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Phobias

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'Phobias' is an essay by the late Dr John Ellard reproduced from the book *The Anatomy of Mirages: a Psychiatrist Reflects on Life and the Mind*.*

Dr Ellard, revered former Editor of *Modern Medicine of Australia* and *Medicine Today* and a distinguished psychiatrist, wrote many essays in the 1970s, 1980s and 1990s on society's most controversial and vexing issues. These were published in various journals including *Modern Medicine of Australia*, and also collected together and published as books. The essay 'Phobias' originally appeared in the July 1986 issue of *Modern Medicine of Australia*.

Most of the readers of this article will be able to remember a time when heights, darkness, small spiders or some other common, harmless object filled them with dread. A significant number of readers, their friends and their patients will still be phobic, but mostly the object will be different. The current prevalence is uncertain, as is the level of phobic-caused disability in the total population, for people with phobias tend to keep quiet about them, fearing ridicule. This article describes the different kinds of phobias and their management.

The essence of a phobia is that the person who suffers from it is seized, with excessive and inappropriate anxiety when confronted by an object or situation which most of us can accept with equanimity. As a result the sufferer takes care to avoid circumstances which will result in distress. That the anxiety is irrational is appreciated by the phobic person just as well as it is by everyone else. As a result some sufferers feel ridiculous and try to keep their phobias to themselves – their doctor is unlikely to hear about them. Some phobias may be controlled by avoiding the feared object: if one has a phobia of giraffes one does not go to the zoo. On the other hand, a phobia of elevators makes living and working in the city very difficult, and treatment is indicated.

One consequence of the shame surrounding phobias is that their prevalence is unknown, except perhaps in the case of childhood phobias. They have been with us a long time, for they achieve mention in Hippocrates' *Epidemics* and Burton's *Anatomy of Melancholy*. It is probable that the disability and suffering occasioned by phobias are much greater than is commonly realised. Since most of them can be relieved, and some cured, the doctor needs a working knowledge of their varieties and of what can be done about them. Our knowledge is incomplete, but sufficient to be useful.

The boundary between normality and phobia is arbitrary. Few adults can stroke the furry body of a large harmless garden spider with the same affection and pleasure that they bestow upon a cat: most regard this reaction as normal rather than abnormal. Nevertheless in ordinary practice there is not much doubt about what is a phobia and what is not, and the properly informed patient is the best judge of what is worth treatment.

The interesting thing about phobias is that they have a wide variety of causes. Discovering a phobia may be likened to eliciting Babinski's reflex; it is an invitation to proceed to further understanding. There are several classifications of phobias, none of them satisfactory. The one offered is perhaps no better than the rest, but helps me sort my patients into groups related to different treatments.

Childhood phobias

It is normal for children under the age of 2 years to have some fear of strangers; usually it goes by the age of 5 years. Various studies have shown that almost all children have some irrational fears, but that less than 1% are disabled by them.[1] It is worth remembering that a child can suffer greatly without being disabled. The irrational fears diminish steadily after the age of 3 years, except for another peak at the age of 10 years. Sometimes they persist into adult life.

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The feared objects include snakes, spiders, the dark, heights, loud noises, small animals and storms. The list is quite different from that of the real dangers of a child's life – traffic, boiling liquids, power points, poisons, swimming pools – but relevant to our remote ancestors, who sat in caves at night, while the creatures of the dark tried to get at them. Perhaps the brave and the insouciant became the victims, while the more reactive and timid huddled together, survived, and became us.

Lorenz's concept of the 'innate release mechanism' is relevant. Just as the uninstructed chicks of certain species of birds are genetically programmed to peck at specific patterns and particular colours (which resemble aspects of the parent's beaks) so perhaps humans possess innate mechanisms which are triggered by biologically relevant objects. In childhood phobias the behaviour is aversive, but there is no reason why we should be surprised at this: other behaviours released in animals include aggression and mating.

It is, then, a reasonable hypothesis that the common phobias of childhood are innate. If they do not trouble child unduly they should trouble no one else, for they are very likely to resolve spontaneously. This resolution is probably achieved by graduated exposure; that is by the child encountering the feared object time and time again while supported by understanding and untroubled adults. Watching someone else handling it without any anxiety at all is also important. Ridicule and forced confrontation are the worst possible tactics.

Simple adult phobias

There are phobias of specific objects and situations, with little or no associated disturbance of the personality. For practical purposes they may be grouped as follows.

Persistent childhood phobias

Their long history and the nature of the fear will give the diagnosis.

Learned phobias

An example will make this variety clear, and provide some important lessons. A man in his late twenties consulted me because anxiety prevented him from walking on hard surfaces, a great disability in a large city. As a small child he had suffered from akinetic seizures in which he fell to the ground, usually on his face. He soon learned where not to walk. In his adolescence his epilepsy was completely controlled, and he had not fallen for a decade: his anxiety still controlled where he could go.

Note that a full and complete knowledge of why he had his phobia made not the slightest difference to its severity. Note also that the phobia had not decayed over the years, for each exposure to the feared situation reinforced the existing anxiety. Very often untreated phobias tend to generalise: for example, an accident-engendered phobia of being a passenger in a car is likely to spread to buses, trains, ferries and other forms of transport.

"The feared objects include snakes, spiders, the dark, heights, loud noises, small animals and storms."

Other

Most often one cannot discover why a particular phobia exists. Fortunately, as stated above, this rarely matters and treatment can proceed nevertheless. The management of the various forms of phobias will be considered in the second part of this article.

Performance anxiety

Whereas the first two groups are easy to distinguish, this one is more diffuse. Some degree of social anxiety is normal enough; few of us can address large and important audiences without some apprehension, and most of us can remember occasions when we have wished that the ground would open up and swallow us. Some suffer more keenly. The prospect of saying a few words at a small closed meeting of benevolent colleagues fills some with panic, and famous and accomplished actors have almost fainted before each entrance on to the stage. This may be thought of as performance anxiety, which may extend beyond obvious situations to such common tasks as writing in the presence of others and sitting for examinations. One needs to distinguish it from the occupational cramps (such as writer's cramp) and from generalised social anxiety, in which the patient's anxiety in particular activities is but part of a larger and more pervasive disorder of the personality. The more circumscribed and concrete the feared situation the more firmly the patient can be located in this group. It is a disorder which merits treatment, for it may seriously impair achievement: examinations are failed, even though the knowledge is adequate.

Agoraphobia

About half the phobic patients who seek medical help will have agoraphobia. It is a complicated disorder which involves the whole personality much more than the conditions discussed so far.

It is not a fear of open spaces; the patient's central anxiety is that he or she will be trapped in a place in which something terrible will happen to them without the possibility of escape or rescue. The National Agoraphobia Survey revealed that the most common fear was of fainting or collapsing, followed by fears of dying, becoming ill, losing control and going mad, and of making a scene.[2] Needless to say there is often an associated panic attack; the illness may begin with one.

Anxiety arises in supermarkets, hairdressers' establishments, aeroplanes, public transport, tunnels, theatres and other restricting places peculiar to each patient. Many agoraphobes can control their anxiety if accompanied by a spouse or close friend (the phobic companion), by having a clear way out of the confining place, by having the car close at hand, or even by wearing sunglasses.

Many patients have panic attacks; some do not. Those that have them fear the next one greatly. Almost all are chronically and diffusely anxious. The illness often arises after a period of turbulence and stress in the patient's life. It is most common in women of childbearing age, but occasionally arises in the teens or after 40, pursuing an irregular course and sometimes going into complete remission for no discernible reason. Some patients restrict their activities so as to avoid the dreaded situations, relieving their anxiety at the expense of becoming a hermit.

Sometimes the panic attacks are so pronounced that the rest of the disorder does not attract much attention, but a few questions will make the diagnosis clear. The distress may be so great that the sufferer turns to alcohol and sedatives for relief. Dependence is common, and management is then more difficult.

Many develop chronic hyperventilation, which equips them with paraesthesiae, unsteadiness and a disturbance of consciousness which adds to their misery.

There are often repercussions in the family. The spouse may be irritated by the restrictions, gratified by the dependence, or both. Pathologically jealous husbands are calmed by having their wives imprisoned by their neuroses so that they always know where they are. Removing the agoraphobia may stir up a hornet's nest of distrust and recrimination, and the treatment of both parties may be necessary, conjointly or otherwise.[3]

> "Some patients restrict their activities so as to avoid the dreaded situations..."

In such families at first sight the husband may seem to be hardheaded and self-sufficient, burdened by a pathologically dependent wife: the problem is often presented to the doctor in those terms. More careful inspection may show that both parties have major problems about dependence, which they are handling in different ways, for a particular reason. The wife, being caught in the traditional role of a woman, can confine herself within her home and carry out those duties adequately enough. The husband, forced by the masculine role to go out into the world does so, but is likely to become dependent on alcohol, excessive involvement in his work or develop some other socially sanctioned defence. Needless to say a shared neurosis of this complexity must have its antecedents, and the family histories of both husband and wife may be most illuminating.[4]

Several other factors need consideration. One of them is biological, for there is clear evidence of an hereditary contribution. The family history may be unequivocal, or the patient may recall an aunt who did not seem anxious, but who rarely ventured beyond her front door. A partial response to antidepressant chemotherapy is also consistent with a biological component.

Another associated factor may be persistence of the separation anxiety of childhood, an adaptive and life-preserving response in the very young. Finally, it is obvious that if every time one goes to a particular place one is terror-stricken, the terror will be augmented by conditioning.

The phobic anxiety depersonalisation syndrome of Roth

This disorder is related to agoraphobia, and shares its general characteristics.

I believe that it can be distinguished from it in the following ways.

- Depression is more frequent and severe: the patient may present with depression rather than anxiety.
- Depersonalisation or derealisation is present. That is, the patient feels that he or she is unreal, and that the world is solid enough, or the reverse. This symptom is almost never volunteered, and has to be elicited by an indirect enquiry such as 'Are there any other symptoms you find it difficult to put into words?'

Depersonalisation and derealisation are associated with many other conditions; for this particular diagnosis to be made one needs anxiety, phobias, depression and depersonalisation or derealisation. Sometimes there are panic attacks as well.

It is my impression that the family history is more definite, and the response to chemotherapy much more specific than is the case with agoraphobia. That is, it seems more biological, and less neurotic.

Sexual phobias

Some sexual difficulties are phobic, in that the patient becomes very anxious about a specific sexual activity, while recognising that this response is inappropriate, and contrary to his or her desires. Some of these phobias are learned, some symbolic and some of unknown causation.

Symbolic phobias

Here the phobia has a meaning, in as much as it symbolises or recapitulates some important event in the life of the patient.

Often the event has been repressed – partially or completely – and the phobia remains as a mark of what has happened. Sexual phobias which follow as a consequence of incest are an example. Appropriate psychological therapy uncovers the original traumatic happenings with their painful emotions, there is a catharsis and the patient improves or recovers.

No one can be sure, but I suspect that patients of this category form but a small

minority of phobias who present for treatment. One may suspect its presence when the phobia does not fit comfortably into the other categories and one has the feeling that there are some elements in the patient's history which seem relevant. Sometimes one is struck by the fact that a surprising amount of the patient's childhood memories are inaccessible to him.

Phobias accompanied by other conditions

It is not uncommon for patients who develop biologically determined depressions to develop phobias at the same time.[5] It is possible for this association to arise de novo in patients who are in their sixth or seventh decade. The phobias go when the depression goes, and return should it relapse.

The mechanism is quite obscure: the point is that the phobias may be ignored provided that the depression is properly treated.

Phobias turn up in association with schizophrenia, obsessional neurosis and a variety of other conditions. The primary condition is the important one requiring the therapist's attention.

School refusal

This condition is mentioned here, although it is not a phobia, because sometimes it is termed 'school phobia', and because on superficial inspection it seems to be phobic in nature. The affected child complains of a fear of attending school, but the basic problem is of being separated from people who are very important emotionally – usually the mother. There are often other symptoms, such as fears of being lost, injured or dying.

Often the mother has a history of school refusal herself with fear of separation from her own mother. Her anxiety about separation causes her to cling to her child, which probably induces excessive dependence. The disorder passes down the generations: the pathology is in more than one person.

General management

Most people with phobias have been told at one time or another to pull themselves together, or forced to face the feared object. I remember one patient with a car phobia whose husband drove her around the suburbs under duress, while she crouched under a rug on the floor of the rear compartment, drinking brandy. Neither her phobia nor her marriage was improved thereby.

The prescription of sedatives is not much better. Phobias are chronic disorders, and sedatives will not cure them. The patient is temporarily relieved but soon finds that the dose which was effective at first loses its effect and escalation follows. Since the symptoms of benzodiazepine withdrawal often closely resemble panic attacks, the difficulties of both the patient and the definitive therapist are much increased thereby. Long-term use of sedatives is comparable with long-term use of alcohol.

"Most people with phobias have been told at one time or another to pull themselves together or forced to face the feared object."

All phobic patients require careful and sympathetic management to remove their underlying fear of ridicule and rejection. The treating doctor needs to make it quite clear that he or she has expert knowledge about phobias, and an appreciation of how distressing and disabling they can be.

One needs to take a sufficiently detailed history to enable the patient to be located within the categories favoured by the doctor, and the patient should be told precisely what the diagnosis is, and why. Fears of incipient insanity or cowardice should be sought and dispelled if they are present. The essential message is that the doctor knows what is wrong, and what to do about it, with the result that in due course the patient will be in control of the anxiety rather than the anxiety in control of the patient. If the therapist is vague, uncertain or apparently uninvolved not much progress will be made.

Specific management

Childhood phobias

It is important to understand why childhood phobias subside, because the same principle underlies the treatment of most adult phobias. They remit because the child meets the feared situation over and over again with supportive and secure adults, so permitting the child to gain mastery of the anxiety a little at a time. If the parents allow the child to see them dealing with the feared situation, progress is likely to be accelerated.

If one of the parents is phobic then that parent must be treated, for his or her anxiety will reinforce the child's phobia.

Simple adult phobias

The literature is confused because different categories of phobias are often lumped together inappropriately, and because the populations studied are often not patients, but university students not much troubled by their fears. Nevertheless it seems clear that behaviour therapy is the treatment of choice. The techniques used most commonly fundamentally resemble the graded exposure of childhood with the use of special techniques to relax the patient and to hasten their desensitisation to the feared situation or object. It is time-consuming, and it requires particular skills in the therapist; the results are worthwhile. Its particular merit is that the patient once more feels in command of himself or herself, which is a great advance.

Medication is best avoided in this group for all the reasons given before, and because it does not achieve much in any case.

Performance anxiety

This is the one phobic condition in which beta blockers come into their own. The somatic accompaniments of anxiety are very important in this disorder: it is difficult to play the violin while swearing profusely, difficult to speak when one's tongue adheres to the roof of one's mouth, and little can be taken in when one's mind is filled with the thumping of one's rapidly beating heart. All this makes the anxiety worse, and each performance is more dreaded than the last.

Beta blockers abolish or greatly diminish the somatic symptoms, and the cycle is broken. Behaviour therapy of the kind mentioned above may also help. If the patient cannot take beta blockers (e.g. because of asthma) then behaviour therapy may be the principal means of treatment, sometimes helped by the occasional intermittent use of sedation in the early stages.

Most patients are better off without it, particularly since sedative drugs are very likely to interfere with the performance which is so important to them.

If beta blockers are to be used then the patient needs to be given a general account of what they do in language he or she can understand. I describe them as adrenalin-blocking agents, which is close enough to the truth. The patient should discover what his or her pulse rate is most of the time, and what dose of the blocking agent will produce a modest bradycardia and for how long. If some simple experimentation is not carried out there is a possibility that postural hypotension will produce a different sort of disaster.

Agoraphobia

Agoraphobia is not easy to treat, partly because it significantly involves the patient's personality, partly because it occurs in a complex social and family context, and partly because we do not know enough about it. As is often the case under these circumstances most therapists use every possible treatment, and obtain reasonable results. Treatment is usually best conducted at a unit with sufficient resources and much depends upon the therapist and patient having a good working relationship. The cornerstones of treatment are:

Graded exposure

This is the same process described above with the therapist representing the patient, and a shorter time scale. One starts with simple tasks during the performance of which the patient can cope with his or her anxiety, and proceeds along a hierarchical list of gradually expanding achievements. It is likely to take many months and much hard work.

It is not always successful, which is not surprising when one contemplates the agoraphobes who can go everywhere with their phobic companion, without any improvement in their unaccompanied performance.

Behaviour therapy

As described above, dealing with each of the feared situations. Behaviour therapy is also used to control the hyperventilation which so often complicates agoraphobia.

Medication

- Sedatives. If possible sedatives should be avoided except for brief intermittent use at the beginning of therapy.
- Tricyclic antidepressants. For some obscure reasons some patients respond to tricyclic antidepressants; their panic attacks and generalised anxiety are much improved. The only way to discover whether the patient will respond in this way is to perform the experiment: one gives enough to produce modest dryness of the mouth. Even more obscurely some patients respond to one tricyclic antidepressant, some to another. There is usually plenty of time for experiment; one is grateful for the success.
- Monoamine oxidase inhibitors. Tranylcypromine and phenelzine also help some patients. One embarks upon their use when simpler measures are not prospering.

Psychotherapy

Naturally one has to deal with the patient's fears and difficulties supportively and insightfully. There is no evidence to suggest that individual psychotherapy of any complexity will do more than ordinary support will do, probably because there are powerful forces in both patient and family holding on to the status quo.

Conjoint therapy

Agoraphobia usually causes a great upheaval in a family, or in a couple. Manipulation and control, covert retaliation, profound dependence and other pathological interchanges may abound, and not be dealt with until all the participants are rounded up and placed in some sort of conjoint therapy. It is sometimes a matter for experts.

The phobic depersonalisation syndrome of Roth

It is my experience that this condition, properly diagnosed, responds to sufficient doses of monoamine oxidase inhibitors quite specifically. Once more the literature is not helpful because of failure to distinguish between the various sorts of phobias. The dose may be quite high – 60 mg of tranylcypromine or 90 mg of phenelzine each day is common and occasionally one has to go a little above that. Some patients are fortunate in that after some time of wellbeing the medication can be withdrawn but others relapse each time one lowers the dose. The patient then has the choice of putting up with the risks and restrictions of therapy with a monoamine oxidase inhibitor or a return of the illness. Most choose the treatment.

Sexual phobias

Usually the more intense the anxiety the better the motivation and the better the result. Desensitisation may be enough but sometimes one has to uncover the traumatic origins of the phobia as well. A sympathetic and helpful sexual partner is essential.

Symbolic phobias

The treatment of phobias of this kind requires that the doctor has some skill as a psychotherapist. Uncovering the traumatic material may not be quite as easy as it sounds and there is always the possibility that the psychopathology exposed may be much more widespread than seems to be the case at first.

Phobias associated with other conditions

Here the treatment is the treatment of the primary condition.

Conclusion

Phobias are common and often limiting or disabling. A doctor equipped with natural curiosity and some basic knowledge can discover them in his patients, sort them into their varieties, and by appropriate treatment or referral banish most of them. MT

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