Phobia: Supporting children and young people with specific fears

Research suggests that around 10% of children and teenagers have a specific phobia that significantly affects their mental health, functioning and development. Stephanie Thornton looks at the incidence, causes and interventions.

So far as mental health issues in children and adolescents go, depression and anxiety are 'top of the bill'. These two often intertwined issues soak up much of the limited resource available for children's mental health. They are so prevalent that they are almost the 'new normal' for our young (Thornton, 2020). And perhaps, in some degree, they always were, and always will be. Both can be rational responses to a dangerous world and to our individual powerlessness. There is a good case to be made, in our very stressed lives, that, except in the minority of cases that meet the criteria of clinical disorder, anxiety and depression should not be medicalised, but rather, addressed as normal emotional responses that we should help our young to learn to manage in the face of our rapidly changing world.

The trouble with the prominence of our concern with anxiety and depression is that it absorbs resources and distracts us from other mental health issues which may be equally damaging, but more amenable to treatment – if the resources were available. One example would be specific fears or phobias.

Developing specific fears is, in fact, a normal, and in many ways positive part of growing up: fear of strangers reflects the recognition of individuals and the realisation that people differ, and are not interchangeable – an important step in social development and understanding other minds. Starting to be frightened of spiders, dogs and so forth can reflect a nascent understanding of practical threats. Being frightened of monsters under the bed or in dark corners reflects a further conceptual development toward understanding abstract hypothetical ideas. Most children entertain fears like these to some degree, at some point in their development. But for some, these fears become entrenched, overwhelming, a disorder – a specific phobia. Phobias are different from normal fears. A phobia is a fear that is disproportionate to the objective risk of encountering the feared thing, or disproportionate to the actual risk posed by such an encounter, or both. This kind of specific fear is maladaptive, exaggerating the risks, stressful to the sufferer, and with the potential to disrupt healthy development in many ways.

The impact of phobias is often underestimated. For example, I once had a colleague who had a phobia of pigeons, which others often saw as puzzling and even amusing, failing to comprehend how debilitating this phobia was. Living and working in London, which is full of pigeons,

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he had a huge problem: walking from his flat to his car, car to office, he experienced huge stress. He struggled to go to lunch with colleagues or walk in the park or take part in many other everyday activities. And he had had this phobia from very early childhood, affecting his social contacts, his activities, his development in many areas. Phobias limit lives. Untreated, phobias may last for decades.

The incidence and age of onset of phobias in the young

Research suggests that around 10% of children and teenagers have a specific phobia that significantly affects their mental health, functioning and development (Wright et al, 2022). Fifteen percent of those referred to CAMHS for anxiety issues have one or more phobias (Ollendick et al, 2002). The most common childhood phobias, reported by 10% of parents, are fear of animals and fear of blood or injections. Many phobias begin in childhood (Öst, 1987): on average, animal phobias begin first, at around age 7 years, blood phobia at age 9 years, dental phobia 12 years, social phobia at age 16 years, claustrophobia at age 20, agoraphobia at age 28. However, it is also clear that phobias can begin in early infancy, as the infamous study of 'Little Albert' demonstrates (Watson and Rayner, 1920).

Cause of phobias

The traditional view of the aetiology of childhood phobias was powerfully influenced by the 'Little Albert' experiment, in which the experimenters induced a fear of a white rat in a child aged around 1 year, by pairing the rat with loud bangs of which the child was previously scared (Watson and Rayner, 1920). This study suggested that phobias are conditioned responses to life experiences. Leaving aside the highly unethical nature of that study, more recent research has challenged the idea that phobias are necessarily conditioned responses to experience (Coelho and Purkis, 2009). Of course, traumatic experience does sometimes induce a specific phobia – but there is growing evidence that phobias can also arise in other ways. Children can learn fears and develop phobias vicariously – from what they learn by observing others, and also through the information they receive (Coelho and Purkis, 2009). For example, a study by Merckelbach et al (1991) of individuals with spider phobia found that 71% had been influenced by the reactions of others more than by direct scary experiences (57%) or information (45%). And though there is no evidence for phobias pre-programmed through evolution, there is some evidence in animals that suggests that we may be readier to learn a fear to an evolutionary relevant thing – for example, a snake – than a neutral thing such as leaves (Seligman, 1970). Debate as to why certain things, like

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snakes and spiders are more likely to elicit phobias continues (Lobue and Adolph, 2019).

Intervention for phobia in children and young people

Sometimes it is obvious that a child or teenager has a phobia, but sometimes it is not – teenagers may hide their issue out of embarrassment, and a child may not encounter the phobic issue during the normal course of the day, so the phobia may not be noticed by others. Parents are probably the best source of information, and perhaps, in view of the report that 15% of anxious children have one or more phobias (Ollendick et al, 2002), parents should be asked about specific phobias if a child or teenager is generally anxious.

The traditional view was that treatment for phobia would involve many weeks of CBT and 'desensitisation' through gradual exposure to the phobic object. Alas, resources are tight now, and children may spend many months or even years on waiting lists for CAMHS. However, in the past two decades, there has been growing evidence for the efficacy of a cost-effective 'one-session treatment' in overcoming phobia (Ollendick and Davis, 2013).

As the name suggests, 'one-session treatment' offers a single treatment session lasting up to 3 hours. During this session, a graduated hierarchy of the child's fear is constructed, and then, starting with exposure to the least feared level (for example, dog in the far distance), and progressing to the most feared (for example, dog jumping up on the child, to be greeted), the child is supported step by step in overcoming the phobia. Support involves a

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variety of means, including 'reinforcement, cognitive challenges, participant modelling, psychoeducation and skills training' (Davis et al, 2019). Davis et al (2009) provide a useful, very detailed account of the practicalities involved in offering this intervention. This one-session treatment has been shown to be highly effective in overcoming phobia and in producing what is in effect a cure (Davis et al, 2019). In fact, there is now clear evidence that one-session treatment is as effective as multi-session therapy for children and teenagers with phobias (Wright et al, 2022). JFCH

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