Social and Specific phobias

Contents

History

- 470-410 B.C.E : Hippocrates – when Nicanor went out drinking, he would get terrified of the flute played by the musicians
- Phobos was Greek God of fear
- 100- Roman doctor Celsus used the word hydrophobia to describe a person who had a fear of water due to rabies

- 1786- Phobia was defined as "A fear of an imaginary evil, or an undue fear of a real one"

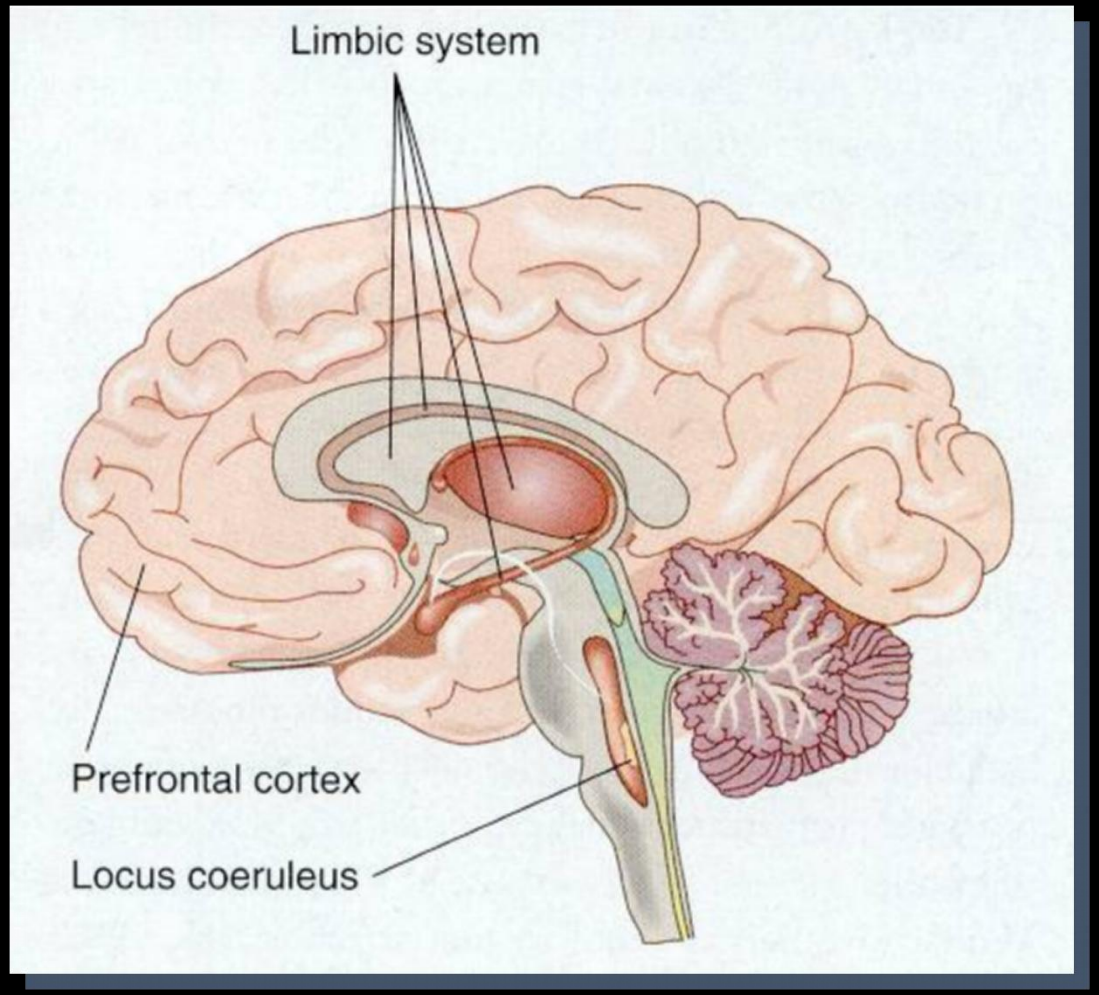
- Late 1800's- Categories were made for the phobias

- 1885- Sigmund Freud studies Phobias
  - 1909 *Analysis of a Phobia in a Five-year-old Boy* (case of little Hans)

- 1947- Phobias became a separate diagnostic category in the International Classification of Diseases
- 1950s- South African psychiatrist Joseph Wolpe develops systematic desensitization Techniques
- 1960s- Phobias are divided into 3 categories: agoraphobia, social phobia, and specific phobias
- 1980- In DSM-III social phobia included as an official psychiatric diagnosis

Components of Anxiety

1. Physical symptoms
2. Cognitive component
3. Behavioral component



Phobias

1. Social phobia
2. Agoraphobia
3. Specific phobias

Anxiety Disorder Subtype	NCS-R (Adults)		NCS-A (Adolescents)						
			Lifetime by Sex (%)		Lifetime by Age (%)			12-mo (%)	Lifetime (%)
	12-mo (%)	Lifetime (%)	Female	Male	13–14 y	15–16 y	17–18 y		
Agoraphobia	0.8	1.4	3.4	1.4	2.5	2.5	2.0	1.8	2.4
Generalized anxiety disorder	3.1	5.7	3.0	1.5	1.0	2.8	3.0	1.1	2.2
Panic disorder	2.7	4.7	2.6	2.0	1.8	2.3	3.3	1.9	2.3
Separation anxiety disorder	6.6	5.2	9.0	6.3	7.8	8.0	6.7	1.6	7.6
Social anxiety disorder	6.8	12.1	11.2	7.0	7.7	9.7	10.1	8.2	9.1
Specific phobia	8.7	12.5	22.1	16.7	21.6	18.3	17.7	15.8	19.3
Any anxiety disorder	18.1	28.8	38.0	26.1	31.4	32.1	32.3	24.9	31.9

Social Phobia

- Also known as Social Anxiety disorder
- Marked or persistent fear in one or more social or performance situations
- Exposure to fear situation is associated with extreme anxiety
- Person recognizes that fear is excessive or unreasonable
- Feared social and performance situations are avoided or endured with intense anxiety

- 13% of the general population
- About equally distributed in males and females, however, males more often seek treatment
- Unacceptable in cultures around the world for men to express fears
- Usually begins around age 15
- Equally distributed among ethnic groups
- 30% of individuals experience remission of symptoms within 1 year, 50% experience remission within a few years
- Avoidant personality disorder major differential diagnosis

Diagnostic criteria ICD-10

(a) the psychological, behavioural, or autonomic symptoms must be primarily manifestations of anxiety and not secondary to other symptoms such as delusions or obsessional thoughts

(b) the anxiety must be restricted to or predominate in particular social situations

(c) the phobic situation is avoided whenever possible.

DSM-5

a) Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others
b) The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively
c) The social situations almost always provoke fear or anxiety
d) The social situations are avoided or endured with intense fear or anxiety
e) The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context

f) The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more

g) The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

h) The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance or another medical condition.

i) The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder

j) If another medical condition is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive

Common anxiety provoking social situations :

1. public speaking
2. talking with people in authority
3. dating and developing close relationships
4. making a phone call or answering the phone
5. interviewing
6. attending and participating in class
7. speaking with strangers
8. meeting new people
9. eating, drinking, or writing in public
10. using public bathrooms
11. driving
12. shopping

Associated features

- inadequately assertive or excessively submissive
- Self-medication with substances is common (e.g. drinking before going to a party)
- Avoidance can be extensive (e.g., not going to parties, refusing school) or subtle (e.g., diverting attention to others, limiting eye contact)
- Shy bladder syndrome
- Anticipatory anxiety

Etiology of Social Phobia

Temperament and Biological Theories

- Behaviorally inhibited children (Kagan)

Biological preparedness

- We are prepared to fear rejecting people
- Social phobia pts more likely to focus on critical facial expressions

Neurochemical Hypotheses

- adrenergic theory
- dopaminergic dysfunction - decreased striatal dopamine reuptake site density

Biological Basis of Temperament

Kagan proposed temperamental differences related to inborn differences in brain structure and chemistry, found inhibited children have:

1. Higher resting heart rates
2. Greater increase in pupil size in response to unfamiliar
3. Higher levels of cortisol (released with stress)
4. Parents showed anxiety disorder history

Social Phobia: Treatment

Medication

- SSRI and SNRI approved for first line treatment
- Monoamine oxidase inhibitor
- Buspirone showed additive effects - used to augment treatment with SSRIs, benefits in elderly pts
- Relapse common with medications discontinued
- BZD in short term useful
- Beta blockers for performance type but poor results in generalized type

Procedures for Anxiety disorders

- 4 components:

1. Exposure therapy : intentionally confronting feared but otherwise not dangerous objects, situations, thoughts, memories, and physical sensations
   - In vivo exposure and prolonged exposure (flooding)
   - Imaginal exposure
   - Interoceptive exposure

2. Stress management Techniques : three “channels,” or modes, of responding: cognitive–phenomenological, physiological, and behavioural

    1) Cognitive - Thought stop
    2) Physiological – Breathing and PMRT
    3) Behaviour – Role playing

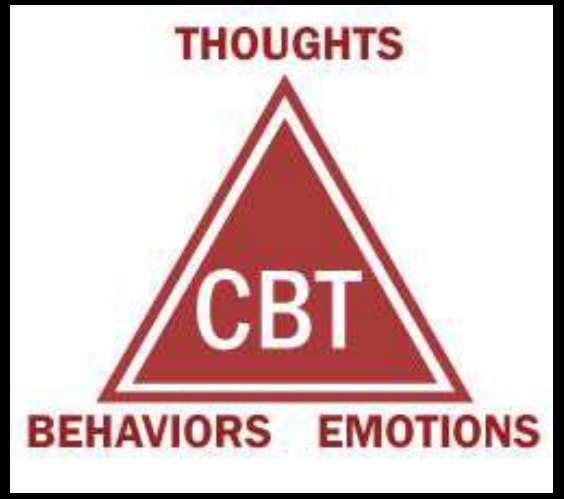
- Acceptance and Mindfulness Based Training : Three treatments are Acceptance and Commitment Therapy (ACT), Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy
- need to first acknowledge that the anxiety exists and to try to objectively, nonjudgmentally observe i

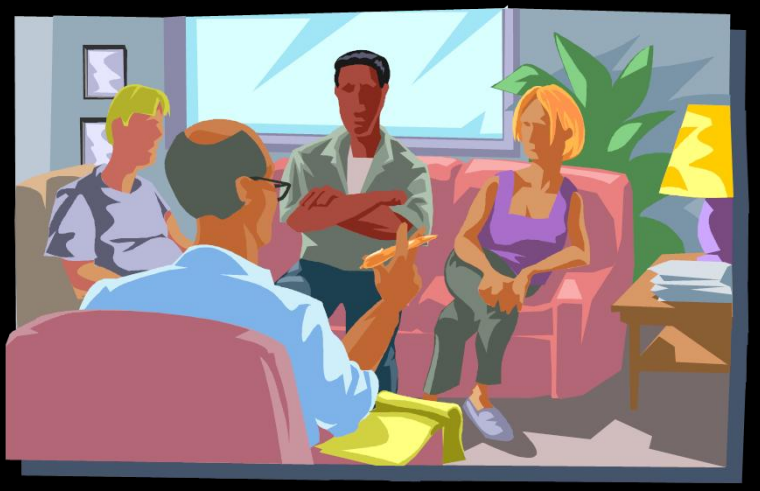
3. Cognitive therapy

- Cognitive-Behavioral Therapy

- Assess which social situations are problematic
- Assess their behavior in these situations
- Assess their thoughts in these situations
- Rehearse or role play feared social situations in a group setting
- Studies show individual therapy > group therapy

- Socratic dialogue
- Downward arrow technique
- Thought Records





4. Interpersonal Skills Training:

- interpersonal deficits that contribute to the maintenance of their anxiety and potentially negatively affect treatment
- assertiveness training
- training in initiating, maintaining, and ending conversations

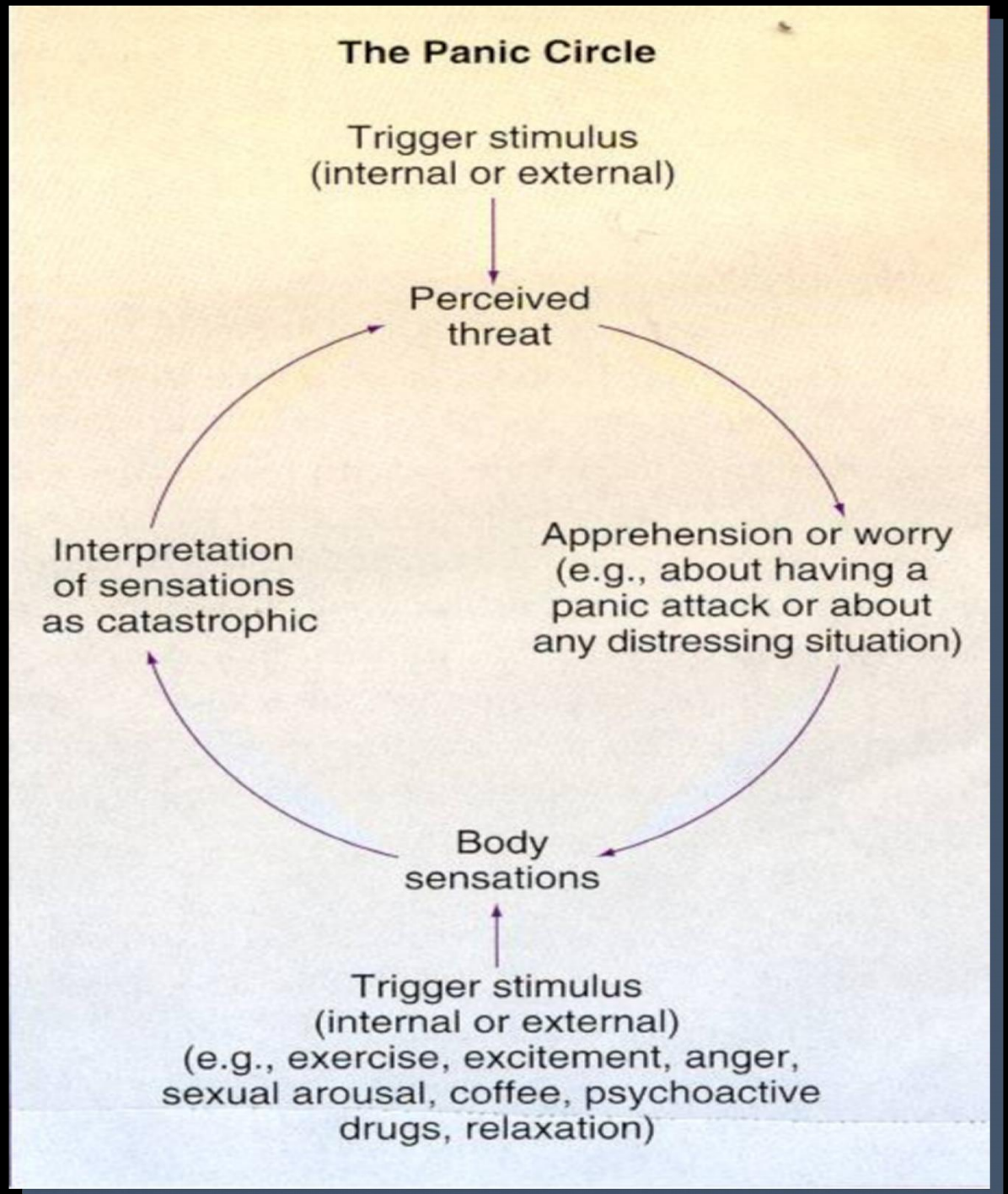
Kagan's Temperamental/Biological Theory and Prevention

- Early identification of at risk children
- Parental training
- Avoid overprotecting
- Encourage children to enter new situations
- Help kids to develop coping skills
- Avoid forcing the child

Agoraphobia

- fear of or anxiety regarding places from which escape might be difficult
- derived from Greek words *agora* and *phobos,* meaning “fear of assembly/public spaces”
- characterized by an irrational fear of being in places away from the familiar setting of home, in crowds or in situation that the patient cannot leave easily

- Overriding fear of open or public space
- Deep concern that help might not be available in such places
- Avoidance of public places and confinement to home in severe cases
- When accompanied by panic disorder, fear that having panic attack in public will lead to embarrassment or inability to escape
- may insist that they be accompanied every time they leave the house


The Panic Circle
Trigger stimulus
(internal or external)
Perceived
threat
Apprehension or worry
(e.g., about having a
panic attack or about
any distressing situation)
Body
sensations
Interpretation
of sensations
as catastrophic
Trigger stimulus
(internal or external)
(e.g., exercise, excitement, anger,
sexual arousal, coffee, psychoactive
drugs, relaxation)

- lifetime prevalence of agoraphobia varying between 2 to 6 percent across studies
- at least three fourths of the affected patients have panic disorder as well
- incidence peaks in late adolescence (1.7%) and early adulthood

Diagnostic criteria ICD-10

(a) the psychological or autonomic symptoms must be primarily manifestations of anxiety and not secondary to other symptoms, such as delusions or obsessional thoughts

(b) the anxiety must be restricted to (or occur mainly in) at least two of the following situations : crowds, public places, travelling away from home, and travelling alone

(c) avoidance of the phobic situation must be, or have been, a prominent feature.

DSM-5

A. Marked fear or anxiety about two (or more) of the following five situations:

1. Using public transportation (e.g., automobiles, buses, trains, ships, planes)
2. Being in open spaces (e.g., parking lots, marketplaces, bridges)
3. Being in enclosed places (e.g., shops, theaters, cinemas)
4. Standing in line or being in a crowd
5. Being outside of the home alone

B. The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms

C. The agoraphobic situations almost always provoke fear or anxiety

D. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety

E. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

H. If another medical condition is present, the fear, anxiety, or avoidance is clearly excessive

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder

Agoraphobia: treatment

- Benzodiazepines: potential for dependence, cognitive impairment, and abuse
- Selective Serotonin Reuptake Inhibitors: Effective doses are essentially the same as for the treatment of depression
- discontinuation syndrome if these medications are stopped abruptly
- Tricyclic Drugs less preferred due to less tolerability

- Supportive Psychotherapy
- Insight-Oriented Psychotherapy
- Behavior Therapy
- Cognitive Therapy
- CBT

Specific phobias

- Phobias occur in about 11% of the population
- More common among women (twice as likely)
- Tends to be chronic
- objects of phobias vary from culture to culture
- More than 100 subtypes reported

Lifetime Prevalence Rates of Specific Phobia

Site	Men (%)	Women (%)	Total (%)
United States (National Comorbidity Survey)	6.7	15.7	11.3
United States (Epidemiological Catchment Area Study)	7.7	14.4	11.2
Puerto Rico	7.6	9.6	8.6
Edmonton, Canada	4.6	9.8	7.2
Korea	2.6	7.9	5.4
Zurich, Switzerland	5.2	16.1	10.7
The Netherlands	6.6	13.6	10.1

Specific phobias

- 31% of first degree relatives of phobic pts also had a phobia (compared to 11% in the general population)
- Relatives tended to have the same type of phobia
- Not clear if transmission is environmental or genetic

Developmentally Normal Fears

Age	Normal Fear
Birth- 6 Months	Loud noises, loss of physical support, rapid position changes, rapidly approaching other objects
7-12 Months	Strangers, looming objects, unexpected objects or unfamiliar people
1-5 Year	Strangers, storms, animals, dark, separation from parents, objects, machines loud noises, the toilet
6-12 Year	Supernatural, bodily injury, disease, burglars, failure, criticism, punishment
12-18	Performance in school, peer scrutiny, appearance, performance

Diagnostic criteria ICD-10

(a) the psychological or autonomic symptoms must be primary manifestations of anxiety, and not secondary to other symptoms such as delusion or obsessional thought

(b) the anxiety must be restricted to the presence of the particular phobic object or situation

(c) the phobic situation or object is avoided whenever possible.

DSM-5

A. Marked fear or anxiety about a specific object or situation

B. The phobic object or situation almost always provokes immediate fear or anxiety

C. The phobic object or situation is actively avoided or endured with intense fear or anxiety

D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context

E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more

F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

G. The disturbance is not better explained by the symptoms of another mental disorder , including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms

Specify if:

Code based on the phobic stimulus:

- 300.29 (F40.218) Animal (e.g., spiders, insects, dogs).
- 300.29 (F40.228) Natural environment (e.g., heights, storms, water).
- 300.29 (F40.23X) Blood-injection-injury (e.g., needles, invasive medical procedures).
  - Coding note: Select specific ICD-10-CM code as follows: F40.230 fear of blood; F40.231 fear of injections and transfusions; F40.232 fear of other medical care; or F40.233 fear of injury.
- 300.29 (F40.248) Situational (e.g., airplanes, elevators, enclosed places).
- 300.29 (F40.298) Other (e.g., situations that may lead to choking or vomiting: in children, e.g., loud sounds or costumed characters)

The Four Major Specific Phobia Categories

Natural Environment

Astraphobia

Hydrophobia

Dendrophobia

Animals

Batrachophobia

Cynophobia

Equinophobia

Mutilation/Medical Treatment

Trypanophobia

Dentophobia

Hemophobia

Situations

Claustrophobia

Aerophobia

Glossophobia

verywell

Phobias: Types

- Blood-Injection Injury phobias (BII)
- Situational phobia
- Natural environment phobia
- Animal phobia
- Pa-leng (Chinese-Frigophobia)
- colpa d'aria (Italian-fear of chills)

Animal phobia is most common in childhood, while blood-injury phobias are most common in adolescents (Silverman, & Moreno, 2005)

Specific Phobia: Behavioral Perspective

Case of Little Albert

Two-factor model:

- Acquisition-classical conditioning: natural feared object is paired with a neutral object

- Maintenance-operant conditioning: child who fears dog may be rewarded by parental attention

Little Albert

WHITE RAT
NS

NO RESPONSE

LOUD NOISE
UCS

FEAR RESPONSE
UCR

LOUD NOISE + WHITE RAT
UCS + NS

FEAR RESPONSE
UCR

WHITE RAT
CS

FEAR RESPONSE
CR

By Louise Crouch
L652

Psychodynamic model

- phobias emerge because individuals have impulses that are unacceptable, and they repress these impulses
- when repression does not work, displacement of anxiety connected to the unresolved conflict upon a situation or object that is less relevant
- the feared situation or object symbolizes the source of the conflict

Specific Phobia: Treatment

- The psychotherapy in form of exposure and systematic desensitization

1. **Exposure therapy:**
   works by moving up the **fear ladder** (Graded exposure)
   Start from low to high
2. **Desensitization:** pairs gradual exposure to phobic stimuli with **relaxation methods.**

Table 1 Sample exposure hierarchy for a patient with specific phobia (animal type)

Activity	Fear level (0 - 100)
Letting several large dogs lick my face	90
Petting several dogs in an enclosed space	85
Letting a large dog lick my face	80
Giving a large dog a treat	75
Petting a large dog	70
Going inside the dog park and letting dogs brush up against me	65
Going to a dog park and standing outside the park	60
Watching Animal Planet dog shows	55
Watching a real-life dog children's movie	40
Watching a cartoon dog movie	35
Looking at pictures of small and large dogs	30

3. **Applied tension therapy**

   For blood – injury – injection type

   muscles of the arms, legs, and torso are tensed but not relaxed, will prevent the drop of blood pressure and fainting (coping skill)

4. **Virtual reality therapy**

   modern technology to simulate ET

Drug	Starting (mg)	Maintenance (mg)
SSRIs		
Paroxetine	5–10	20–60
Paroxetine CR	12.5–25	62.5
Fluoxetine	2–5	20–60
Sertraline	12.5–25	50–200
Fluvoxamine	12.5	100–150
Citalopram	10	20–40
Escitalopram	10	20
Tricyclic Antidepressants		
Clomipramine	5–12.5	50–125
Imipramine	10–25	150–500
Desipramine	10–25	150–200
Benzodiazepines		
Alprazolam	0.25–0.5 tid	0.5–2 tid
Clonazepam	0.25–0.5 bid	0.5–2 bid
Diazepam	2–5 bid	5–30 bid
Lorazepam	0.25–0.5 bid	0.5–2 bid
MAOIs		
Phenelzine	15 bid	15–45 bid
Tranylcypromine	10 bid	10–30 bid
RIMAs		
Moclobemide	50	300–600
Brofaromine	50	150–200
Atypical Antidepressants		
Venlafaxine	6.25–25	50–150
Venlafaxine XR	37.5	150–225
Other Agents		
Valproic acid	125 bid	500–750 bid
Inositol	6,000 bid	6,000 bid

SUMMARY

- Social anxiety disorder one of the most common mental disorders
- Psychotherapy improves long-term outcomes
- CBT treatment of choice in non-pharmacological interventions
- In vivo exposure helpful in specific phobias
- SSRI and SNRI first line option
- Start low and go slow
- Routine increase to higher doses not recommended, but might benefit in subgroups
- Concomitant BZD as initial therapy in short-term may be useful
- 8-12 weeks at optimum doses may be needed to assess efficacy and evidence for benefit of maintenance Rx at least up to 6 months

references

- Sadock, Benjamin J.; Sadock, Virginia A.; Ruiz, Pedro Kaplan & Sadock's Comprehensive Textbook of Psychiatry, 10th Edition 2017 Wolters Kluwer
- American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub; 2013 May 22.
- Becker, E., Rinck, M., & Turke, V., et al. (2007). Epidemiology of specific phobia subtypes: findings from the Dresden Mental Health Study. *Europe Psychiatry*, *22*, 69-74
- George, C. (2008). Solution-focused therapy: strength-based counseling for children with social phobia. *Journal of Humanistic Counseling, Education & Development*, *47*(2), 144-156.
- Khodarahimi, S. (2009). Dreams in Jungian psychology: the use of dreams as an instrument for research, diagnosis and treatment of social phobia. *Malaysian Journal of Medical Sciences*, *16*(4), 38-45.
- Würz, A., & Sungur, M. (2009). Combining cognitive behavioural therapy and pharmacotherapy in the treatment of anxiety disorders: True Gains or False Hopes?.*Klinik Psikofarmakoloji Bulteni*, *19*(4), 436-446
- Becker, E., Rinck, M., & Turke, V., et al. (2007). Epidemiology of specific phobia subtypes: findings from the Dresden Mental Health Study. *Europe Psychiatry*, *22*, 69-74

THANK YOU


"I was afraid to fly till I learned I was safer here than in my car. Now I'm afraid to get off the plane."