

Anxiety: Specific Phobias Management (Behavioral Health) – CE

ALERT

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

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.⁶ Along with avoidance, other characteristic responses include hyperarousal and distorted thinking related to the feared object or situation.² 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.⁵

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.¹⁶ 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.⁸ In addition, there is evidence that specific phobias are associated with certain medical conditions, including cardiac disease, migraine, respiratory conditions, and gastrointestinal disorders.¹⁸

Specific phobias can lead to impairment in a patient's daily function and are, in most cases, precursors of other mental health conditions; however, most patients never seek treatment for their specific phobia.¹⁶

The purpose of treatment is to desensitize the patient to the phobic stimulus. There are a variety of methods that can be used to accomplish this goal. Methods include participant modeling, relaxation, reinforcement, and vicarious learning.¹³ One of the most effective interventions is exposure therapy (ET), which can be provided in either a graduated, systematic method where exposure to the phobic stimulus is presented over a period of time or in a more intensive method, called flooding. Both are effective ways of helping the patient confront the fear, restructure the response to the stimulus, and eliminate the

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phobia.¹⁵ One-session treatment (OST), which integrates cognitive concepts, reinforcement, modeling, psychoeducation, and skills training into an extended session period has also demonstrated effectiveness in the treatment of specific phobia.³

Medications are not typically used in the treatment of specific phobias.⁵ If medications are used, they are used in combination with ET or another form of cognitive behavioral therapy (CBT).⁵

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. Consider that the patient's extreme anxiety state may negatively impact his or her ability to hear and process questions and information accurately.
5. Assess the patient for suicidal or homicidal ideation or thoughts of self-harm. Use an organization-approved standardized tool for suicide assessment.²
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.

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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.⁸
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.¹⁶
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.¹⁸

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.² 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.

Rationale: Lack of treatment of phobias in general can have a negative impact on the patient's mental health.⁵

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.
13. Respond to crisis in a calm, therapeutic, and nonthreatening manner. Use the least restrictive interventions to prevent harm to patients or staff.

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14. Explore the patient's concerns and fears to elicit information regarding potential phobias and their impact on the patient's daily life.

Rationale: Patient's 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.⁵

15. Provide support and encouragement to the patient who is being treated with ET.

Rationale: ET, whether delivered in vivo or through virtual mechanisms, increases a patient's anxiety levels.¹⁵

16. Remain nonjudgmental and empathic to reduce the patient's discomfort and potential shame.

Rationale: At times, patients experience shame related to their phobias, and they are uncomfortable discussing them.⁴

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 improved and not impaired by fears in response to specific phobias.
- The patient develops positive coping skills to manage responses to specific phobias effectively.
- The patient is able to participate in the activities in the therapeutic milieu.

UNEXPECTED OUTCOMES

- The patient experiences increased fear related to specific phobias.
- The patient's ability to function is impaired and negatively impacted by specific phobias.
- The patient is too anxious to participate in the assessment process or in any activities in the therapeutic milieu.

DOCUMENTATION

- Education
- Patient's behaviors and response to interventions

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- Patient's progress toward goals
- Assessment of pain, treatment if necessary, and reassessment
- Patient's ability to replace avoidance with more productive coping skills

ADOLESCENT CONSIDERATIONS

- Combining CBT and ET techniques with virtual reality techniques has demonstrated effectiveness in adolescents with autism spectrum disorder who may have difficulty with traditional CBT or ET interventions.⁹

OLDER ADULT CONSIDERATIONS

- Older adult patients with a disproportionate fear of falling may be experiencing a specific phobia (basophobia), which can lead to avoidance of physical activities and social interactions.¹⁷ Preliminary research has demonstrated that a program combining ET and exercise is effective in reducing fears within this population.¹⁷
- Phobias related to blood and injection injury can have a significant impact on an older adult's health.¹¹

SPECIAL CONSIDERATIONS

- Fear of injections or needles (trypanophobia) is another fear that is experienced by all age groups. This fear can have a negative impact on a patient's general health, by inhibiting participation in preventive care measures (e.g., receiving flu vaccines, or follow-up treatments).¹⁰
- Phobias can develop during pregnancy and, if left untreated, can have a negative impact on the patient and her infant.¹²

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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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