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# Ten Common Specific Phobias

A *specific phobia* involves a *fear of one particular type of object or situation*—for example, flying, a type of animal, or going to the dentist. You tend to avoid the situation altogether or else endure it with dread. The fear is of the situation itself, not of having a panic attack. If you avoid a situation primarily out of fear of having a panic attack, you are more likely to be dealing with agoraphobia (see chapter 1). Yet panic can occur if you unexpectedly find yourself confronted with a specific phobic situation you've routinely avoided.

Specific phobias affect many people. More than half of the population in the United States has some degree of performance anxiety, and fear of flying affects approximately 20 percent of the population. To be diagnosed with a specific phobia, however, not only do you have a strong fear and avoidance of a specific situation, but your phobia also interferes significantly with your occupational and/or social functioning. Using this stronger criterion, about 10 percent of the population have a diagnosable specific phobia that causes impairment at some time in their life.

There are many types of specific phobias, and phobia lists enumerate over a hundred types with exotic names. This chapter provides descriptions of ten common types of specific phobias, along with proposed causes and common approaches to their treatment. Resources such as books and audio programs relevant to a particular type of phobia are mentioned, when available. Although the list of common phobias described here is by no means complete, the cognitive behavioral principles and treatment strategies described can be applied to any type of phobia.

The phobias described include the following:

- Performance anxiety
- Fear of flying
- Claustrophobia
- Fear of disease (hypochondria)
- Dental phobia
- Blood/injection phobia
- Fear of vomiting (emetophobia)
- Fear of heights

- Animal and insect phobias
- Fear of death

Even if you are not dealing with any of the specific phobias described above, reading through the chapter will provide some insight into the variety of causes as well as the most common effective treatments for phobias of all kinds. For an in-depth description of the details and mechanics of facing phobias in general, see chapter 7.

## Performance Anxiety

The fear of performing or speaking in front of an audience is the most common phobia, affecting up to 70 percent of the population worldwide. In the context of fear of public speaking, it's sometimes referred to as *glossophobia*. It's a complex fear and can involve any one or all of the following components:

- Fear of being judged as awkward or inadequate by others
- Fear of underperforming or making a mistake, as in a musical recital or sports performance
- Fear of having your anxiety be visible to others, as in sweating, stammering, or blushing
- Fear of failure and/or rejection, as in a job interview or oral examination
- Anxiety over uncertainty as to how you will do when you have to perform

Performance anxiety often has a strong anticipatory aspect, with considerable worry in advance of the performance or speaking presentation. The anxiety usually increases as the time of the performance approaches. For many, the anxiety goes away as soon as they actually start speaking, singing, or performing. Others, however, continue to have distracting symptoms during the performance such as pounding heart, hand tremors, sweating, nausea, or dry mouth. In the worst case, the anxiety becomes severe enough to interfere with the performance and/or disrupt speech.

Performance anxiety affects all kinds of people whether they are novices or professionals. Singer Barbra Streisand, for example, spent twenty-seven years avoiding any performance before a live audience.

### *Causes*

The long-term cause of performance anxiety may be a single traumatic experience with speaking before a group or doing a musical recital as a child. Or you may simply be prone to social anxiety and shyness from early childhood. You consistently avoid speaking or performing in front of others, and, in the more extreme case, avoid being in groups in general.

Performance anxiety is a distinct problem from social phobia (see chapter 1), however, affecting large numbers of people who otherwise do not avoid or fear participating in groups.

The immediate cause of performance anxiety often lies in deep-seated core beliefs and images where you may think or picture yourself losing control or being incompetent in front of others. You may imagine that you will make dreadful mistakes, believe that your performance has to be perfect to be acceptable, or exaggerate the importance or status of the people you will speak to. These self-defeating thoughts can be very stubborn and persistent, leading to long-term avoidance of any situation where you might have the opportunity to perform or speak before others.

## *Treatment*

Cognitive-behavioral treatment of performance anxiety consists of identifying self-defeating core beliefs (and images) and gradually internalizing more constructive beliefs that:

- You really do have the ability to perform well in front of others.
- It's possible to embrace or "flow with" anxiety when it comes up rather than resist it.
- It's human and okay to make mistakes.
- Others will approve of you if you are "just yourself."
- You will likely not appear anxious to others, even if you feel anxious inside.
- People are not scrutinizing you to see if you flub the speech or performance.
- By focusing on the message you want to convey, you can deflect attention away from anxiety.
- With practice and adequate rehearsal, you can assure a good performance.

The replacement of dysfunctional beliefs is then followed by a gradual hierarchy of exposures to progressively more challenging performance opportunities. For example, in the case of public speaking, you would start by speaking to one or two friends, then speak to a larger group of friends, and finally speak before a group of strangers. Also, the number and perhaps status of the people you speak to would be gradually increased.

An important facet of treatment includes learning to refocus away from excessive concern about yourself and your appearance and instead think about how what you do might benefit, help, or entertain the people in your audience. Refocusing on how you can help or benefit people can make a big difference. The more you can think about how you are contributing to your audience, the less you focus on your own internal thoughts and feelings.

Other practical tips often mentioned in programs on public speaking include:

- Spend plenty of time rehearsing your speech or performance in advance (ideally in front of a friend) to build confidence.

- Take a walk to release nervous energy an hour or two before your performance, and make sure you don't perform on an empty stomach. (Keep your blood sugar level up.)
- Have a glass of water available next to the podium so you have something to do should your mind get distracted by anxious thoughts or body symptoms.
- If you're afraid of your audience, imagine them as babies with bonnets or in their underwear to remind yourself they are just people.
- If it's part of your philosophy, say a prayer and turn your performance over to your deity.

### *Medication*

Many performers use beta-blocker medications such as propranolol or metoprolol in advance of a performance to reduce body symptoms such as sweating, shaky hands, or pounding heart. These can be quite effective. Less common but sometimes useful are tranquilizers or sedatives the night before (to ensure sleep). While the latter can be helpful in reducing anxiety or aiding sleep, they have the downside of sometimes flattening access to your feelings and inner spontaneity. Too high a dose can also interfere with mental clarity.

### *Resources*

The books and CDs of Janet Esposito are highly recommended for dealing with performance anxiety. Her first book, *In the Spotlight*, provides an excellent general introduction, while her recent book *Getting Over State Fright* provides specific affirmations and practices to help reframe your approach and attitude toward performing in front of others.

## Fear of Flying

Fear of flying is the second most common phobia (after fear of public speaking) and affects about 20 percent of the population, who either avoid flying or do so with discomfort. It can cripple a person's life in major ways, such as avoiding desirable jobs that require flying or going on vacations to visit family and friends.

Frequently, the fear of flying overlaps with other phobias, particularly *claustrophobia*—the fear of being enclosed on a plane with no ability to exit for a set period of time. Fear of heights (*acrophobia*) may also play a role. For some, the main fear is of a plane crash, despite the realistic odds of a crash being less than one in ten million. Other fears can include a fear of encountering air turbulence, a fear of hijackers, or just a general fear of relinquishing control—putting one's life in the hands of the pilots.

Flying phobia can involve avoiding flights altogether or flying only with the aid of sedation from alcohol and/or prescription tranquilizers. Fearful fliers are often afraid they will have a full-blown panic attack while flying, and this may be based on a bad previous experience.

## *Causes*

The most frequent cause of flying phobia is a traumatic experience with flying, either related to another phobia (such as heights or feeling enclosed) or as a result of encountering air turbulence, getting sick (vomiting) while in flight, and/or having a bad panic attack. Once you start to avoid flying, the longer you avoid it, the more formidable the idea of ever flying again seems to become.

Occasionally, witnessing scenes of an air crash on TV will be enough to initiate a phobia in certain individuals. Also, having a negative experience *after* the flight, such as flying to a meeting only to be told you are fired, could be traumatic enough to instigate a strong negative association with flying.

## *Treatment*

Education and cognitive behavioral therapy are the mainstays of effective treatment for flying phobia. Education includes information on how planes fly and all of the multiple precautions that are taken to ensure safety. The fact that planes are designed to withstand several times the amount of air turbulence they would ever encounter is helpful in diminishing fears that come up around the prospect of a bumpy ride due to turbulence. Understanding that certain abrupt noises, such as putting the landing gear down, is just a routine part of the flight can help those who jump at any unexpected sound. Finally, just knowing that the statistical odds of any single commercial plane crashing are less than one in ten million (much more favorable odds than being killed or badly injured in an auto crash) helps many people.

Cognitive behavioral therapy consists of teaching people panic control strategies (see chapter 6) and then working to shift catastrophic cognitions based on the individual's specific fears. A hierarchy of progressive exposures to flying is set up, beginning with a trip to the airport and culminating with an actual flight, usually no more than one hour in duration. A typical hierarchy of exposures for fear of flying can be found in appendix 2. Sometimes therapists who specialize in flying phobia have an arrangement with an airline to allow their clients to enter and sit on a grounded plane a few days in advance of making an actual flight—an important intermediate exposure. On the day of the actual first flight, the therapist either accompanies or has a support person accompany the person.

Distraction is often helpful in facilitating a fearful flier's initial flight. The therapist or support person continuously talks to the phobic both before and during the flight to divert their attention away from fearful thoughts and body symptoms. The phobic may also take a "tool kit" on board the flight, with favorite forms of distraction such as magazines, a CD player with guided visualizations, or puzzle books.

Medication may be an additional treatment intervention in some cases. Tranquilizers such as Xanax or Ativan, or beta blockers such as propranolol or metoprolol, may be used to help both the subjective experience of anxiety as well as physical body symptoms prior to and during the flight. Many people uneasy with flying self-medicate with alcohol both before and during the flight. One problem is that alcohol has a stronger effect in a pressurized cabin

(due to lower oxygen levels) so that one or two drinks may produce high levels of intoxication for some people.

Additional guidelines for fearful flyers:

- Educate yourself about how planes operate. For example, it's helpful to know that even if an engine fails, the plane can continue to fly. The SOAR program, mentioned below, provides detailed education about flying.
- If feeling confined is an issue, be sure to choose an aisle seat (also true if height above the ground is an issue).
- Give yourself plenty of time the day you make your initial flight—don't end up rushing.
- Have a support person go with you and talk to you (distraction) the first few times you fly.
- If possible, make your initial flight no more than one hour long each way.
- Have a "tool kit" of things that will distract you while on board the plane.
- Use prescription medication only if you feel you need to have an extra safety margin against anxiety. Avoid all caffeine the day you fly.

### *Resources*

There are several special programs and websites that have a wealth of information (as well as paid programs) for flying phobia. Two of the better-known programs are the SOAR program (see fearofflying.com) and Reid Wilson's program Achieving Comfortable Flight (see anxieties.com).

## Claustrophobia

Most people know that *claustrophobia* refers to a fear of being closed in and having no escape. It can take a variety of forms, including fear of small and/or crowded rooms, fear of being stuck in traffic, fear of tunnels, fear of subways, fear of being stuck waiting in line, or fear of sitting in a chair while receiving a procedure. It can overlap with other phobias. Many people who fear flying are really afraid of the forced confinement of being on board the plane for a set period of time. Or a fear of elevators may have a strong claustrophobic component. One of the best-known forms of claustrophobia occurs in the course of being confined in the small, tunnel-like chamber of an MRI scanner. This can be a serious problem if you need such a procedure.

For a certain proportion of claustrophobics, there is a second stage of the problem. The fear of confinement, if not relieved, leads to a fear of suffocation, of not getting enough air. Either the fear of confinement, or confinement combined with the fear of suffocation, can lead to panic attacks. Panic attacks include the usual array of symptoms such as sweating, shaking,

and heart palpitations. With claustrophobia, you may also feel that the walls are closing in on you and you may experience a desperate urge to escape.

Claustrophobia can generalize to a whole range of situations. You may come to avoid crowds in general, or you may always sit near the door of any room containing other people in order to have easy access out. Traveling may be very difficult for some claustrophobics, since any form of traveling, whether by plane, train, or car, requires a sustained period of confinement.

### *Causes*

There is no clear consensus on what causes claustrophobia. The most common explanation is a traumatic experience in childhood where you were frightened while being confined in some way. However, there are plenty of people with claustrophobia who cannot recall any such experience. Some degree of resistance to confinement is common for all animals and humans, but claustrophobia appears to be a very exaggerated form of this reaction.

### *Treatment*

As with other phobias, cognitive behavioral therapy is used effectively to treat claustrophobia. In the cognitive component, the therapist would help you to identify and challenge catastrophic beliefs, such as the false idea that being confined to a crowded room or a crowded plane is potentially threatening or dangerous. You would work on strengthening the belief that there are many advantages to being able travel over avoiding travel simply because of your fear of confinement. After working on shifting your fearful beliefs, you would undergo a custom-made hierarchy of exposures progressing from simple to more difficult types of confinement situations that bother you. For example, in the case of tunnels, you would progress from short to longer ones, likely having a support person go with you at first. In the case of public transportation (buses or trains), you would progress from short trips with a support person eventually to longer trips alone.

Virtual reality has also been used effectively to treat claustrophobia. Researchers found that virtual reality—recreating a three-dimensional video experience on an MRI procedure—reduced anxiety when subjects subsequently went through the real procedure (Garcia-Palacios et al. 2007/2008).

Medications, including tranquilizers and beta blockers, are sometimes used to treat claustrophobia in instances where the situation you are afraid of occurs infrequently, such as making a flight.

## Fear of Disease (Hypochondria)

*Hypochondria* is defined as excessive worry about having a serious disease, even after medical reassurance. Often a particular symptom, such as gastric discomfort, chronic headaches, or heart palpitations, is taken to be evidence of a life-threatening disease. Having a bad head-

ache might be taken as evidence of a brain tumor, or a chronic cough as evidence for cancer. Forgetting where you put something might be taken as an indication of Alzheimer's disease.

Some people continuously seek out various doctors and have repeated exams to confirm whether they have the dreaded disease, while others avoid doctors altogether out of fear that their worst-case scenario will turn out to be true.

Hypochondria is often thought of as an OCD-spectrum disorder because it frequently involves intrusive fears followed by compulsive checking (such as feeling for lumps or continually retaking one's blood pressure). In other cases, it is more like a phobia, consisting of sensitization and avoidance around anything that reminds you of, for example, cancer. The more you tend to engage in self-monitoring, doctor-seeking, or reassurance-seeking behavior, the more the problem fits an OCD-spectrum disorder model. One difference between OCD and hypochondria is that OCD sufferers tend to fear getting a disease, while hypochondriacs fear they already have a disease.

About 3 to 5 percent of the population experience hypochondria at some point in their life. Men and women are about equally affected.

## *Causes*

Many different kinds of factors can lead to hypochondria. It may develop through unconscious identification after the death or serious illness of a close family member. Suddenly you become afraid that you could develop the same or a similar disease. Even approaching the age at which a loved one's premature death occurred may be enough to trigger worry about oneself.

Predicted pandemics, such as a worldwide flu outbreak, lead some people to become obsessed with becoming ill. Even seeing a special on TV about a particular illness may be enough to trigger serious worry about that disease.

Family studies of hypochondria find little evidence of a genetic predisposition. However, having a first-degree relative with OCD increases the likelihood that you might develop obsessive preoccupation with a particular disease.

## *Treatment*

Cognitive behavioral therapy is the first-line treatment for hypochondria. The cognitive component focuses on identifying and countering false beliefs that lead you to overestimate the threat posed by your symptoms. The risk of actually having a life-threatening disease is usually very low, much lower than your estimated risk. The behavioral part focuses on stopping the quest for continual reassurance from doctors and others. Also, you would work on stopping continuous monitoring of your body for evidence of the problem, which only reinforces your fear. Excessive research about the disease on the Internet would also be discontinued. Being frequently exposed to symptoms that evoke worry about disease—without engaging in body monitoring, reassurance seeking, or Internet research—is an approach very similar to exposure and response prevention utilized in the treatment of OCD.

Another approach used with hypochondria is imaginal exposure. Here you would write out your worst-case scenario of having the dread disease (such as cancer or AIDS) in vivid detail. Your script would be audio-recorded, and you would listen to the recording repeatedly until you desensitized to the fears and worries it evokes. While this can be an uncomfortable process at first, it ultimately reduces the frequency and intensity of intrusive worries about the disease.

Mindfulness-based therapy may be used to treat hypochondria just as it is in the case of OCD. The goal of mindfulness-based therapy (such as acceptance and commitment therapy) is to develop the ability to more willingly experience uncomfortable thoughts, feelings, and sensations without struggling with or trying to control them. This may naturally lead you to engage in less worry-based behavior such as doctor visits, body monitoring, or reassurance seeking. For more information about mindfulness-based therapy, see chapter 19.

Finally, as with OCD, SSRI (selective serotonin reuptake inhibitor) medications can be helpful in reducing anxiety (and depression) around excessive concern about having a disease.

## Dental Phobia

Dental phobia can involve fear and avoidance of dentistry in general, or a more specific fear about having a particular dental procedure. In some cases, it appears that the problem is not a phobia at all but symptoms of post-traumatic stress disorder in response to a previous, traumatic dental experience.

More than half of adults in America experience some anxiety about going to the dentist, though a much smaller number are phobic to the point of avoiding dentists altogether unless they have an acute, painful dental emergency. Obviously, this can create very serious problems for dental health, resulting in much more serious and intrusive procedures down the road when you have not had regular cleanings and routine dental maintenance over the years.

Women and young children report a higher incidence of dental phobia than men. The more invasive the procedure (for example, oral surgery), the greater the likelihood of dental phobia or at least considerable anticipatory dental anxiety.

### *Causes*

There are multiple ways you can develop a fear of going to the dentist. The most common is actually having had a painful or traumatic dental experience. A second factor is the personality of the dentist. Even in the absence of painful experiences, many people develop fears simply as the result of working with a dentist they found cold, impersonal, or uncaring.

Other causes can include hearing about someone else's bad experience or a generalization of fear from doctor phobia—that is, you can be afraid of receiving any procedure in an antiseptic clinic administered by a health professional.

Often a dental phobia can overlap with the fear of confinement (being in a chair you can't leave for a period of time) or a fear of loss of control (relinquishing complete control to

the dentist, especially in the cases where you are sedated or put to sleep for the procedure). Sometimes there is a fear of surrendering to the effects of the anesthetic.

## *Treatment*

As with other phobias, the first-line treatment for dental phobia is cognitive behavioral therapy. This would include three components.

1. Learn panic control techniques as described in chapter 6 of this book (for example, abdominal breathing and the use of specific coping statements).
2. Identify and challenge catastrophic fears about the phobic situation—the tendency both to overestimate the danger or threat of the situation and to underestimate your ability to cope, as described in chapter 8.
3. Gradual exposure to the phobic situation. A hierarchy of progressive exposures would be set up to the dentist's office, then the treatment room, and, finally, a specific procedure such as receiving an injection. In the latter case, you might first see the syringe, then handle it, then witness the dentist giving a "placebo" injection to himself, then finally receive the injection while in an induced state of relaxation. An example of a hierarchy of exposures relevant to dental phobia can be found in appendix 2.

There is one crucial variable beyond cognitive behavioral therapy that is critical for successful treatment: the personality and style of the dentist in caring for his or her patients.

Most dental phobics will attest to the fact that the most important factor in helping them to overcome their fear was the bedside or "chairside" manner of the dentist. Is she or he warm, caring, attentive, reassuring, and willing to explain things simply and clearly? Such personal qualities go a long way to mitigate anxiety. Other things that can be done to make the overall dental environment easier for phobics include dispensing with traditional antiseptic smells, having the staff wear nonclinical clothes, and playing relaxing music in the background.

Specialized clinics that claim to offer fear-free dentistry exist in many major metropolitan areas. It's helpful to ask friends if they have found a dentist with whom they feel an easy and comfortable rapport.

Medications are commonly used to manage anxiety about dental procedures. Nitrous oxide (or "laughing gas") may be used to help you relax, though some people are afraid of the mask that needs to be worn to administer the gas. Benzodiazepine tranquilizers such as Xanax or Valium may be administered orally or intravenously ahead of the procedure. While such medications help you to relax, you remain conscious and able to communicate with the dentist. In general, if you are prone to dental anxiety, ask your dentist about using a dental anesthetic that does not contain epinephrine.

General tips helpful for dental phobics:

- When trying out a new dentist, meet in advance of any procedure to get a feel for him or her personally as well as to scope out how you feel about the office setting.

- Take a supportive friend along when you go to the dentist, but don't let your friend speak for you. Instead, be sure you communicate directly to the dentist.
- For any new procedure, have the dentist explain and demonstrate the procedure in some detail before actually performing it.
- Have a pre-agreed hand signal you can use to let the dentist know when you need to take a break or in case you need more local anesthetic.
- Expect that you can find a dentist who is caring, responsive to your needs, willing to explain everything, and who provides lots of positive reinforcement. If the dentist is not someone you can trust and feel comfortable with, look for someone else.

### *Resources*

For further helpful information on dealing with dental phobias, go to dentalfearcentral.org. Also check out the many resources linked to this site.

## Blood/Injection Phobia

Fears of blood, injuries associated with blood, and injections often go together. About 70 percent of people who are phobic of blood also have a phobia of injections. On the other hand, only about 30 percent of injection/needle phobics have fears of blood and injury. A phobia of injections can have very serious health consequences, if you refuse to receive blood tests or potentially life-saving medication that needs to be taken by injection or IV. About 25 percent of people with blood/injection phobias jeopardize their health by avoiding visits to doctors altogether (Thompson 1999).

Of all anxiety disorders, blood/injection phobia has the strongest degree of family association. Up to 60 percent of people with this type of phobia have a family member with the same problem, compared to about a 5 percent association rate among family members for claustrophobia or animal phobias. The overall incidence of blood-injection phobias in the general population is about 3 percent.

Another unusual characteristic of blood/injection phobias, distinguishing them from all other phobias, is that they often involve a fainting response. When confronted with the sight of blood (your own or another's) or the prospect of receiving an injection, there is a twofold response. The first phase is a normal anxiety response with increased heart rate, increased blood pressure, and other panic-like symptoms. This is followed by a sudden drop in blood pressure, slowing down of heart rate (called *bradycardia*), and reduced blood flow to the brain, which often results in fainting. (Referred to as a "vasovagal response," it appears that the vagus nerve stimulates the parasympathetic nervous system to overcompensate for the initial sympathetic nervous system arousal associated with anxiety.) About 75 percent of people with blood/injection phobias tend to faint, allowing them to escape from the feared stimulus.

## *Causes*

Since phobias of blood, injury, and injections tend to run in families, the most likely cause is children learning and internalizing the fear from their parents and siblings.

## *Treatment*

Cognitive behavioral therapy, emphasizing gradual exposure, works well for blood/injection phobias. However, because of the fainting response, an additional technique called *"applied tension"* is included. Upon the first sensation of possibly fainting, you are instructed to tense your feet, legs, and arms quickly all at once. This raises blood pressure and blocks the fainting response. Even more important, it gives you confidence that you have a coping strategy you can use to overcome fainting. With this confidence, it's much easier to negotiate exposure.

It takes some resourcefulness to come up with effective hierarchies for these types of phobias. A possible hierarchy for blood phobia would include:

1. Read an article about bleeding.
2. Look at photos of blood.
3. Look at photos of injuries involving blood.
4. Watch videos or movies involving blood and injuries.
5. Hold a jar or test tube containing blood.
6. Visit a blood bank.
7. Witness a veterinary surgery (if this can be arranged).

For injection phobia, a possible hierarchy might include:

1. Look at photos of people receiving a shot.
2. Look at videos of people receiving a shot.
3. Visit a doctor's office and watch someone get a shot.
4. Visit a doctor's office and watch someone receive a blood draw.
5. Handle syringes.
6. Have a health professional touch a syringe needle to your skin without penetration.
7. Receive a shot in the arm.
8. Receive a blood draw.

As with other phobias, it is best to start the hierarchy at whatever step causes mild anxiety, and repeat any difficult steps several times until the anxiety subsides. A support person going with you to a medical setting can be quite helpful. Medication (a tranquilizer)

can be used to help negotiate a particularly difficult step, but it's generally not recommended if you are prone to fainting. In order to gain confidence that you won't faint, applied tension should be used the moment you feel light-headed. As described above, this includes suddenly tensing your feet, legs, and arms together at once. In some cases where fainting is a difficult problem, the exposures may be done first lying down, then sitting up, and finally standing.

In medical and particularly dental settings, a variety of anesthetics may be used to reduce the fear of being injected. These usually include some kind of numbing gel applied to the gum followed by a very gradual injection of anesthetic. Often you aren't even aware of the needle at all. Most competent dentists are proficient in administering painless injections.

## Fear of Vomiting (Emetophobia)

Fear of vomiting, sometimes called *emetophobia*, is surprisingly prevalent. It can take various forms, including the fear of vomiting itself, a fear of doing so in public, a fear of seeing vomit, or a fear of seeing someone else throw up.

Emetophobia can develop in childhood or adulthood and last for many years without treatment. Sometimes it accompanies other fears, such as the fear of eating, or other disorders, such as eating disorders (anorexia and/or bulimia) or obsessive-compulsive disorder.

Most people with emetophobia rarely actually vomit and may not have done so since childhood. Yet when the fear is severe, your life can be restricted in many ways. You may avoid long car trips or only go places where you know a restroom is easily available. Or you may be afraid to be around babies or sick people who you believe have an increased risk of throwing up. Frequently, you are hypervigilant around any gastrointestinal symptoms. In this phobia, nausea is the worst thing that can happen to you. You are afraid to vomit, which aggravates the nausea, which in turn increases the urge to vomit, and around the cycle goes until you may panic.

### *Causes*

A general fear of losing control can often be found in the background of people who are fearful of vomiting. For some, the phobia begins with a particularly bad instance of vomiting in childhood, or seeing vomiting in a loved one who is very ill. The more traumatic the initial experience was, the more likely a phobia may develop. In other cases, no traumatic past incident can be found, and the fear seems to center more around losing control of oneself.

### *Treatment*

If you are emetophobic, the first thing to find out is what it is you are truly afraid of. Is it vomiting itself, or is it a fear of rejection if others were to see you vomit? Or does it have to do more generally with losing control of your body? It's important to identify and work through the core fear or fears.

Next, it's important to make a list of all the situations you avoid because of your fear. For example, you might avoid long car trips, taking a boat cruise, eating certain foods that you think could make you sick, being around babies and young children, and going on amusement park rides. List all of the situations you avoid in order of difficulty and then gradually take the risk to face and enter each one of them. Working up such a hierarchy will help you to reclaim your life as well as reduce the fear of vomiting itself.

Finally, gradual exposure to the vomiting itself will help desensitize you to your fear. One way to do exposure is to write down a series of vomiting scenarios, starting off easy and progressing up to the worst-case vomiting scenario you can imagine (for example, you describe in graphic detail vomiting all over yourself and others while being in the presence of work associates who disapprove). Read through your written vomiting scenarios repeatedly, or, better yet, have someone read them to you over and over several times, until the scenes lose their ability to evoke much anxiety.

Another way to do exposure (not exclusive of the first) is to look at a series of vomiting scenes, progressing from color photos of vomiting to videos and movies that have graphic vomit scenes. Ultimately, you should progress to a live vomiting situation—for example, a nursery where babies are having lunch and spit up on themselves. If you are bold, you can progress to self-induced vomiting, though emetophobic experts are mixed on whether this is helpful.

By doing one or both types of exposure, you will begin to desensitize yourself to vomiting and shift your core belief around vomiting being something horrific to it merely being a normal bodily function.

Medications are generally not used for emetophobia (except sometimes in helping you to enter a previously avoided situation). Most emetophobics tend to avoid antianxiety medications for fear they will cause vomiting. Natural remedies for nausea, such as ginger tea or 7Up, may be helpful in reducing long-lasting symptoms of nausea that exacerbate anxiety.

### *Resources*

Good information on emetophobia can be found at these websites: emetophobia-clinic.com and emetophobiaeraser.com.

## Fear of Heights

The fear of heights, or *acrophobia*, is another very common phobia. Frequently, it combines with other phobias, such as the fear of flying, fear of riding elevators, or fear of driving over a high bridge. The most frequent form of the fear is being high up in a building.

Sometimes the fear of heights is confused with vertigo. *Vertigo* is a sensation of spinning usually caused by a medical condition, and it rarely occurs with acrophobia. A more common reaction to heights is dizziness and difficulty trusting your own sense of balance. Frequently, you may grab on to something to steady yourself, and if that doesn't help, you may panic.

People with acrophobia should avoid construction work at heights or climbing tall ladders. Unfortunately, this is one phobia where panic might, in some circumstances, lead to a dangerous fall.

Acrophobia can result in severe restrictions on your life if it causes you, for example, to avoid taking a job offer that would involve being high up in a building or visiting someone in the hospital on a high floor.

## *Causes*

A certain amount of acrophobia is instinctive in all animals. It has an evolutionary advantage in preventing falls. However, a true phobia of heights is typically learned and is an exaggeration of the normal, adaptive fear response to heights. It may develop as the result of an actual fall or the memory of an incident where you were very afraid of falling as a child. People prone to having problems with balance may be more susceptible to developing a fear of heights, but the research on this is inconclusive.

## *Treatment*

Cognitive behavioral therapy is effective in overcoming the fear of heights. The acrophobic is first taught panic-control strategies (see chapter 6) and then undergoes a gradual, progressive exposure to a hierarchy of situations that involve increasing heights. This can be done by going up successive floors in a building and looking out of a window or even walking onto balconies. As with other phobias, having a support person accompany you when you first attempt exposure can be very helpful. Here is an example of a hierarchy of exposures for the fear of heights:

1. Go to the second story of a building and look out a window for ten to sixty seconds. Have a support person go with you if you wish.
2. Look out of a second-story window for two to five minutes. Look straight out and then down. Have a support person go with you, if you wish.
3. Repeat steps 1 and 2 alone, or with phone access to a support person and then alone.
4. Go to the third floor of a building and look out of a window for ten to sixty seconds. Take someone with you, if you wish.
5. Repeat step 4 for two to five minutes. Look straight ahead and then down.
6. Repeat steps 4 and 5 with phone access to your support person, then alone.
7. Continue the process in steps 1 through 6 for progressively higher floors in a taller building. Beyond the fourth floor, take an elevator to higher floors.
8. Continue advancing to higher floors in small increments until you reach your desired goal (ideally, the highest floor of the tallest building in the area where you live).

9. If possible, go out on a balcony or observation deck at your goal height (you may want to try balconies on lower floors first) with your support person, then alone.
10. Repeat step 9 for longer durations and walking closer to the guardrail.

Virtual exposure has also been used effectively with the fear of heights. This involves recreating a hierarchy of height scenarios in virtual reality using special equipment. Clinics that can afford the equipment prefer this option because it allows therapists to treat more people in a more efficient and timely manner.

## Animal and Insect Phobias

Phobias of specific types of animals or insects abound. The fear can be of snakes, bats, mice or rats, dogs, cats, certain birds, frogs, spiders, bees or cockroaches, to name some of the most common examples. People with this type of phobia avoid not only a particular animal/insect but areas where they believe they might be exposed to the feared creature. Evidence of the presence of the feared animal/insect, such as seeing a spiderweb, hearing a dog bark, or being near a zoo is enough to evoke strong fear. Sometimes merely seeing a picture of the animal will lead to a panic attack.

In childhood, many of these fears are so common that they are considered normal fears. Only when they significantly disrupt your life and/or cause you significant distress—as a child or an adult—do they qualify as a full-blown phobia. In general, animal and insect phobias tend to be more common in women than men, especially in regard to snakes, mice, spiders, and cockroaches.

### *Causes*

It has been proposed that certain animal phobias, such as fear of snakes or large animals, are innate in all mammals because they confer an evolutionary advantage in promoting survival. In many cases, though, the cause of the phobia appears to be a previous traumatic experience, such as being bitten by a dog, scratched by a cat, or stung by a wasp. It's also possible for children to acquire fears of animals from their parents. Simply observing a parent express fear at the sight of a mouse or a spider may instill the same fear in the child. There have also been instances where simply watching a horror film that featured a particular animal was sufficient to cause a phobia.

### *Treatment*

Overcoming animal and insect phobias is straightforward and involves gradual exposure to the feared creature. As with exposure to any other phobia, it's necessary to set up a hierarchy of incremental experiences of the animal, progressing from photos and videos to eventual live contact. A generic hierarchy applicable to any animal/insect phobia might run something like this:

1. Draw a picture of the animal.
2. Look at black and white photos.
3. View color photos.
4. Watch a video of the animal.
5. Handle a toy version of the animal.
6. Look at the animal from a distance (this could involve a trip to a pet store or zoo).
7. Move progressively closer to the live animal.
8. Watch someone touch or hold the animal.
9. Touch or hold the animal in a cage and, ultimately, directly.

**Note:** The last two steps may require a visit to a pet store, nature center, or zoo. In cases where it's not possible to touch the animal (bears, for example), sustained close observation at a zoo would be the highest step in the hierarchy.

As with all exposure hierarchies, working through the various steps requires commitment, perseverance, and a willingness to tolerate varying degrees of anxiety. If anxiety becomes extreme, it can be useful to have a support person accompany you through the most difficult steps. Sometimes medication, such as a beta blocker or a benzodiazepine, may be helpful to facilitate getting through a particularly challenging step, but the medication eventually needs to be relinquished. In beginning the hierarchy, it's best to start with whatever step evokes mild anxiety, skipping any early steps that do not elicit anxiety at all. Repeat a step more than once if you need to until anxiety diminishes to a low level.

In working through the hierarchy, it's also important to think about what it is about the animal or insect that you find particularly frightening. In the case of a dog, for example, is it the barking, the appearance, the size, the way they move, or mainly the idea of being attacked? Once you pinpoint what specific characteristics of the creature bother you the most, then it's important to focus on those characteristics as you progress through the exposure. Once you've desensitized to the most bothersome characteristics, you are more likely to remain free of the phobia indefinitely.

## Fear of Death

The fear of death, sometimes referred to as *thanatophobia*, can involve any one or several of a variety of distinct fears. Here are some of the most common types of fear:

- Fear of nonexistence, a permanent end to life
- Fear of the unknown—not knowing what will happen after death
- Fear of negative afterlife based on religious beliefs, such as the idea of hell or purgatory
- Fear of sickness, pain, and suffering associated with death

- Fear of the death of a loved one to whom you are closely attached
- Fear of what will happen to loved ones in your family after your death
- Fear of dead things, such as a corpse or something associated with death, such as coffins, funeral homes, and cemeteries (this type of fear is referred to as *necrophobia*)

Sometimes the basic fear is simply one of losing control. Dying is out of your control, and you may attempt to hold death at bay through frequent visits to doctors and ritualistic health practices (an instance where the fear of death overlaps with hypochondria).

## *Causes*

Causes of the fear of death vary depending on which of the above fears is dominant. Existentialist philosophy maintains that the fear of nonexistence is innate to the human condition and shared by all human beings at a deep level. Some have even gone so far as to claim that the fear of death (in the sense of permanent nonexistence) is the "core" or underlying fear behind all fears. There is certainly at least some truth to the existentialist point of view. All of us, at one point or another, have had anxiety about our eventual demise.

Other fears of death center around religious beliefs about punishment and hell in the afterlife. Counselors who deem these beliefs to be fictitious need to be sensitive in working with clients who take them quite seriously.

The fear of pain and suffering associated with death may arise from a traumatic experience of witnessing a loved one go through a protracted process of dying. Often the death of a loved one may lead to an increased fear of one's own death as well as fear of sights and objects associated with death.

## *Treatment*

Treatment of thanatophobia, of course, depends on the specific nature of your particular fear. Working with the fear of nonexistence may require some deep philosophical reflection on the meaning of life and the recognition that probably the best way to deal with death is to live life as well as you can. It's also important to realize that none of us is unique in this regard; everyone has to deal with death.

Some people respond favorably to reading literature that provides evidence for the survival of consciousness following death. An extensive literature on near-death experiences, and numerous individual accounts of what people "saw" during such experiences, provides compelling evidence for many that death is not a permanent end to existence.

Among books that describe visions of the "other side" by people who have had near-death experiences, the following are a good place to start: *Life After Life* by Raymond Moody and *Evidence of the Afterlife* by Jeffrey Long and Paul J. Perry.

Fear of the death of a loved one can be difficult, but may be seen as a "spiritual call" to develop inner strength and the capacity to stand on your own even in the absence of someone dear. Some people are heartened by the belief that, after their death, they will be reunited

with loved ones who "went before," a possibility that is clearly indicated by the literature on near-death experiences.

Finally, if your fear of death started with a traumatic experience of witnessing a friend or family member's death, it may be helpful to try hypnotherapy or eye-movement desensitization and reprocessing to work through and reconfigure traumatic memories.

## Summary of Things to Do

1. Read about any specific phobia in this chapter that affects you. You may wish to work with a therapist or a supportive friend in actually undertaking a detailed exposure plan to overcome your fear. A Google search of any of the phobias described in this chapter will yield websites that offer further information, advice, and various treatment options.
2. Even if you don't struggle with any of the phobias described in this chapter, reading the treatment sections for all of the various phobia types may give you some new insights on how to work through whatever phobia(s) you do have. Also see chapter 7 for further information on the details of facing a phobia.

## Further Reading

Bourne, Edmund J. *Overcoming Specific Phobia: Therapist and Client Protocols* (two-book set). Oakland, CA: New Harbinger Publications, 1998.

Brown, Duane. *Flying Without Fear*. Second edition. Oakland, CA: New Harbinger Publications, 2009.

Maisel, Eric. *Performance Anxiety*. New York: Back Stage Books, 2005.