Specific phobia in adults: Epidemiology, clinical manifestations, course, and diagnosis

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INTRODUCTION

Specific phobia is an anxiety disorder characterized by clinically significant fear of a particular object or situation that typically leads to avoidance behavior. Phobic fears include animals, insects, heights, water, enclosed places, driving, flying, seeing blood, getting an injection, and choking or vomiting.

The phobic anxiety may be triggered by anticipation of the stimulus, actual exposure to the stimulus, and even hearing the stimulus name spoken aloud (eg, hearing the word spider for an individual with spider phobia). The focus of fear may include disgust, danger of harm, and/or the experience of physical symptoms in the phobic situation [1].

This topic describes the epidemiology, pathogenesis, clinical manifestations, course, and diagnosis of specific phobia in adults. Specific phobias relating to clinical procedures (eg, blood-injection-injury phobia) and other manifestations of acute procedural anxiety; specific phobias and other anxiety disorders in children; and pharmacotherapy and psychotherapy for specific phobia in adults are discussed separately.

- (See "Anxiety disorders in children and adolescents: Epidemiology, pathogenesis, clinical manifestations, and course".)
- (See "Overview of fears and phobias in children and adolescents".)
- (See "Specific phobia in adults: Treatment overview".)

- (See "Specific phobia in adults: Cognitive-behavioral therapy".)
- (See "Acute procedural anxiety in adults: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Acute procedural anxiety and specific phobia of clinical procedures in adults: Treatment overview".)

SPECIFIC PHOBIA SPECIFIERS

There are five main specifiers (which can be considered types) of specific phobias in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) that are based on the nature of the phobic stimulus [2]:

- Animal (eg, spiders, insects, dogs).
- Natural environment (eg, heights, storms, water).
- Blood-injection-injury (eg, needles, invasive medical procedures). This type of phobia is sometimes associated with a vasovagal fainting response that differentiates it from the other types. (See "Acute procedural anxiety and specific phobia of clinical procedures in adults: Treatment overview".)
- Situational (eg, airplanes, elevators, enclosed places). (See "Acute procedural anxiety and specific phobia of clinical procedures in adults: Treatment overview", section on 'MRI claustrophobia'.)
- Other (eg, situations that may lead to choking or vomiting; in children, eg, loud sounds or costumed characters).

EPIDEMIOLOGY

Prevalence — Prevalence rates in the United States for specific phobia range from 3.5 to 8.7 percent (12-month), and 7.7 to 12.5 percent (lifetime) in adult samples. The rates vary depending on study methodology (eg, the threshold used to determine distress and impairment) and demographic factors [3-6].

Although fears are common in children and most are transient, prevalence estimates of phobias in children are actually low although there is wide variation among findings (from 2.6 to 9.1 percent). (See "Overview of fears and phobias in children and adolescents".)

International epidemiological studies suggest similarly high rates with lifetime prevalence estimates of specific phobia ranging from 5.2 to 6.1 percent in countries such as Korea [7], Oman [8] and China [9], to 11.5 to 12.8 percent in Turkey [10] and Germany [11]. Although some research suggests that the prevalence of specific phobia may be lower in older adults [12], a study of a representative sample of 558 70-year-old Swedish adults found a one-month prevalence rate of 10 percent [13]. Prevalence rates in children and adolescents are estimated to be approximately 5 percent in community samples and 15 percent in clinical samples [14].

Similar to most other anxiety disorders, specific phobias are more common in females than males. As an example, 13.8 percent of women and 4.5 percent of men met criteria for specific phobia in the study of 558 Swedish adults [13]. However, sex differences vary across specific phobia types and are stronger for animal phobias and smaller for blood-injection-injury and height phobias [15]. (See "Acute procedural anxiety in adults: Epidemiology, clinical features, assessment, and diagnosis".)

In a study of 43,093 United States adults, increased risk for specific phobia was associated with being female, young, and low income, while decreased risk is associated with Asian or Hispanic populations [4].

It is not uncommon for patients to report more than one phobia throughout the course of the illness. For example, in a community sample of 915 participants (age 15 to 54) with a lifetime history of specific phobia, 24.4 percent reported one phobia, 26.4 percent reported two phobias, 23.5 percent reported three phobias, 10.4 percent reported four phobias, and 17.3 percent reported more than four phobias [16].

Comorbidities — Common comorbidities associated with specific phobia include other anxiety disorders as well as mood disorders and alcohol dependence.

In a national epidemiologic survey of 43,093 adults in the United States, specific phobia was associated with other anxiety disorders (odds ratio 6.5), panic disorder with agoraphobia (odds ratio 14.6), social phobia (social anxiety disorder; odds ratio 7.9), generalized anxiety disorder (odds ratio 6.0), major depressive disorder (odds ratio 2.5), bipolar II disorder (odds ratio 4.1), and alcohol dependence (odds ratio 4.1) [4]. The presence of specific phobia has also been correlated with the presence of posttraumatic stress disorder, separation anxiety disorder, and bipolar disorder [6].

- (See "Posttraumatic stress disorder in adults: Epidemiology, pathophysiology, clinical features, assessment, and diagnosis" and "Unipolar depression in adults: Epidemiology" and "Generalized anxiety disorder in adults: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)

- (See "Social anxiety disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Posttraumatic stress disorder in adults: Epidemiology, pathophysiology, clinical features, assessment, and diagnosis" and "Unipolar depression in adults: Epidemiology" and "Generalized anxiety disorder in adults: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)
- (See "Risky drinking and alcohol use disorder: Epidemiology, clinical features, adverse consequences, screening, and assessment".)
- (See "Posttraumatic stress disorder in adults: Epidemiology, pathophysiology, clinical features, assessment, and diagnosis" and "Unipolar depression in adults: Epidemiology" and "Generalized anxiety disorder in adults: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)

PATHOGENESIS

The development of specific phobia is influenced by a complex interaction of biological, psychological, and social/environmental factors.

Genetic factors — Specific phobias tend to aggregate in families. First-degree relatives of individuals with specific phobia have an increased risk (31 percent versus 11 percent) of having the disorder compared to first-degree relatives of individuals without a history of a mental disorder [17]. However, the particular phobia that is transmitted is typically different although often it is from the same type (see 'Specific phobia specifiers' above). As an example, a parent who reports a fear of dogs has a child who reports a fear of snakes. Both phobias are within the animal type but the feared animal differs. Evidence for genetic transmission varies across phobia types and is highest for blood-injection-injury phobias (59 percent) [18,19], and lowest for natural environment and situational phobias [20]. (See "Acute procedural anxiety in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Terminology'.)

A meta-analysis of twin studies found that specific phobias are moderately heritable [19]. Twin studies suggest that environmental influences play a stronger role than genetic factors in developing the disorder [21]. In particular, individual-specific environmental influences such as experiencing a traumatic event in the phobic situation are an important etiological pathway, whereas family-specific environmental influences (eg, shared environment) are not [17]. The nature of the genetic contribution has yet to be specified but may be a low threshold for alarm reactions or an overactive baroreflex in the case of blood-injection-injury phobia specifically [22,23].

Genetics also play a role in the heritability of personality traits that increase vulnerability for the development of specific phobia. (See 'Personality factors' below.)

Neurobiological factors — Studies using functional magnetic resonance imaging have found neuroanatomical pathways associated with specific phobia. For example, hyperactivation has been found in structures more broadly associated with negative emotional responses, such as the amygdala and the insula [24]. As an example, a study found that individuals with spider phobia displayed significantly higher amygdala activation than did nonphobic controls in response to a predicted threat. Additionally, greater activation was measured in the bed nucleus of stria terminalis and the right anterior cingulate cortex in response to an unpredicted threat [25]. Individuals with spider phobia had enhanced functional connectivity of the bed nucleus of stria terminalis and the amygdala compared with controls [25].

The classification of phobia types is also supported by imaging research suggesting unique underlying neural substrates associated with the animal and blood-injection-injury types [26,27]. As an example, a study examined gray and white matter volume using voxel-based morphometry (an analytic approach to examine differences in brain structure) in 33 individuals with snake phobia, 26 individuals with dental phobia and 37 healthy controls [27]. Individuals in the dental phobia group had significantly greater grey matter volume in brain regions associated with emotional processing (right subgenual anterior cingulate gyrus, left insula, left orbitofrontal and left prefrontal cortices) than did the snake phobia or the healthy control group. The dental phobia group also had greater white matter volume in the left prefrontal cortex compared with the snake phobia group.

Other research comparing phobic fear activation and nonphobic activation suggests that visually elicited phobic reactions activate object recognition areas and deactivate prefrontal areas involved in cognitive control over emotion-triggering areas (ie, amygdala), resulting in motor readiness for fight or flight [28].

Personality factors — There is some evidence that disgust sensitivity (the tendency to experience disgust in response to certain stimuli) is a developmental factor for certain animal and blood-injection-injury phobias [29,30]. Anxiety sensitivity, a dispositional variable reflecting beliefs that the physical sensations of anxiety are harmful, has also been found to be elevated in specific phobia, particularly in the situational type [31]. (See "Acute procedural anxiety in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Terminology'.)

Cognitive factors — A growing body of information processing research reveals that individuals with specific phobia exhibit attentional biases to threat-related information, including enhanced detection, and perceptual and cognitive distortions consistent with their

phobias [32-35]. It is unclear whether cognitive biases play a role in the development of the fear; however, it is generally accepted that they play an important role in maintaining the disorder. These cognitive biases likely reflect variation in neurobiology described above. As an example, expectancy bias (the exaggerated likelihood of encountering the phobic stimuli) has been associated with increased negative modulation of activity in the lateral prefrontal cortex, precuneus, and visual cortex in response to the encounter expectancy of a spider (versus a snake or a bird) in a group of 18 individuals with spider phobia. This pattern was not seen in 18 control participants [35].

Social and environmental factors — A host of social and environmental factors may play a role in the development of specific phobias including the context of a traumatic event, stress at the time of the event (that may lead to an increased fear response), previous and subsequent exposure to a phobic stimulus, and level of support [23]. Learning processes are of particular importance in the development of specific phobia [23]. Three pathways to fear development have been proposed within the context of biological constraints [36]:

- Direct conditioning involves experiencing a traumatic event in the phobic situation such as being hurt or frightened (eg, being bitten by a dog, being in a car accident, fainting at the sight of blood). In a retrospective study of precipitating events in the development of dental anxiety, participants identified disruptive emotional and interoceptive reactions during dental treatment as most strongly associated with the development of dental anxiety. Dental experiences involving feelings of helplessness were most strongly associated with a development of specific phobia [37]. (See "Acute procedural anxiety in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Terminology'.)

- Vicarious acquisition involves observing someone behaving fearfully in the phobic situation or witnessing a traumatic event such as witnessing someone being bit by a dog or seeing a family member behave fearfully in the presence of a spider.

- Informational transmission involves learning to be fearful through information obtained verbally from others or through the media, such as hearing about someone being bitten by a shark or reading about a plane crash.

Studies with normal comparison groups find that learning experiences are equally common in individuals who do and do not have phobias, suggesting that certain individuals are more likely to develop phobias after experiencing conditioning events [38-40]. As an example, a retrospective study comparing 30 individuals with flying phobia with 30 matched health controls found that frightening flying experiences were common in both groups (50 versus 53

percent) and both groups were similarly influenced by vicarious learning (37 versus 23 percent); however, the presence of stressful life events during the frightening flying experiences (60 versus 19 percent) and the influence of informational learning through the media following these experience (70 versus 37 percent) were significantly greater for those in the flying phobia group [40]. These findings suggest that stressful life events may enhance conditionability and informational transmission through media exposure may reinforce development of a flying phobia [40].

Evolutionary pathway — Some fears emerge without any prior learning experiences and may be innate or biologically determined [41]. This pathway may account for the substantial proportion of individuals who indicate they have had their phobia for as long as they can remember. Innate fears may be considered adaptive from an evolutionary perspective. This pathway is along the lines of Seligman's preparedness theory, which states that some individuals are prepared to develop some associations that lead to fear (eg, being afraid of dogs after being bitten by a dog) and not others (being afraid of flowers after being pricked by a thorn) to facilitate survival. Evidence for preparedness theory is mixed [24].

One etiological model for the development of specific phobias during childhood proposes that specific learning experiences interact with normal developmental fears and genetically-based behavioral patterns, resulting in persistent fears that result in specific phobias, which are then maintained by cognitive biases [42].

CLINICAL MANIFESTATIONS

Specific phobia is not typically seen as the primary presenting problem in most clinical settings (unless the clinical setting is an anxiety disorders specialty clinic). Specific phobia may be seen when it co-occurs with other disorders that are usually the focus of clinical attention, such as other anxiety disorders, mood disorders, and alcohol dependence [43]. There is some evidence that the individuals who present for treatment of their specific phobia differ from those who do not seek help in terms of the number and types of specific phobias [44]. (See 'Comorbidities' above.)

Specific phobia types differ in various ways, including age of onset, focus of fear, timing, and predictability of the phobic response and physiological fear response. Additionally, treatment response, level of impairment, and reporting of associated symptoms of anxiety, depression, and other emotional or behavioral problems can vary [1,23,45,46]. (See "Acute procedural anxiety in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Clinical manifestations'.)

It is common for the phobic fear to be present for a period of time before it becomes clinically significant [4,32]. Individuals often state that they recognize the fear is completely irrational or excessive but they are unable to control their response to the feared situation or object. The fear may be a source of embarrassment and is often accommodated by varying strategies of avoidance.

As an example, someone with a fear of spiders may avoid situations that increase the likelihood of seeing a spider (eg, the basement, garage, backyard, and outdoor vacations). They also may attempt to control the environment to reduce spider exposure (eg, not opening the windows in summer, tucking in the end of the blanket even in hot weather, wearing long sleeve shirts and pants in summer).

Functional impairment associated with specific phobia can range from minimal to significant depending on the degree of fear, and the degree of impact in everyday life. For some people, the fear may be accommodated such that the impact in everyday life is minimized or not perceived as significant [43,47]. For others, the specific phobia can be quite impairing and even life threatening, as in the case of choking phobia (in extreme cases, an individual may avoid consuming any solid food or thick liquids) and blood-injection-injury phobia (an individual may avoid necessary medical procedures) [43]. An increased number of fears has been associated with increased disability [4]. (See "Acute procedural anxiety in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Clinical manifestations'.)

Findings have been mixed on differences in impairment across phobia types. Some studies find that situational and blood-injection-injury phobias are more impairing than animal or natural environment phobias, but other studies have found no differences [11,48]. As an example, one study in youth found that, compared to animal phobias, natural environment phobias were associated with greater somatic, anxious, and depressed symptoms, and increased social problems [49].

COURSE OF ILLNESS

When untreated, phobias tend to be lifelong. Age of onset is typically in mid-childhood [3,4] or early adolescence [13] but varies depending on the type of phobia. Animal and blood-injection-injury phobias are more likely to begin in childhood; whereas, situational and natural environment phobias tend to occur in late adolescence or early adulthood [11,31]. There is some evidence that prevalence of specific phobia may decline in older adults [50].

- In a large representative sample of United States adults with specific phobia, the mean duration of the disorder was 20 years, with only eight percent reporting receiving treatment specifically for specific phobia [4].

- A prospective study of 137 women (age 18 to 25) found that 41.6 percent of individuals diagnosed with specific phobia at baseline were partially remitted, and 19 percent were fully remitted after an average of 17 months. A remitting course was associated with residual protective factors at baseline including positive mental health and life satisfaction [51].

- A prospective study of 558 older adults assessed for specific phobia at age 70 found that the prevalence of the diagnosis decreased with age from 9.9 percent at age 70 to 4.0 percent at age 79 [50].

Prognosis is excellent, particularly with exposure-based treatment [52]. (See "Specific phobia in adults: Treatment overview" and "Specific phobia in adults: Cognitive-behavioral therapy".)

DIAGNOSIS

The most common phobias seen in clinical practice by physicians are typically those that have caused significant impairment in functioning and lifestyle (eg, driving, flying) or have an impact on health (vomiting, choking, blood-injection-injury, enclosed places). As an example, an individual who has of phobia of enclosed places will have great difficulty undergoing a needed MRI and this will come to the attention of the ordering physician.

Assessment for symptoms and associated behaviors — It is important for the evaluating clinician to recognize that the assessment procedure itself may be anxiety-provoking. Just the patient saying the phobic word aloud or reading it on paper may provoke an anxiety reaction. Thus, it is important to convey the need for assessing the problem, as well as the therapeutic benefit of addressing the fear directly.

We include detailed information on the following as part of our thorough assessment:

- Focus of anxiety in the phobic situation and reasons for avoidance – This may include fear of anticipated harm or danger (ie, plane crashing in flying phobia), physiological symptoms of anxiety (ie, fainting in blood-injection-injury phobia), and concerns about emotional control (having a panic attack and losing control in a driving phobia). (See "Acute procedural anxiety in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Clinical manifestations'.)

- Fear predictability – The fear response associated with specific phobia is typically invariably experienced upon exposure to the phobic stimulus.

- Range of situations feared and variables that influence fear intensity – Phobias may be associated with a single situation (eg, travelling by airplane in the case of flying phobia) or a wide range of situations related to the specific phobic fear. As an example of a fear manifested in many situations, an individual with a fear of snakes may avoid saying the word "snake", watching certain nature programs on television, walking in forests, and toy stores. A host of variables may influence fear intensity and are specific to each individual's presentation. As an example, an individual with a driving phobia may report that the fear is influenced by time of day, degree of traffic, type of road, speed limit, weather conditions, and the presence of others in the car.

- Safety behaviors used to reduce anxiety **–** Safety behaviors are actions an individual takes to prevent a feared outcome from occurring or cope with a perceived threat [53,54]. It is common for individuals with specific phobia to engage in safety behaviors to manage their fear. Overt safety behaviors include escape and avoidance. Subtle safety behaviors are more difficult to detect and may include cognitive distraction and thought suppression as well as carrying an item that is perceived to provide comfort or protection. As examples:

  - An individual with dog phobia may cross the street to avoid walking past a dog and may carry pepper spray for protection

  - An individual with a fear of flying may consume significant amounts of alcohol to reduce the experience of anxiety on a flight

  - An individual with a height phobia may avoid visiting people who live in apartment buildings and may also avoid looking out the window

  - An individual with a fear of thunderstorms may stay in the basement during a storm

- Skills deficits that may play a role in the specific phobia **–** This is particularly relevant for a specific phobia of driving. A person may not have adequate driving skills, especially if they have avoided driving and thus a portion of the fear may be realistic.

- Factors specific to symptom presentation in older adults **–** In older adults, additional factors that should be considered include the impact of age-related sensory impairments on communication of symptoms, presence of medical illnesses that may contribute to anxiety, and factors that may lead to symptom underreporting such as inability to

recognize the experience of anxiety symptoms and the misattribution of anxiety to physical symptoms [55].

Diagnostic criteria — The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) criteria for specific phobia are described below [56]:

- A. Marked fear or anxiety about a specific object or situation (eg, flying, heights, animals, receiving an injection, seeing blood).

  Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.

- 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 six 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 (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).

Specifiers based on the phobic stimulus:

- Animal (eg, spiders, insects, dogs)
- Natural environment (eg, heights, storms, water)
- Blood-injection-injury (eg, needles, invasive medical procedures)
- Situational (eg, airplanes, elevators, enclosed places)
- Other (eg, situations that may lead to choking or vomiting; in children; eg, loud sounds or costumed characters)

If a person has a significant fear but does not encounter the phobic situation and is not distressed by the fear, then a diagnosis of specific phobia would not be warranted. For example, a person who has a fear of fish, but does not live by a body of water, does not encounter fish in the course of daily living, and is not bothered by having the fear would not receive a specific phobia diagnosis.

Differential diagnosis — The information obtained in the assessment can help to generate a differential diagnosis as a number of disorders feature fear and avoidance of specific situations. To distinguish a specific phobia from other psychiatric disorders, it is helpful to consider the focus of the fear, the circumscribed nature of the fear and avoidance, and whether the fear is captured by another psychiatric disorder.

Agoraphobia — Multiple specific phobias may resemble agoraphobia. To distinguish these disorders, consider the focus of fear in the situation. In specific phobia, the focus of fear is on aspects of a particular situation, so multiple specific phobias will be associated with multiple fears (eg, driving is avoided for fear of an accident; elevators are avoided for fear of being stuck; outdoor places are avoided for fear of spiders). In agoraphobia, avoidance is typically across a range of situations, yet the focus of fear is the same across situations (eg, driving, elevators, and outdoor places are avoided for fear of panic symptoms or the unavailability of help if needed). (See "Agoraphobia in adults: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis".)

Panic disorder — Panic attacks may occur in both panic disorder and specific phobia. To differentiate these disorders it is helpful to consider the context of the panic attack. Panic disorder is characterized by uncued or unexpected panic attacks, whereas panic attacks within the context of specific phobia are typically cued by encountering the feared situation or stimulus. (See "Panic disorder in adults: Epidemiology, clinical manifestations, and diagnosis".)

Social anxiety disorder — Social anxiety disorder related to discrete performance situations may be mistaken for a specific phobia (eg, public speaking or performing on stage). In this case it is important to discern the reasons for the fear and avoidance. Fears specific to being publicly scrutinized, embarrassed, or negatively judged by others are subsumed under the diagnosis of social anxiety disorder. (See "Social anxiety disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)

Posttraumatic stress disorder — Individuals with posttraumatic stress disorder (PTSD) may avoid situations associated with the trauma, and a specific phobia may develop after experiencing a traumatic event in the phobic situation. To distinguish between these disorders, it is important to consider the constellation of symptoms reported and the range of situations

avoided. For example, a person who experienced a traumatic motor vehicle accident and now avoids driving may receive a diagnosis of specific phobia of driving if the fear and avoidance are confined specifically to driving situations. However, if the person also reports reexperiencing symptoms, persistent avoidance of trauma cues, numbing of general responsiveness, and increased arousal, a diagnosis of PTSD may be warranted. (See "Posttraumatic stress disorder in adults: Epidemiology, pathophysiology, clinical features, assessment, and diagnosis".)

Separation anxiety disorder — Both specific phobia and separation anxiety disorder are associated with situational avoidance. Consideration of the focus of fear is helpful in distinguishing these two disorders. In separation anxiety disorder, situations are avoided for fear of being separated from an attachment figure or for fear of harm befalling an attachment figure. In specific phobia, fear and avoidance are related to a circumscribed situation or object and is unrelated to the presence/absence of an attachment figure. (See "Overview of fears and phobias in children and adolescents".)

Illness anxiety disorder — A patient presenting with a specific fear of getting or having a specific illness may be best diagnosed with illness anxiety disorder. Patients with illness anxiety the disorder are intensely anxious about the possibility of an undiagnosed illness, or devote excessive time and energy to health concerns. (See "Illness anxiety disorder: Epidemiology, clinical presentation, assessment, and diagnosis".)

Eating disorders — Fear and avoidance of specific foods may characterize both eating disorders and specific phobia, other type (fear of choking). In this case, it is helpful to determine the focus of fear and reasons for avoidance. If certain foods are feared and avoided due to concerns of weight gain, then a diagnosis of eating disorder may be warranted. If certain foods are feared and avoided due to concerns of choking, then a diagnosis of specific phobia, other type (fear of choking) may be warranted. In both cases, consequent weight loss may be substantial. (See "Eating disorders: Overview of epidemiology, clinical features, and diagnosis".)

Other diagnostic considerations — Specific phobia needs to be distinguished from normative states of fear. Unlike normative fear, phobic fear [57,58]:

- Is excessive and out of proportion to situational demands
- Cannot be alleviated with rational explanation
- Is out of voluntary control
- Leads to situational avoidance
- Is maladaptive and persistent over time
- Is not age or stage-specific

Cultural beliefs, values, and traditions may play a role in fear expression, with research showing that fears may differ in both their nature and intensity across different ethnic groups residing within the same country [59]. Thus, it is important to consider the cultural context when conducting an assessment of fears. As an example, if an individual reports fear of a particular animal, but is raised within a cultural context where that fear is normative, one should not consider the fear to be excessive or unreasonable unless it is over and above the cultural norm.

Specific phobia in children — The clinical manifestations and diagnosis of specific phobia differ in some respects in children. (See "Overview of fears and phobias in children and adolescents".)

ASSESSMENT TOOLS

Diagnostic interviews and self-report measures are useful for determining a diagnosis, screening, gathering detailed information on anxiety, and assessing symptom intensity and severity.

- The Anxiety Disorders Interview Schedule for the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (ADIS-5) standard version [60] includes dimensional ratings of fear and avoidance for 19 objects or situations from the five specific phobia subtypes. There is a Child and Parent version available that uses Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria [61]. This instrument is extremely useful for thoroughly assessing the presence of specific phobia. Although an individual may have a specific phobia, they are unlikely to report it unless they are asked. The downside of this measure is that it is time consuming and thus is best used with an individual presenting with significant anxiety as the primary problem.

- There are self-report measures specific to types of specific phobia (table 1). These measures are useful for determining the range of symptoms, establishing initial symptom severity, and for measuring treatment progress and outcome. The Specific Phobia Questionnaire [62] is a screening tool for assessing a range of fears associated with the five specific types as well as associated interference. The Circumscribed Fear Measure can be used to assess specific phobia across different phobia types [63]. The Severity Measure for Specific Phobia also assesses the intensity of symptoms across the five specific phobia types and is available in both adult and child (age 11 to 17) versions.

- The behavioral approach task involves having the individual confront the feared situation so that the clinician can assess fear intensity, variables that affect fear intensity,

phenomenology of the anxiety response, anxious cognitions, and safety behaviors [15]. This method of assessment is most relevant in a setting where treatment will be provided, as it is useful for treatment planning purposes.

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Anxiety and anxiety disorders in adults".)

SUMMARY

- **Specific phobia** – Specific phobia is an anxiety disorder characterized by clinically significant anxiety associated with anticipation of, or exposure to, a circumscribed situation or object that often leads to avoidant behavior and results in considerable distress and impairment in functioning. (See 'Introduction' above.)

  The five types of specific phobia are animal, natural environment, blood-injection-injury, situational, and other. (See 'Specific phobia specifiers' above.)

- **Epidemiology** – Specific phobia is among the most common mental disorders, associated with high rates of comorbidity. Specific phobias are more common in females than males; however, sex differences vary across specific phobia types and are stronger for animal phobias and smaller for blood-injection-injury and height phobias. (See 'Epidemiology' above.)

- **Clinical manifestations** – Specific phobia can be associated with significant impairment and disability but is not typically seen as the primary presenting problem in clinical settings (unless the clinical setting is an anxiety disorders specialty clinic). Clinical attention is usually focused on common comorbid disorders such as other anxiety disorders, mood disorders, and alcohol dependence. (See 'Clinical manifestations' above.)

- **Course of illness** – When untreated, phobias tend to be lifelong. Age of onset varies depending on the type of phobia. Animal and blood-injection-injury phobias are more likely to begin in childhood, whereas situational and natural environment phobias tend to occur in late adolescence or early adulthood. There is some evidence that prevalence of specific phobia may decline in older adults. (See 'Course of illness' above.)

- **Assessment** – As part of our assessment, we include detailed information on the focus of the anxiety and the reasons for avoidance of situations. Additionally, the range of situations that are feared, the variability of the intensity, the predictability of fear, and the safety behaviors used to reduce anxiety should be assessed. The information obtained can help generate a differential diagnosis; a number of disorders feature fear and avoidance of specific situations. (See 'Assessment for symptoms and associated behaviors' above.)

- **Diagnostic criteria –** Criteria that need to be met for a diagnosis of specific phobia in adults include (see 'Diagnostic criteria' above):

  - Marked fear or anxiety about a specific object or situation
  - Immediate anxiety after exposure to the phobic object or situation
  - Avoidance of the phobic object or enduring it with disproportionate fear
  - The fear, anxiety, or avoidance cause clinically significant distress or impairment in social, occupational, or other areas of functioning

- **Differential diagnosis –** To distinguish a specific phobia from other psychiatric disorders, it is helpful to consider the focus of the fear, the circumscribed nature of the fear and avoidance, and whether the fear is captured by another psychiatric disorder. Disorders that may have similar presentation to specific phobia include agoraphobia, panic disorder, social anxiety disorder, Posttraumatic stress disorder, illness anxiety disorder, eating disorders, and separation anxiety disorder. (See 'Differential diagnosis' above.)

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