Specific phobia in adults: Treatment overview

AUTHORS: Randi E McCabe, PhD, Eric Bui, MD, PhD
SECTION EDITOR: Murray B Stein, MD, MPH
DEPUTY EDITOR: Michael Friedman, MD

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: **Oct 2023.**
This topic last updated: **Jul 10, 2023.**

INTRODUCTION

Specific phobia is an anxiety disorder characterized by clinically significant fear of a particular object or situation that typically leads to avoidance behaviors. Phobic fears include animals, insects, heights, water, enclosed places, driving, flying, and choking or vomiting. Some specific phobias involve responses to medical procedures, such as injections, dental work, or blood.

Specific phobias are among the most common mental disorders and can be highly disabling [1,2]. However, they are also among the most treatable mental disorders [3-6]. Despite availability of effective treatments, the majority of individuals with specific phobias are hesitant to seek treatment [7]. This may be due to lack of knowledge that the phobia is treatable, embarrassment to disclose the phobia to a health professional, accommodation of the phobia through avoidance, or fear of increased anxiety or discomfort in the course of treatment [5].

The initial management of specific phobia including choosing treatment modality, and subsequent pharmacologic management are reviewed here. The epidemiology, pathogenesis, clinical manifestations, and diagnosis of specific phobias, and treatment of specific phobia with cognitive-behavioral therapy are discussed separately. The management of phobias related to specific clinical procedures (ie, dental phobia, blood and injection phobia, claustrophobia during magnetic resonance imaging [MRI] procedure) are discussed elsewhere as are topics related to specific phobia and anxiety in children and adolescents.

- (See "Specific phobia in adults: Epidemiology, clinical manifestations, course, and diagnosis".)

- (See "Specific phobia in adults: Cognitive-behavioral therapy".)
- (See "Acute procedural anxiety and specific phobia of clinical procedures in adults: Treatment overview".)
- (See "Overview of fears and phobias in children and adolescents".)

INITIAL MANAGEMENT DECISIONS

To treat or not to treat — We use shared decision making in formulating the treatment plan, including whether to treat the specific phobia. We review the impact of the phobia on overall quality of life including level of distress, presence of avoidance behaviors, and interference with daily functioning. In cases where the specific phobia leads to an impact on daily life (eg, work, interpersonal), we encourage treatment. In cases where the impact of the specific phobia is less pervasive or in cases where the phobic stimulus is infrequently encountered, we are guided by the individual preference. In these cases, the patient may decide not to pursue treatment or to pursue a specific form of treatment (eg, as needed pharmacologic management for infrequently encountered stimulus such as a rare airline flight).

Individuals with a recent diagnosis of specific phobia are often motivated to seek treatment when they learn that effective treatments are available.

Addressing co-occurring anxiety disorders — Prior to treating specific phobia, we are sure to do a thorough assessment for common co-occurring disorders such as anxiety disorders, mood disorders, and substance use disorders. We also determine the primary disorder of concern (ie, the disorder that is associated with the greatest distress and/or impairment and/or the one that the patient would like to focus on) and typically focus on its treatment. Presenting symptoms may be due to co-occurring disorders, which, if successfully treated, may improve the presenting symptoms and overall quality of life [8].

However, some specific phobias may be severe, even life threatening (eg, choking, fear of medical procedures), and thus warrant clinical priority for treatment. (See "Management of panic disorder with or without agoraphobia in adults" and "Generalized anxiety disorder in adults: Management".)

TREATMENT

Cognitive-behavioral therapy with exposure: First line for most — For most patients with a diagnosis of specific phobia, we suggest first-line treatment with cognitive-behavioral therapy (CBT) that includes exposure rather than other forms of psychotherapy or medication

management [9]. Treatment with exposure therapy may be emotionally taxing. Patients may be reluctant to pursue exposure therapy. Strategies to overcome this reluctance are discussed separately. (See "Specific phobia in adults: Cognitive-behavioral therapy".)

Choosing an exposure therapy — Exposure therapy methods include in vivo exposure, imaginal exposure, virtual reality exposure. While in vivo exposure has the most evidence supporting it in the treatment of specific phobia, other treatments such as imaginal or virtual reality exposure have a role when the stimulus is infrequent, difficult to recreate, or as part of a hierarchy leading to in vivo exposure.

Discussion of CBT with exposure for specific phobia in adults, types of exposure, components of CBT, and other cognitive or behavioral interventions are discussed in detail elsewhere. (See "Specific phobia in adults: Cognitive-behavioral therapy", section on 'Types of exposure' and "Specific phobia in adults: Cognitive-behavioral therapy", section on 'Administering exposure therapy'.)

Efficacy of exposure therapy — CBT with exposure is an effective treatment for specific phobia. Among psychosocial interventions tested in specific phobia, CBT with exposure has been the most extensively studied in clinical trials [5]. In a meta-analysis of trials, treatment with exposure-based therapy led to greater improvement in symptoms of specific phobia than wait-list control conditions (18 trials, large effect size), placebo treatments (five trials, moderate to large effect size) and active nonexposure interventions (six trials, large effect size). At follow-up, the average subject receiving exposure treatment was doing better than 75 percent of those receiving placebo and 64 percent of those receiving active nonexposure treatment [5].

Among exposure treatments for specific phobia, in vivo exposure appears to be more effective than other forms of exposure; however, this advantage was not found at follow-up. For example, in a meta-analysis of seven studies in vivo exposure compared with alternative mode of exposure yielded an advantage at posttreatment; however, at follow-up this advantage was no longer supported [5]. Few studies directly compare the efficacy of exposure treatment variations, results are mixed, and heterogeneity of studies limits their interpretation [5,10-16]. Further studies are warranted.

Additionally, forms of exposure therapy delivered via the internet or mobile-based applications appear to be effective as compared with waitlist or other control conditions [13,17,18].

There are no randomized clinical trials directly comparing CBT with exposure and medication for specific phobia.

Benzodiazepines as alternative initial treatment

Indications and precautions — For individuals who are reluctant to undergo CBT (despite being informed about the relative risks, benefits, and supporting evidence), when the phobic stimulus is infrequently encountered and unavoidable (eg, needing to fly for work), or in cases where the exposure therapy is unavailable over the short term (eg, patient with fear of flying presents for treatment one week prior to scheduled flight), we typically use a benzodiazepine to treat the specific phobia. For some patients, the knowledge that they have the medication enables them to overcome the avoidance of flying.

However, we typically do not combine benzodiazepines with exposure therapy as the sedative properties of the benzodiazepine, may interfere with engagement in exposure treatment. Additionally, they may undermine the efficacy of exposure treatment as patients may believe that they "need" the medication to engage with the phobic stimulus thereby attenuating the effect of the exposure or perpetuating avoidance behaviors [19,20].

For example, in one trial, the acute and delayed effects of a short-acting benzodiazepine, alprazolam, on individuals with a flying phobia was studied; 28 females with a flying phobia were randomly assigned to receive 1 mg of alprazolam or placebo given 1.5 hours prior to a short first flight and then one week later were exposed to another short flight without medication [21]. Individuals treated with alprazolam reported reduced anxiety during the first flight as compared with the placebo treated group. However, on the second flight, individuals who had previously received alprazolam (during the first flight) as compared with those who received placebo, reported greater levels of anxiety and an increased in the number of panic attacks. The conclusion was that alprazolam appears to hinder therapeutic effects of exposure in flying phobia and may lead to increased anxiety at subsequent encounters with the phobic stimulus.

We advise the patient that using benzodiazepine to manage one feared situation might increase the anxiety in future encounters with that situation, and that once the decision to use benzodiazepine is taken, they will likely be needing it each time. Because of this potential "pharmaco-dependance" effect, and their (unfavorable) side effect profile, the decision to initiate benzodiazepines, even on an as-needed basis, requires carefully weighting risk/benefit ratio with the patient.

Side effects of benzodiazepines include sedation, impaired psychomotor performance, amnesia, and abuse as well as dependence and withdrawal symptoms after long-term treatment [22]. The risk of misuse of benzodiazepines is largely confined to individuals with a history of or an active substance use disorder; however, a family history of substance abuse may be a risk factor for some individuals [23]. In individuals with a history of prior substance use disorder we discuss the risks of benzodiazepine use and when given, we prefer a

benzodiazepine that is longer acting and with slower onset of action (eg, clonazepam) to reduce misuse liability. Additionally, we prescribe the minimum amount of medication. For example, in an individual with a past history of substance use disorder who has a fear of flying and will be flying for work in one week, we would give clonazepam 1 mg tablets, one tablet for each flight without refills.

Choosing and administering benzodiazepines — When using benzodiazepines for specific phobia, we prefer to use benzodiazepines with longer acting and with slower onset of action (eg, clonazepam) to limit the risk of substance use disorder. For example, when using clonazepam, we tell the patient to take 1 mg as initial dose one hour prior to the phobic stimulus being encountered.

However, if the exposure to the feared object or situation is very short lived, we could use a benzodiazepine with shorter onset of action (eg, lorazepam), to limit the duration of potential side effects (eg, short flight prior to an important work meeting). In this situation we would use lorazepam 0.5 to 1 mg as the initial dose 30 minutes prior to the phobic stimulus being encountered.

We advise patients to take a test dose of the prescribed medication prior to using it for the phobic situation to ensure it does not lead to oversedation. Additionally, we advise patients to avoid alcohol, driving and using heavy machinery during the hours after taking the medication. Consuming alcohol with the medication may lead to additive severe side effects such as sedation, confusion, or impaired coordination.

Efficacy — There are no rigorous data from clinical trials reporting that benzodiazepines are effective for specific phobia. In our experience, flying phobia anxiety can be managed with benzodiazepines short term (ie, for the length of a flight); however, well-designed randomized trials are needed to further test their efficacy for specific phobia in general [10,24,25]. Discussion of the use of benzodiazepines in the treatment of acute procedural anxiety or specific phobia of clinical procedures is found elsewhere. (See "Acute procedural anxiety and specific phobia of clinical procedures in adults: Treatment overview".)

SUBSEQUENT TREATMENT

Robust response — Treatment gains from exposure therapy appear to be maintained for at least one year [26-28]. We suggest ongoing self-exposure on a regular basis to maintain treatment gains [29]. (See "Specific phobia in adults: Cognitive-behavioral therapy", section on 'For robust treatment response and maintenance of gains'.)

Treatment gains from benzodiazepines last only as long as the patient continues to take the medication, and thus continuing treatment is required.

Inadequate response

Inadequate response to exposure therapy — There are no clinical trials of strategies to treat specific phobia that does not respond to initial treatment with exposure or for those who choose not to participate in exposure therapy due to levels of distress. Our initial step in addressing inadequate response to exposure therapy is to confirm that the individual is not engaging in a behavior that might hinder the efficacy (eg, taking benzodiazepine or drinking alcohol before exposure session). After confirming this we typically add one or more additional components including cognitive therapy, psychoeducation, safety behaviors, anxiety management, and applied tension. (See "Specific phobia in adults: Cognitive-behavioral therapy", section on 'For inadequate response to exposure therapy'.)

Inadequate response to pharmacologic management — Minimal evidence supports the use of the following agents in the treatment of specific phobia. We do not routinely use these agents; however, in some cases we use them as a treatment of last resort. The choice of the drug is guided by the potential contra-indications (eg, asthma contraindicate beta-blockers), the demonstrated efficacy in conditions with similar phenomenology to the targeted specific phobia (eg, selective serotonin reuptake inhibitor [SSRI] claustrophobia that is similar to panic disorder for which SSRI have demonstrated efficacy), or potential comorbid conditions (SSRI have demonstrated efficacy in generalized anxiety disorder).

- **Beta-adrenergic blocking agents** – Although used for social anxiety disorder, performance type, only minimal and conflicting data, supports the use of beta-adrenergic blocking agents in the treatment of specific phobia [30-32].

- **SSRIs** – Small clinical trials suggest possible efficacy but have not demonstrated a conclusive benefit [33,34]. May be most useful for situational phobias that are similar to panic disorder (eg, claustrophobia).

Minimal evidence supports the use of D-cycloserine [35-40], hydrocortisone [41-43], methylene blue [44], quetiapine [45] or yohimbine [30] as augmentation agents when administered immediately before CBT exposure sessions.

PERCEIVED HELPFULNESS OF TREATMENT

While randomized trials appear to show that treatment of specific phobia is effective, it is unclear if patients experience treatment as helpful or not in clinical practice [5,6,10]. Cross-sectional population-based World Health Organization mental health surveys conducted in 24 countries with a population-based sample of 112,507 assessed the perceived helpfulness of treatment and the persistence of help-seeking after receiving unhelpful treatment in respondents who reported lifetime prevalence of specific phobia [46]. Of that sample, 23 percent found treatment helpful after the first professional seen while the cumulative probability of finding treatment helpful was 85.7 percent after seeing up to nine professionals. The overall proportion of those ever receiving helpful treatment was 47.5 percent, which could have been improved by persistence in help-seeking. This study underscores the need to refer individuals with specific phobia to clinicians skilled in providing evidence-based treatment and to encourage further help seeking if initial attempts are perceived as unsuccessful.

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 AND RECOMMENDATIONS

- **Specific phobia** – Specific phobia is an anxiety disorder characterized by clinically significant fear of a particular object or situation that typically leads to avoidance behaviors. Specific phobias are among the most common mental disorders and can be highly disabling. They are also among the most treatable mental disorders. (See 'Introduction' above.)

- **Initial management decisions** – We use shared decision making in formulating the treatment plan, including whether to treat. In cases where the specific phobia leads to an impact on daily life (eg, work, interpersonal), we encourage treatment. In cases where the impact of the specific phobia is less pervasive or in cases where the phobic stimulus is infrequently encountered, we are guided by the individual preference. (See 'Initial management decisions' above.)

- **Co-occurring disorders** – We prioritize the treatment of co-occurring anxiety disorders such as generalized anxiety disorder, panic disorder, or other comorbid disorders (eg, mood disorder) if they are causing the most distress/impairment or identified by the

patient to be of principal concern. Presenting symptoms may be due to co-occurring disorders, which, if successfully treated, may improve the presenting symptoms and overall quality of life. (See 'Addressing co-occurring anxiety disorders' above.)

- **Cognitive-behavioral therapy (CBT) as initial treatment** – For most patients newly diagnosed with specific phobia, we suggest first-line treatment with CBT that includes exposure rather than other forms of psychotherapy or medication management (**Grade 2C**). While comparative treatment studies are lacking, CBT with exposure appears highly efficacious in most patients. (See 'Cognitive-behavioral therapy with exposure: First line for most' above.)

- **Benzodiazepine as alternative initial treatment** – For individuals in which CBT with exposure is unavailable, not tolerated, refused, or in cases where the stimulus is rarely encountered and unavoidable, we suggest treatment with a short-acting benzodiazepine (eg, lorazepam) versus other medications (**Grade 2C**).

  We limit prescriptions of benzodiazepines in patients with a history of a substance use disorder and inform all patients that benzodiazepine might interfere with engagement in exposure therapy and worsen anxiety in future encounters with the feared situation. (See 'Benzodiazepines as alternative initial treatment' above.)

Topic 114843 Version 11.0

→