

Anxiety: Specific Phobias Assessment (Behavioral Health) - CE

ALERT

Osmophobia, the fear of odors, is a potential risk factor for suicidality in patients with migraine headaches.¹⁴

Fear of needles and injections can interfere with a patient's preventive care and treatment.¹²

OVERVIEW

Specific phobia is a category of anxiety disorder defined in the *DSM-5: Diagnostic and statistical manual of mental disorders* as the experience of fear or anxiety related to a specific object or situation that does not correlate to the level of danger presented by the object or situation. The exaggerated fear can lead to significant distress and impaired social or occupational functioning. The basis of the disorder is the relationship of the unreasonable fear or anxiety to a distinct object or entity called the *phobic stimulus*.¹ The American Psychiatric Association (APA) further defines specifiers related to common phobic stimuli, including animals (e.g., spiders, insects, dogs), the natural environment (e.g., heights, storms, water), blood injection injury (e.g., needles, invasive medical procedures), situational (e.g., airplanes, elevators, enclosed spaces), and other (e.g., situations that may lead to choking or vomiting, or for children, loud noises or costumed characters).¹

Specific phobias can be rooted to fears that are either innate or learned secondary to exposure. In either situation, the fear response is excessive and leads to strenuous efforts to avoid the object or situation that provokes the fear.² Along with avoidance, other characteristic responses include hyperarousal and distorted thinking related to the feared object or situation.⁴ The physical hyperarousal can be severe and involve symptoms consistent with panic (e.g., palpitations, shortness of breath, nausea, fear of dying).¹ Patients may be aware that the fear they experience is not consistent with the danger; however, that insight does not mitigate the response.⁶

Specific phobias typically have an early age of onset, beginning in childhood and, in most cases, persisting through adulthood. Fears in childhood are common. If a child experiences a transient fear that does not cause significant impairment, this would not be considered a specific phobia.¹ Females experience specific phobias more often than males, and the experience of a specific phobia is typically associated with the experience of other psychiatric disorders.¹⁵ There is also evidence that patients who experience two subtypes of specific phobias have a significantly higher likelihood of developing generalized anxiety disorder, obsessive-compulsive disorder (OCD), or both than patients who experience only one specific phobia.⁹ In addition, there is evidence that specific phobias are associated with certain medical conditions, including cardiac disease, migraine, respiratory conditions, and gastrointestinal disorders.¹⁶

The most frequently experienced specific phobia is fear of animals, with snakes (ophidiophobia or ophiophobia) and spiders (arachnophobia), being among the most common.¹⁷ Other fears that are common specific phobias include fear of heights (acrophobia), fear of flying (aerophobia), and fear of closed spaces (claustrophobia).⁶ Fear of injections or needles (trypanophobia) is another fear commonly experienced by children, adolescents, and adults. This fear can have a negative impact on general health by inhibiting participation in preventive care measures (e.g., receiving flu vaccines, follow-up

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treatments).¹² Lack of treatment of phobias, in general, can have a negative impact on mental health.⁶

Assessing for specific phobias can be done via standardized assessment tools such as the Circumscribed Fear Measure,¹¹ the Diagnostic Interview Schedule,⁶ or via tools addressing the specific phobic stimuli (e.g., Snake Questionnaire [SNAQ], Spider Questionnaire [SPQ]).¹⁷ Unstructured interviews can also be used to assess the presence of a specific phobia. The evaluation can be made based on the patient's description of the fear, the fact that the fear is out of proportion to the danger it presents, that it is persistent, typically lasting for 6 months or more, and that it is not more appropriately attributed to another condition.¹

EDUCATION

- Establish a rapport with the patient, family, and designated support person that encourages questions. Answer them as they arise.
- Consider the patient's, family's, and designated support person's values and goals in the decision-making process.
- Assist the patient, family, and designated support person with recognizing signs and symptoms of acute exacerbation of the illness.
- Explain the manifestations of the illness and expected progression of symptoms if the patient experiences a relapse. Describe what the family and designated support person are likely to see, hear, and experience (e.g., exaggerated fear of an object or situation to the extent that even the thought of an encounter with the object or situation can cause significant distress). Advise the patient, family, and designated support person of steps to take if relapse occurs.
- Explain to the patient, family, and designated support person that the main goal is to provide a safe, secure place to receive treatment.
- Explain how the behavioral health unit may be different than other settings. Interaction is promoted between patients and staff, and group meetings are encouraged. To ensure patients' safety, they are checked on frequently throughout the day.
- Educate the family and designated support person regarding the nature of psychiatric illness and expected signs and symptoms (e.g., exaggerated fear of an object or situation, leading to painstaking efforts at avoidance or the experience of debilitating symptoms of anxiety, including panic, or both).
- Assist the patient, family, and designated support person with engaging and participating as drivers of the plan of care.
- Explain the importance of following the medication regimen as ordered. The patient should not alter the dose or stop taking the medication even if symptoms have subsided and he or she is feeling better.

ASSESSMENT

1. Perform hand hygiene.
2. Introduce yourself to the patient, family, and designated support person.
3. Verify the correct patient using two identifiers.
4. Assess the patient's mental status and ability to understand information and participate in decisions. Include the patient as much as possible in all decisions.
5. Assess the patient for suicidal or homicidal ideation or thoughts of self-harm. Use an organization-approved standardized tool for suicide assessment.⁸

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6. Evaluate the patient's, family's, and designated support person's understanding of the patient's illness.
7. Assess and discuss the patient's goal for treatment.
8. Collaborate with the patient, family, and designated support person to develop a plan of care.
9. Identify the patient's psychiatric advance directives, if available.
10. Determine the patient's desire for the family or designated support person to be kept informed and involved in treatment.
11. Determine the family's or designated support person's ability to support the patient during treatment.
12. Assess the patient for the presence of specific phobias, realizing that patients with more than one specific phobia may be at higher risk for depression and OCD.⁹
13. Assess the patient's level of dysfunction related to the specific phobia, including level of avoidance, as well as emotional and physical discomfort experienced.
14. Assess the patient for comorbid psychiatric disorders.¹⁵
15. Assess the impact of the specific phobia on the patient's general health and well-being, including assessment of medical conditions that may be related to the specific phobia.¹⁶
16. Assess for a history of and current health problems that may be the result of the specific phobia; for example, influenza from avoiding injections, or advanced cancer from avoiding screening and appropriate medical tests and procedures.

STRATEGIES

1. Perform hand hygiene.
2. Verify the correct patient using two identifiers.
3. Assess the patient for suicidal or homicidal ideation or thoughts of self-harm. Use an organization-approved standardized tool for suicide assessment.⁸ If homicidal or suicidal ideation is present, implement appropriate precautions based on the patient's status.
4. Explain the strategies to the patient, family, and designated support person and ensure that they agree to treatment.
5. Maintain a calm, collaborative communication approach, avoiding the use of coercion.
6. Create an environment of trust that allows the development of a therapeutic relationship.
7. Orient the patient to the unit. Include discussion of unit routines, guidelines, patient's rights and expectations, and schedules. Inform the patient that he or she will be checked on frequently throughout the stay.
8. Create an environment that advocates for the patient's needs using an interdisciplinary team. Engage the team in collaborative assessment and treatment planning with the patient.
9. Engage the patient in treatment, including participation in therapeutic groups and individual sessions.
10. Administer psychiatric medications as ordered and monitor the patient's response to the medications.
11. Monitor the patient's responses and social interactions in the milieu; reinforce appropriate social skills.
12. Implement appropriate precautions based on the patient's status.

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13. Respond to crisis in a calm, therapeutic, and nonthreatening manner. Use the least restrictive interventions to prevent harm to patients or staff.
14. Explore the patient's concerns and fears to elicit information regarding potential phobias and their impact on the patient's daily life.

Rationale: Patients typically do not seek treatment for specific phobias and tend to address their fears through avoidance. The avoidance may involve extreme measures that can impact a person's activities of daily living.⁶

15. Assess the patient's insight into his or her fears and anxieties and assist him or her with understanding the nature of the disorder and available treatment options. Remain nonjudgmental and empathic, reducing the patient's discomfort and shame. Offer hope that the patient's phobias can be alleviated through treatment.

Rationale: At times patients experience shame related to their phobias, and they are uncomfortable discussing them.⁵

17. Collaborate with the patient, family, designated support person, and team in planning for patient discharge and follow-up care.
18. Provide the appropriate education related to medications, crisis management, and follow-up care to the patient, family, and designated support person at the time of discharge.
19. Explain to the patient, family, and designated support person that ongoing treatment is vital to continuing recovery. Making and keeping follow-up appointments is critical.
20. Perform hand hygiene.
21. Document the strategies in the patient's record.

REASSESSMENT

1. Reassess the patient's pain status and provide appropriate pain management (e.g., medication, relaxation, mindfulness skills).
2. Reassess the impact of specific phobia on the patient's daily function.

EXPECTED OUTCOMES

- The patient's ability to function is not impaired by fears in response to specific phobias.
- The patient can manage responses to specific phobias effectively and participate in the assessment process.

UNEXPECTED OUTCOMES

- The patient experiences increased fear related to specific phobias.
- The patient's ability to function is negatively impacted by specific phobias, and he or she has difficulty participating in the assessment process.

DOCUMENTATION

- Education
- Patient's behaviors and response to interventions
- Patient's progress toward goals
- Assessment of pain, treatment if necessary, and reassessment
- Patient's ability to replace avoidance and effectively manage response to specific phobias

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ADOLESCENT CONSIDERATIONS

- Approximately one half of adolescents diagnosed with autism spectrum disorder also experience an anxiety disorder, with the majority experiencing specific phobias.² In most cases, the phobias experienced are unusual, such as a fear of toilets or machines.¹⁰ The phobias can significantly impact learning and daily functioning.¹⁰

OLDER ADULT CONSIDERATIONS

- Phobias related to blood and injection injury can have a significant impact on an older adult's health.¹³

SPECIAL CONSIDERATIONS

- Pathological fear of childbirth (tokophobia) is a condition that can affect any pregnant patient but is more likely to be experienced by a patient in her first pregnancy.³ It is also more likely in women who have existing psychiatric disorders, particularly depressive disorders.³ It is of concern because it can lead to interruption of the pregnancy, sterilization, or a request for a cesarean delivery.³

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*In these skills, a “classic” reference is a widely cited, standard work of established excellence that significantly affects current practice and may also represent the foundational research for practice.

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Author: Loraine Fleming, DNP, APRN, PMHNP-BC, PMHCNS-BC

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