

Children's Fears: Developmental or Disorder?



What Educators Should Know

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What is Normal Fear?

Also referred to as normative fear, fear is a natural part of child development. As uncomfortable as it can be to experience feelings of fear, it is an essential developmental process that prepares children to navigate difficult situations. Fear can create a positive, motivational experience, resulting in a sense of confidence and empowerment. In fact, experiencing fear may even influence children to behave in safer ways. For example, a child who is afraid of heights may avoid climbing on objects that he or she may fall off of (2010, Matthews).

According to Robinson & Rotter (1991), the notion of *power* is a significant factor in determining how well a child can cope with fear-inducing objects and situations. Essentially, a child's feelings of power, or lack thereof, are associated with the ways in which a child may respond to fear. Furthermore, the idea of *power* includes three concepts: security, self-worth, and control. Therefore, children who feel secure, valued, and have a certain level of control over their lives tend to handle fears more effectively (Robinson & Rotter, 1991).

From this, it is of the utmost importance for parents and educators to focus on assisting children in developing healthy coping skills by instilling feelings confidence and value. Moreover, in learning to manage fearful situations, children must be given a level of autonomy and independence. That is, children need to be given the freedom to experiment with various coping strategies (2010, Matthews).

Normal & Common Fears

The ten most common childhood fears, as per the administration of the Fear Survey Schedule for Children-Revised (Muris, Merckelback, & Collaris, 1997):

1. Not being able to breathe
2. Getting a serious illness
3. Bombing attacks
4. Getting hit by a car
5. Fire/getting burned
6. Burglar breaking in
7. Getting lost
8. Falling from a high place
9. Death/dead people
10. Spiders

Interestingly, common childhood fears can change. Fears are a function of the diagnostic tool used for assessment. The ten most common fears upon asking the *free option question*, *What do you fear most?* (Muris et al., 1997).

1. Spiders
2. Being kidnapped
3. Predators
4. The dark
5. Frightening movies
6. Snakes
7. Being hit by a car
8. Falling from a high place
9. Parents dying
10. Burglar breaking in

Further Resources

Worrywisekids.org

- http://www.worrywisekids.org/anxiety/specific_phobias.html

Anxiety Disorders Association of America

- <http://www.adaa.org/living-with-anxiety/children>

Healthychildren.org

- <http://www.healthychildren.org/English/health-issues/conditions/emotional-problems/Pages/Understanding-Childhood-Fears-and-Anxieties.aspx>
- <http://www.healthychildren.org/English/health-issues/conditions/emotional-problems/Pages/Phobias.aspx>

Strategies That Help

To be successful in assisting children dealing with the development process of fears, educators, clinicians, and parents must become educated in the developmental aspects of children's fears. It is vital to know what fears are age and stage-appropriate (2010, Matthews).

Activities in the home and school must focus on the development of the concepts of *power, control, security, and self-worth*, which are the necessary constructs for healthy fear coping skills (Robinson & Rotter, 1991).

Robinson & Rotter (1991) suggest that educators should integrate classroom activities that explore age-appropriate, developmental fears through the use of stories, civics lessons, and special projects that utilize the subjects of art, history, geography, math, science, reading, and spelling.

Educators and parents must remember the following:

- Never use a child's fear as a form of discipline.
- Never make fun of a child's fears.
- Always listen and try to be as supportive and sympathetic as possible.
- Help the child explore strategies to overcome their fears.
- Encourage the child to talk about their feelings.

Ages and Stages of Fear

Fears change across ages and stages of development.

Typically, fears vary in frequency, intensity, and duration, yet tend to be mild, age-specific, and transitory (Ollendick, King, & Muris, 2002).

Age	Fear
0-6 months	Loss of support, loud noises, sudden movement
7-12 months	Strangers, sudden appearance of large objects, loud noises
1 year	Separation from parent, strangers, injury, toilet
2 years	Large animals, dark rooms, large objects and machines, loud noises, sudden changes in
3 years	Dark rooms, masks, large animals, snakes, separation from parent
4 years	Dark rooms, noises at night, large animals, snakes, separation from parent
5 years	Wild animals, bodily injury, dark, bad people, separation from parent

Source: Robinson III, E., & Rotter, J. (1991). Children's fears: Toward a preventative model. *School Counselor*, 38(3), 187.

Ages and Stages of Fear Continued

Age	Fear
6 years	Ghosts, monsters, witches, dark, being alone, thunder and lightening
7 years	Dark, monsters, storms, being lost, kidnapping, being alone
8 years	Dark, people (kidnapper, robber, mugger), guns or weapons, being alone, animals
9 years	Dark, being lost, bad dreams, bodily harm or accident, being alone
10 years	Dark, people, bad dreams, punishment, strangers
11 years	Dark, being alone, bad dream, being hurt by someone, being sick, tests, grades
12 years	Dark, punishment (being in trouble, bad grades), being alone, being hurt or taken away, tests, grades
13 years	Crime, being hurt or kidnapped, being alone, war and nuclear war, bad grades, tests, punishment
14+ years	Failure at school, personal relations, war, tests, sex issues (pregnancy, AIDS), being alone, family concerns

Source: Robinson III, E., & Rotter, J. (1991). Children's fears: Toward a preventative model. *School Counselor*, 38(3), 187.

Treatment

The most successful treatment protocols for phobias involve exposing the child to feared objects and situations. This is a key component in breaking the association between the feared object and the experience of feeling afraid (Matthews, 2010).

According to King et al. (2005), "...exposure is a necessary ingredient of intervention programs for children" (p. 51). Furthermore, the authors stress the need for *intensive parental involvement* in the treatment of phobic children (King et al., 2005).

Three Categories of Treatment:

1. Behavioral Procedures:
 - Systematic desensitization
 - Modeling
 - Contingency Management
2. Cognitive Behavioral Interventions
3. Behavioral Family Interventions

Common Symptom Manifestations

King, Muris, and Ollendick (2004) state, “Childhood fears and phobias can be conceptualized in terms of three response systems: cognitive, physiological, and overt/behavioral” (p. 264). That is, children exhibit a myriad of symptoms when experiencing feared objects and situations. Typically, children show that they are afraid or anxious through the following responses:

1. Cognitive: Common responses include statements regarding feelings of fear (*I feel scared*), negative self-statements (*I can't go school*), and anticipating encounters with the feared object that will bring about harm to one's self (*The bird will scratch me*).
2. Physiological: Increased heart rate, sweating, dry mouth, nausea, trembling, shaking, headaches, stomachaches, and changes in respiration.
3. Overt/behavioral: Avoidance or escape of the feared object or situation. When avoidance is not possible, children may exhibit tantrums, freeze or hold a rigid body posture, thumb suck, cry, and cling to parents. Sleep disturbances such as inability to fall asleep and excessive sleep can occur.

Gender Differences

Boys and girls tend to be afraid of different objects and situations, and they rank their fears differently (Muris et al., 1997). Additionally, girls tend to exhibit higher levels of fear and anxiety in comparison to boys (Muris, 2007).

Boys Fears - Free Option	Girls Fears - Free Option
1. Spiders	1. Spiders
2. Predators	2. Being kidnapped
3. Being hit by a car	3. Parents dying
4. Snakes	4. The dark
5. Burglar	5. Frightening movies
6. Frightening movies	6. Thunderstorms
7. The dark	7. Being teased
8. Being teased	8. Bats
9. Frightening dreams	9. Bats/Ghosts/Spooky things
10. Medical operations	10. Sleeping in the dark/ Making mistakes

Source: Muris, P., Merckelbach, H., & Collaris, R. (1997). Common childhood fears and their origins. *Behavior Research and Therapy*, 35(10), 929-937.

Abnormal Fear - Phobias

For some children, the process of developmental fears goes away thereby causing the development of ineffective fear coping strategies (Robinson & Rotter, 1991). For such children, encounters with feared objects and situations become severely debilitating and interfere with normal daily functioning (Robinson & Rotter, 1991). Such children may or may not understand that their fear is excessive or unreasonable.

The research of Marx (as cited by Ollendick et al., 2002), defined a phobia as:

1. Out of proportion to the demands of the situation
2. Cannot be explained or reasoned away
3. Beyond voluntary control
4. Leads to avoidance of the feared situation

However, the work of Miller, Barrett and Hampe (as cited by Ollendick et al., 2002) expanded upon that and specified childhood phobia as:

5. Persists over an extended period of time
6. Unadaptive
7. Not age or stage-specific

What causes Phobias?

The etiology of childhood phobias is not fully understood.

It was originally thought that all childhood fears were acquired through Rachman's pathways of fear acquisition:

1. Direct conditioning
2. Vicarious conditioning
3. Information/instruction (Ollendick, et al., 2002).

Current research has discovered that there are many possible pathways for the development of fears and specific phobias, due to the inconsistencies that exist when a phobia develops in the absence of Rachman's pathways (Ollendick et al, 2002).

According to Ollendick et al. (2002), "...causes may be multiply-determined, if not over-determined" (p. 101).

Additional developmental pathways:

1. Heredity
2. Biology
3. Child temperament
4. Environment
5. Parental influences on a child

Prevalence & Comorbidity of Phobias

Clinical diagnoses of specific phobia have a prevalence rate of approximately 5% of children and adolescents in community settings compared to a rate of about 15% of children and adolescents in clinical settings (Ollendick et al., 2002).

Anxiety disorders and childhood phobias appear to have a high rate of comorbidity. Muris (2007) states, "... generalized anxiety disorder, separation anxiety disorder, specific phobia, and to a somewhat lesser extent, social phobia frequently co-occur" (p. 25). In addition, depression has the highest comorbidity and, to lesser extents, oppositional defiant disorder, conduct disorder, attention deficit hyperactivity disorder, and substance abuse frequently coexist with phobias and other anxiety disorders (Muris, 2007).

From this, children's fears can be significantly more severe than they appear to be on the surface. Although childhood fears are a normal developmental process, this process can very easily change from normal to disordered (2010, Matthews).

DSM-IV-TR Criteria—Specific Phobia

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) lists the following criteria for specific phobia:

- 1) Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation
- 2) Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally-bound or situationally-predisposed panic attack
- 3) The person recognizes that the fear is excessive or unreasonable
- 4) The phobic situation is avoided, or else endured with intense anxiety or distress
- 5) The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupation or academic functioning, or social activities or relationships, or there is marked distress about having the phobia
- 6) in individuals under 18 years, the duration is at least 6 months.

Source: American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorder, four edition, text revision*. Washington, DC: American Psychiatric Association

Case Study

Normal Fear

Ben, age 6, gets into bed with his favorite stuffed animals, Teddy and Mr. Elephant, and gets ready to listen to a bedtime story. As his mom finishes the last lines of his favorite book, he asks his mom to check in his closet and under his bed for monsters. His mother gladly indulges his requests and replies, “All clear, Ben! No monsters in here!” She then reminds Ben that his nightlight will be on and that she and Daddy are just down the hall. She also says, “Ben, if you feel afraid of the dark, squeeze Teddy and Mr. Elephant extra tight.” With that, Ben rolls over and softly reminds Teddy and Mr. Elephant that there is nothing to be afraid of while slowly falling asleep.

Abnormal Fear

Jake, age 10, lays in bed listening to his father reading him a story before bed. As his father reads, Jake keeps interrupting and inquiring if he has to sleep with all the lights off. His father replies, “Jake, the nightlight will be on. It’s okay. There is nothing to be afraid of.” Jake tightly clutches a beloved stuffed animal while his entire body begins to tense. After his father kisses him goodnight, Jake lays in bed trying to tell himself that there is nothing to be afraid of. As the minutes tick by, he feels increasingly anxious. His palms begin to sweat, and his stomach starts to hurt. Finally, he leaps out of bed and turns on all the lights. Jake eventually falls asleep, but frequently wakes up in the middle of the night paranoid of the dark and runs to his parents room. This cycle occurs nightly, disrupting the sleep of the entire family (2010, Matthews).

Assessment

“Best-practice assessment of phobic children should be multi-informant (child, parent, and teacher) and multi-method (i.e. relying on more than one data gathering procedure). Further, the assessment tools used should be psychometrically sound and also be age-appropriate, taking into account the child’s level of functioning and cognitive verbal skills” (King, Muris, & Ollendick, 2005, p. 50).

King et al. (2005) recommend the following diagnostic tools:

1. Child Version of the Anxiety Disorders Interview Schedule for DSM-IV
2. Fear Survey Schedule for Children –Revised
3. Spider Phobia Questionnaire for Children
4. Multidimensional Anxiety Scale for Children
5. Screen for Child Anxiety Related Emotional Disorders
6. Spence Children’s Anxiety Scale

Ultimately, a comprehensive, yet caring, sensitive approach involving parents, teachers, and the child should be taken when assessing children’s fears. While it is important to utilize research-based diagnostic tools, it is even more paramount to talk to the child to obtain a more personalized, detailed view of their individual fears (2010, Matthews).