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Etiology of childhood phobias: current status of Rachman's three pathways theory

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Abstract

Despite advances in the assessment and treatment of childhood phobias, little is known about their etiology. Rachman has proposed that phobias are acquired through three different pathways: direct conditioning, modeling or instructions/information. We evaluate the empirical support for Rachman's theory in relation to the origins of childhood phobias. Although we find support for Rachman's theory, a number of methodological and theoretical issues are emphasized. For example, insufficient attention has been given to the reliability and validity of retrospective subject reports on the acquisition of childhood phobias. Also some findings on the origins of childhood fears and phobias are more consistent with a nonassociative account of phobia onset, thus providing an interesting challenge to Rachman's theory. © 1998 Elsevier Science Ltd. All rights reserved.

Children experience many fears over the course of development. Numerous studies have documented the quantitative and qualitative changes that occur in the normal developmental fear pattern (reviews by King et al., 1988; Morris and Kratochwill, 1983). These fears are usually short-lived and not of sufficient magnitude to be problematic. On the other hand, some children exhibit fear reactions that are maladaptive, persist for a considerable period of time and cause much distress. Fears of this nature are referred to as 'clinical fears' or 'specific phobias'. Common examples of these phobias include excessive fears of animals, water, heights, thunderstorms, darkness, and medical and dental procedures. Following the tripartite model originally developed by Lang (1968, 1977), childhood fears and phobias can be conceptualized in terms of three response systems: cognitive, physiological and overtbehavioral. King et al. (1988) have documented the variety of cognitive responses (e.g.

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thoughts of being scared, self-deprecatory thoughts), physiological responses (e.g. increased heart rate and changes in respiration), and overt-behavioral responses (e.g. rigid posture, thumbsucking and avoidance) that may occur in the fearful or phobic child.

In recognition of their seriousness and stability, phobias are included in the two most widely accepted diagnostic classification systems (American Psychiatric Association, 1994; World Health Organization, 1992). For example, the fourth edition of the Diagnostic and statistical manual of mental disorders (DSM-IV) specifies the following criteria for 'specific' phobia: (a) marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation; (b) exposure to the phobic stimulus almost invariably provokes an immediate anxiety response or panic attack; (c) the person recognizes that the fear is excessive or unreasonable; (d) the phobic situation(s) is avoided or else endured with intense anxiety; (e) the phobia causes significant interference to functioning or there is marked distress about having the phobia; (f) in individuals under 18 yr, the duration is at least 6 months; and (g) the anxiety or phobic avoidance are not better accounted for by another disorder such as obsessive-compulsive disorder and separation anxiety disorder. In relation to developmental factors, the DSM-IV acknowledges that children may not recognize their fears as excessive or unreasonable. Thus, phobias in young children may be expressed in 'childhood' ways such as crying, tantrums, freezing or clinging. A similar definition of specific phobia (referred to as 'isolated' phobia) is given in the ICD-10.

In the past 10 years, a number of well controlled epidemiological studies have been conducted on the prevalence of phobic disorders (as well as other anxiety disorders) in community samples of children and adolescents (e.g. Anderson et al., 1987; Bird et al., 1988; Costello et al., 1993; Kashani et al., 1987; McGee et al., 1990). Estimates of specific phobia range in prevalence from 2.4 to 9.1%, and average about 5% across studies. In their excellent review of epidemiological studies, Costello and Angold (1995, p. 115) conclude that "OAD/ GAD (overanxious disorder/generalized anxiety disorder), separation anxiety, and simple (i.e. specific) phobia are nearly always the most commonly diagnosed anxiety disorders, occurring in around 5% of children, while social phobia, agoraphobia, panic disorders, avoidant disorder and obsessive-compulsive disorder are rare, with prevalence rates generally below 2%". Thus, on a comparative basis, specific phobias occur with considerable frequency; moreover, they are more prevalent among girls than boys (Anderson et al., 1987; Graziano and De Giovanni, 1979). Epidemiological findings also suggest a modest level of continuity for anxiety disorders in general, as well as specific phobias in particular across intervals varying from 2 to 5 yr. In short, childhood phobias appear to be relatively stable (see Costello and Angold, 1995; Ollendick and King, 1994; Nottelmann and Jensen, 1995, for reviews).

Fortunately, childhood phobias can be successively treated via exposure-based interventions such as *in vivo* desensitization, participant modeling and contingency management procedures (see reviews by King & Ollendick, 1997; Ollendick & King, 1997). Successful intervention hinges on a careful diagnostic and behavioral assessment of the phobic child (see King et al., 1997). Despite the significant advances that have occurred in the assessment and treatment of childhood phobias, their etiology and maintenance remains a perplexing issue for therapists and researchers. Children's phobias are believed to have a complex etiology involving genetic, constitutional and environmental factors (King et al., 1988; Ollendick, Hagopian and King, 1997). Environmental-based explanations of childhood phobias are of particular interest for

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