the feared situation until the level of anxiety decreases. The least anxiety-provoking situation is tackled first, followed by the next step in the hierarchy and so on. In behavioral terms, social anxiety is seen as a learned response, which can be unlearned through prolonged, repeated exposure. This strategy, according to behavioral therapy will lead to habituation of the anxiety. It is also important to mention that exposure therapy is useful for all categories of phobias.

2. Social skills training

Social skills training is based on the assumption that people with social phobia either have a deficit in their social skills or are unable to use these skills because of their anxiety. The treatment uses behavioral techniques such as modelling, role-play and corrective feedback to improve person's social performance. It is known that one of the reasons the person experiences anxiety is their

belief that they consistently fail to meet the demands they make of themselves. These standards remain intact because safety behaviors, which are used to reduce the risk of negative evaluation, prevent the person learning that catastrophic consequences do not follow if they fail in a social performance. Social skills training, with its emphasis on appropriate social behavior, might prevent the person being exposed to failures, and this experience may be necessary if these rigid beliefs are to change.

3. *Applied relaxation*

Applied relaxation consists of teaching the patient to use progressive muscle relaxation, and ultimately to relax in response to a cue word. This is practiced first in situations that are not anxiety-provoking and it is then used during anxiety-provoking social situations.

❖ COGNITIVE TREATMENTS:

1. *Cognitive restructuring*

Cognitive restructuring is defining as a process in which person challenges the negative thinking patterns that contribute to your anxiety, replacing them with more positive, realistic thoughts. There are three main steps: identifying your negative thoughts (with anxiety disorders, situations are perceived as more dangerous that they really are); challenging your negative thoughts (therapist will teach you how to evaluate your anxiety-provoking thoughts); replacing negative thoughts with realistic thoughts (when you have identified the irrational predictions and negative distortions in your anxious thoughts, you can replace them with new thoughts that are more accurate and positive).

2. *Combined cognitive – behavioral treatments (CBT)*

Cognitive behavior therapy is probably the most well-known and the most practiced form of modern psychotherapy and has been integrated into highly structured package for the treatment of patients suffering from social phobia. The sessions of CBT for social phobia are devoted to training clients in the basic tenets of cognitive therapy, especially the link between faulty assumptions or irrational thinking about social situations and anxiety experienced in those situations. This therapy consists from two main components: cognitive therapy which examines how negative thoughts, or cognitions, contribute to anxiety and behavior therapy which examines how you behave and react in situations that trigger anxiety.

3. *Cognitive - behavioral group therapy (by Heimberg). Components of therapy:*

a) Education – patients are given a description of the cognitive-behavioral model of social phobia and a rationale for the treatment.

b) Cognitive restructuring – patients are taught to identify negative thoughts and are then taught how to challenge those thoughts by looking for thinking errors.

c) Exposure – repeated exposure to anxiety-provoking situations using in-session role-pays (exposure is seen as an opportunity to practice identifying and challenging automatic thoughts).

d) Homework – patients are encouraged to use exposure and cognitive restructuring between sessions.

4. *Clark and Wells's (1995) cognitive therapy. Components of therapy:*

a) Education - the therapist describes the model of social phobia to the patient.

b) Modifying self-focused attention - behavioral experiments are used to reduce self-consciousness and to illustrate the effect of switching from self-focused to externally focused attention.

c) Safety behaviors - during social interactions the patient practices increasing and decreasing safety behaviors to challenge beliefs about the consequences of not performing these behaviors.

d) Verbal reattribution -the patient is taught to identify and challenge idiosyncratic negative thoughts related to social interactions.

e) Video feedback -the patient watches a video of themselves during a social encounter and their distorted self-image is contrasted with the true observable self.

f) Modifying pre- and post event processing - patients practice disengaging from worry before and after social interactions.

g) Modifying conditional assumptions and beliefs - assumption and beliefs about social performance (e.g. 'I must always speak fluently or people won't take me seriously') are challenged using standard verbal restructuring techniques. Behavioral experiments in which the patient purposefully fails during social performances (e.g. purposefully hesitating when speaking) are used to illustrate the inaccuracy of these beliefs.

❖ MEDICATIONS

The most commonly prescribed medications for social phobia are anti-anxiety medications and antidepressants. Anti-anxiety medications are powerful and there are different types. Antidepressants are used to treat depression but they are also helpful for social phobia. They are probably more commonly prescribed for social phobia than anti-anxiety medications. Antidepressants may take several weeks to start working. Some may cause side effects such as headache, nausea, or difficulty sleeping. It is known that a type of antidepressant called monoamine oxidase inhibitors (MAOIs) are especially effective in treating social phobia. Another type of medication called beta-blockers can help control some of the physical symptoms of social phobia such as excessive sweating, shaking or a racing heart.

❖ **Agoraphobia**

Agoraphobia is an abnormal fear or anxiety about feeling helpless in an embarrassing situation in which help may not be available, in the event of having an unexpected or situationally predisposed panic attack or panic-like attack. Typical agoraphobic situations include shopping malls, waiting in line, movie theaters, travelling by car or bus, crowded restaurants, and being alone. Agoraphobia places a huge strain on the person's social and occupational functioning and on interpersonal relationships and the social network. Most people with agoraphobia develop the disorder after first suffering from one or more spontaneous panic attacks – feelings of intense, overwhelming terror accompanied by symptoms such as sweating, shortness of breath, or faintness. These attacks seem to occur randomly and without warning, making it impossible for a person to predict what situation will trigger such a reaction. The unpredictability of the panic attacks "trains" individuals to anticipate future panic attacks and, therefore, to fear any situation in which an attack may occur. As a result, they avoid going into any place or situation where previous panic attacks have occurred. Two – thirds of those with agoraphobia are women. Symptoms usually develop between late adolescence and mid 30's. The onset may be sudden or gradual.

➢ *Symptoms of agoraphobia*

1. Anxiety in response to being away from an environment that is seen as 'safe'.
2. Symptoms of significant anxiety and sometimes a panic attack such as breathlessness, sweating, dizziness, fast heart rate, sensation of choking, nausea, and feelings of extreme fear or dread.

3. Anticipation of anxiety if the person is required to leave their safe environment.
4. Low self-esteem and loss of self-confidence.
5. Reluctance to leave the house or venture beyond familiar surrounds.
6. Depression, which can sometimes accompany the condition.

➢ *Treatment for agoraphobia*

1. *Cognitive therapy*

Cognitive therapy is based on the idea that certain ways of thinking can trigger, or fuel, certain mental health problems such as anxiety, depression and phobias. The therapist helps you to understand your current thought patterns. In particular, to identify any harmful, unhelpful, and false ideas or attitudes which you have that can make you anxious. The aim is then to change your ways of thinking to avoid these ideas. It can help your thought patterns to be more realistic and helpful.

2. *Behavioral therapy*

Behavioral therapy aims to change any behaviors which are harmful or not helpful. For example, with phobias your behavior (your response to the feared object) is harmful, and the therapist aims to help you to change this. Various techniques are used, depending on the condition and circumstances. For example, in agoraphobia, the therapist will usually help you to face up to feared situations, a little bit at a time. A first step may be to go for a very short walk from your home with the therapist who gives support and advice. Over time, a longer walk may be possible, then a walk to the shops, and then a trip on a bus, etc. The therapist teaches you how to control anxiety when you face up to the feared situations and places. For example, by using deep breathing techniques. This technique of behavioral therapy is called exposure therapy - where you are exposed more and more to feared situations, and learn how to cope.

3. *Cognitive behavioral therapy*

Cognitive behavioral therapy is a mixture of the two where you may benefit from changing both thoughts and behaviors. CBT is usually done in weekly sessions of about 50 minutes each, for several weeks. You have to take an active part, and are given homework between sessions. For example, you may be asked to keep a diary of your thoughts which occur when you become anxious.

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