PHOBIAS

Charles A. Sarnoff MD

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Table of Contents

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There are few childhood psychological aberrations that appear as suddenly and dramatically as phobia. As often as not, a quiet evening is shattered by frightened screams from the child's bedroom, or a pleasant outing or vacation idyll gives way to the chaos of a child cringing at the sight of seaweed or at the sound of distant rolling thunder. There is a sudden dissociation of the child's sense of reality from the reality testing of the observer. Because of this, phobia is easily recognized as mental illness. Even the most antipsychological or psychologically unsophisticated parent recognizes that here is a situation beyond his prior experience. There are immediate signs of the child's distress, and there is behavior beyond the control of the family. Discomfort to both the child and the family, and the strangeness of the symptoms, are often enough to bring the parents to a child psychiatrist in search of help.

The parents will see the phobia as the primary problem, and relief of it the only goal. When this relief is obtained and the acute phase has passed, parents without knowledge of such matters may see no need for further treatment. The phobia is regarded in retrospect as though it were a recent cold. Once gone, it is considered cured. The neurotic underpinnings, which form the nest from which such symptoms may again be spawned, are left for the therapist to warn about and to ponder.

> A 10-year-old boy could not get to sleep because of intense fears of a monster who, he feared, inhabited the night. He would enter his parents' bedroom and keep them awake with tales of his feared imaginings. In play therapy the boy drew a picture of the monster. The picture was cut out, mounted on a backing of cardboard, and used by the child to ambush families in cars on their way to holiday fun. Within ten sessions, this play theme was linked to a real family situation. The boy's father was known to call home on a Saturday to tell his son to wait for him there, rather than go out to play with his friends. The father had repeatedly disappointed the child, keeping him waiting for as long as five hours without a call to tell him that important business had come up. This was anger-provoking for the child. I encouraged the father to keep the appointments he made with his son. I told him not to set up interferences with his son's play dates with friends unless he, the father, was actually with the child. This relieved some of the pressure to be angry, which had been projected onto the fun-killing monster of the child's imagination. Swiftly the symptoms cleared as the child shifted his arena for the expression of his now-attenuated fears from home to play therapy. Within eight weeks of the start of therapy, the father left a message during the session before his son's therapy session to inform me that the child had improved, and that the session scheduled for that very day would be the last.

Unfortunately, relief of symptoms is not cure. The experienced clinician knows that the capacity to produce phobic symptoms during latency will, in other times and climes, bring forth other painful

symptoms. In keeping with the age and level of maturity of the patient, old wine will find its way to new bottles.

In the case above, the child's aggression took the form of feared fantasy figures. His father's behavior was shielded from the child's anger and direct criticism by a family-social context that permitted anger only if it dared be spoken in phrases derived from the cryptic language of symbols. The path to symbols and symptoms was traversed because of this external inhibition and because of the existence of preexisting neurotic and disordered cognitive underpinnings. These supported access to the use of fantasy derivatives so strong that there could be maintained an avoidance of confrontation with reality. These fantasy derivatives were the child's only means of processing and mastering the stress of his father's behavior. When fantasy derivatives are manifested in symbols that persecute, and are responded to with avoidance, the clinical condition is called a phobia. It is to a study of such conditions that this chapter is devoted.

Definitions

In common parlance, *phobia* refers to a fear of a specific object or situation. This fear is sufficiently great to cause the subject of the fear to try strenuously to avoid contact with the feared object or situation. Such avoidances as that which results from fear of horseback riding after a fall from a horse could be fit into this definition.

The specific medico-scientific term *phobia* implies the existence of a more complex condition than such a phobic avoidance reaction. In psychoanalytically informed terminology, *phobia* implies the existence of a fear whose object is unknown to the subject of the fear. The subject, or patient, has his conscious awareness cut off from the feared object by repression. In place of the feared object, and hiding it, there appears a symbol. This manifest symbol is related to that which is hidden through some cryptic, often abstract bridge. Avoidance of the symbol makes possible continued contact with that which is the true object of fear.

Thus the characteristics of a true phobia are:

1. an avoidance reaction;

2. a symbol or symbolic situation that is avoided;

3. a true object of fear, which is represented by the symbol;

4. repression of the link between the symbol and the truly feared object, which the symbol represents;

5. sustained affect (anxiety, fear) that has been transferred from the truly feared objects to the symbol;

6. the phobia protects an endangered object relationship or activity.

The role of psychotherapy in dealing with phobias places emphasis on uncovering the nature of the true object of fear. This makes it possible to work out false ideas about the object or to accept unacceptable aspects of a life situation that threaten its continuation.

The phobias of latency-age children satisfy the requirements of a true phobia, but they have their own peculiarities that set them apart from true phobias found in adults. These differences are useful to know in working with phobic children. Phobias in children are easier to work with. Repression is not as strong. The true object of fear is more easily detected. The parents are still present in the life of the child. Therefore the child's gains from the phobia are primary gains. The earliest relationships are still extant and are represented in the phobia.

In the adult, in contrast, the phobia is sustained by a link to secondary social gains. Reliable parental love has been either locked in by dependence generated by the phobia or replaced by an unhealthy relationship of interdependence. In the latter case, the gain is the neurotic interaction itself. Few of the social graces and skills required to establish a healthy relationship are present. The phobic symptoms may have become so linked to a lifestyle that the symptoms have lost much of their status as reactions to conflict and have become autonomous sources of behavior. For this reason, in all childhood phobias, and especially in those that appear in adolescence, direct confrontation with the feared symbol is indicated to avert the fixing in place of the phobia.

There follow descriptions of adult and child phobias.

Anna was 31 years old. She lived on an island that was connected to a nearby city by a bridge. She lived with

her parents and earned her money by operating a typing service from her home. She longed to date, live in the city, and have a full life. Unfortunately, she had a bridge phobia. The only way that she could cross the bridge was with her mother, who served as her companion. She could not leave to make a life for herself.

Bart was in his mid-50s. He ran a small men's clothing store in a transitional neighborhood. One day an intruder entered his store, bound him, held a gun to his head, and took his money. Bart was told by the intruder that he should not call the police for two hours after the intruder had left the store. He complied.

After the episode, at first he was filled with fear. He took a few days off. Then on the day he was to return to work, he experienced severe chest pain. He and his sister went to their family physician, who found no physical abnormalities. Bart was convinced that he was having a heart attack. How could he return to work?

His wife now supported the family, which consisted of the couple and Bart's sister. When Bart first came to my office, his wife and sister accompanied him. He explained that the only way that he could travel was with a companion. His wife was his phobic companion. (The companion is a frequent feature of phobia. It is less often detected in childhood phobia, simply because the parent as companion is phase-appropriate.)

In Bart's mind, the heart pain and the robbery were things apart. He told of each separately. Two facts, however, soon became apparent. The pain prevented him from going to work and he was fearful of another robbery. Any connection between these thoughts were obscured in Bart's mind by the justification provided by the pain. I decided that the traumatic aspects of the neurosis should be worked through abreaction, (repeated telling of the traumatic experience). It soon was apparent to Bart himself that whenever he spoke of the robbery, he clutched his chest and changed the topic to his "illness." He could see the connection, and confronted the resolution he had dreaded. He would sell his store, move to another neighborhood, and go to work in a cousin's shoe store.

With this insight, the working through of the trauma, and the social situational adjustments that had to be made, Bart's chest symptoms cleared completely. He became able to travel without his wife. He was still accompanied to sessions by his sister, however. I asked him if his problems could be considered to be resolved if he still required his sister as a companion. "Oh!" he said, "That has been going on since she was a girl. She's phobic. I'm *her* companion."

Jim was 7 years old. He spoke of monsters that he feared. He had seen them in a movie on TV, and they had reappeared in his dreams and awakened him. Now he was afraid to be left alone at sleep time because they would come after him. He often checked the bedroom to make sure his father was all right. In the games that he played, he covered his head with his sweater and threatened his friends as though he were the monster.

The symptoms resolved so quickly that it was hard to determine all the dynamics. One of the monsters in the dream was very big. In association to questions about the large monster, Jim told of thinking that his father was a giant after hearing the bedtime story "Jack and the Beanstalk." The traumatic element in seeing the movie monsters merged with a projection of his hostility onto his father. This produced a situation in which Jim felt the relationship with his father would be threatened by the hostility felt to be a characteristic of either person. The monsters as carriers of anger for both father and son made continuation of the father-son relationship possible.

These cases illustrate the differences between adult and child phobia which have already been described. There is an additional difference that deserves our attention. That difference takes into ac-

count the venue of the. phobic symbol. The phobic experience in the adult is polarized toward symbols encountered in the physical world. For the phobic child, the venue of phobic symbol is polarized toward the world of fantasy and dreams, with a touch of the real that brings the condition to the attention of the parents. This is a developmental characteristic.

In adults, psychoanalytic symbols are normally found in dreams (oneiric symbols). The symbols that mediate neurotic symptoms are patterned after them. The symbols of adult phobias are limited in content by the requirement that they have a physical world locus.

In children psychoanalytic symbols are normally found in dreams (oneiric symbols) and in the plastic elements available in playroom settings and toy stores (ludic symbols; Piaget 1945). There is a naturally wider choice of symbols, associated with repression (psychoanalytic symbols), for use in the formation of childhood phobias. This results in the tendency for the symbols of latency-age phobias to cluster in a polarity dominated by play, dreams, and imagination.

Armed with this information one can understand the free interchange that occurs between dreams and play. In child therapy contexts, dream figures can be turned into play figures with ease. Just make cutouts or clay models. Thus play can be manipulated to include sensitive material. Interpretation can be made using play objects. Most important is the fact that foreknowledge of the extent of the lair of the phobic symbol helps to organize questions in diagnostic interviews. The child who denies fears in reality situations may have phobic symbols to fear in dreams, in play, in fantasy, and in the darkening hours that follow “the children’s hour.”

Not all fears are true phobias. The same feared object may be a reality to be feared for one person, a reminder of a trauma for another, a true phobia for yet another, and a precipitant of psychotic symptomatology for yet another. Fear of flying is such a symptom in adults (Sarnoff 1957). School phobia is such a symptom in children. This sort of spectrum of disease patterns occurs most often when there are obligatory occupational situations.

Fear of Flying

Real Cause

Paula was 28 when she noticed that someone had neglected to remove the panel that excluded dust from the engine of the aircraft in which she sat ready to take off. She voiced her fears, to the gratitude of everyone.

Recall of a Trauma

Fred, a pilot, was 23 when he began to vomit before each flight. The vomiting was a product of a conscious fear engendered when he saw the plane of his wingman hit a tree during a low-level flight exercise.

True Phobia

Arvin was 21. He was in basic flight training in the Air Force. He began to have trouble landing his aircraft after he began to solo. The difficulty was attributed to a loss of depth perception. He apparently could not judge his distance above the ground and therefore bounced his plane when he landed. No physical impairment could be found to explain the difficulty. When confronted with a promise that he would get a waiver for his deficiency, he had an acute anxiety attack. Note that the air forces of the world take disciplinary action against pilots with fear of flying. The social stigma is so great that the fear may be repressed and impeding symptoms introduced.

Psychotic Reaction

Phillip was 32. He was a pilot. He experienced erections, ejaculations, and hallucinations when flying. He refused to fly.

School Phobia

Real Cause

Jane was 15 when she developed infectious mononucleosis and was forced to stay home from

school for six weeks. When the time came to return to school, she began to cry and simulate her old symptoms. In a diagnostic interview, it was determined that the week of her return was midterm week. She was not prepared. Tutoring and later reentry were recommended. This regimen was followed, and Jane returned to school without mishap.

Recall of a Trauma

Timmy was 5. He had just entered kindergarten. His expectation was great, and so was his eagerness. His mother was quite surprised, therefore, when in the second week of school he feigned

illness and refused to go to school. "Help! Help!" he screamed, as his parents tried to pull him out from under a couch, whose farther leg he was grasping for dear life. When he was quietly asked what troubled him and reassured that he could speak freely, he told of threats by a bully on the bus to cut off his hand. The bully was spoken to, and Timmy learned to read.

True School Phobia

Lee was 7. Trembling and crying each morning, she refused to go to school. She sneezed repeatedly and claimed that she was afraid of school and too sick to go. Her mother was overwhelmed by this behavior. Not only did she have to get Lee off to school, she also had to take care of the toddlers left when her friend and neighbor of many years had suddenly died. In therapy it was determined that Lee feared to leave her mother's side because she was afraid that her mother, too, would die.

Psychosis

Lil was 11. She insisted on coming home from school when she realized that her mother had placed a radio transmitter in an aspirin her mother had given her that morning. At times she heard the chewing of dinosaurs outside the classroom window.

The material below will be devoted to true latency-age phobias, those associated with repression and symbol formation.

The Implications of Latency-Age Phobias

Most of the phobic states that occur during the latency age period are as transient as latency itself. For this reason there is danger that such symptoms will not be taken seriously. The implications of the appearance of a phobia in latency are twofold. One is immediate, and involves the response of the unsophisticated observer, often the parent. The other is long-term. It engages the expertise of the therapist to whose attention the symptom has been drawn.

Because of their transience, childhood phobias tend to be considered normal and to presage little long-range danger. Indeed, the immediate effects of phobia (e.g. anxiety and parental discomfort) can be adjusted to or ameliorated as soon as the phobic symptoms pass. The long-term implications of a latency-age phobia present a much greater magnitude of concern. The underpinnings of phobia persist after the symptoms have disappeared, predisposing the child to manifestations of their influence in the mature years that are to follow.

From what has been said, it must be clear that while the therapist should be concerned with the immediate effects of childhood phobias, as are parents, it is necessary to emphasize the long-term effects that could be the products of failure to treat the underlying pathology. This emphasis is required to counter the fact that the hidden nature of phobic underpinnings invites neglect. The childhood phobia often serves as a barometer indicating the inner tempests that brew during the psychosexual and cognitive maturational phases of childhood. These in turn were spawned by pathology in past development. They presage future storms.

Immediate Implications

The discomfort wrought by childhood phobias on family and child are often sufficient to bring the parents to the child psychiatrist in search of help. The phobia is portrayed as the primary problem, and its relief as the only goal. When signs of distress and behavior beyond the control of the family clear, no further need for the therapist is felt. (See case on pp. 187-188.)

Rarely does parental concern go beyond the immediate discomfort of the child and family. Therefore, it is wise for the therapist early in the treatment to educate the parent of the phobic child in

understanding the impact of phobic underpinnings as well as information to be used to recognize them.

Long-Term Implications

Epiavoidances. Rarely is thought given by parents to the eventual effect of the interferences with learning and the inhibitions of social grace acquisition that accompany childhood phobia. Only very informed parents voice concern for the implications that transcend the immediate difficulty. Specific phobias may result in specific deformations in future function. For instance, a child who fears water may not learn to swim. In the case of school phobia there is an interference with functions that are extremely important for later life—not only academics and learning skills, but many social experiences as well. Thus, phobic epiavoidances may interfere seriously with development and educational progress.

> An 8-year-old girl clung to her mother's skirt, sucking her thumb intently. She gazed at the children with whom she had been playing just moments before, until to her dismay a large dog had appeared on the scene. The others petted the dog. Only after it left did the child rejoin her friends. They teased her. Within the power order of children, she fell to last place. Her socialization and choice of friends shifted to few and fearful children like herself.

Underpinnings. The long-term effects of the underpinnings of childhood phobia are not always as easily discernable as the long-term effects just discussed. These underpinnings are by nature unconscious and therefore not easily perceived. Their implications for the future are often too abstract for those lacking in experience to understand. Each phobic child should be studied to determine the degree to which severe pathological and psychopathogenic distortions of ego function are present.

The presence of a phobia in childhood could in some cases be a predictor of health. First, in order to form a phobia, the child has to be capable of projection of introjects. Theoretically this capacity precludes the presence of childhood schizophrenia. If so, it would follow that childhood phobia and childhood schizophrenia are mutually exclusive before the age of 10.

Second, the development of the ability to project contributes to the development of social contacts in adolescence. The child can follow fear fantasies about peers into relationships with those peers. One is drawn in body and in attention to those whom he fears. If a child has the ability to separate the sense of reality (i.e., fantasy—the reality one feels) from reality testing (i.e., physis—the reality one can touch), then projection may form a bridge to peers and be a useful mechanism in adolescent adjustment (Sarnoff

1972).

The presence of a phobia in childhood can in some cases be viewed as normal. Healthy young minds are capable of repression, condensation, displacement, projection, and denial. These are the mechanisms at work in producing a phobia. At any time, these mechanisms can produce a transient phobia or a frightening dream. The mere existence of a childhood phobia does not indicate or predict a fragile or pathological adjustment in adult years. One must, in the evaluation of the phobic child, look beyond these defenses to detect possible personality weaknesses.

The presence of a phobia in childhood can in many cases be a predictor of future emotional problems. Specific types of ego weakness that predispose to the development of latency-age phobia contribute to adjustment failures in later life. The therapist who works with the phobic child must evaluate these ego weaknesses to decide whether extensive therapy, with goals beyond the alleviation of the phobic symptoms, is indicated. Some of these weaknesses are:

1. A poor symbolizing function with heightened cathexis of fantasy priorities. These youngsters dwell on their fantasies, leaving reality to shift for itself. They are unable to separate that which they sense as reality from that which in reality can be tested. They often seem unaware that their perception is unusual or even bizarre.

   A nurse on an adolescent ward tried to help the patients to be less gullible. "You wouldn't believe it if someone said they saw green men, would you?" she asked. A child of 11 responded, "When I look in the mirror, sometimes my face is green."

   A child avoided school because she heard the sound of dinosaurs outside the classroom window.

   Healthier types of symbols in phobia formation include animal phobias, amorphous creatures (before the age of 8 ½), and symbols drawn from current social emphasis. An example of the last follows.

   A child of 7 was brought for treatment because of his fears that he would be eaten by goblins. These fears were quickly dispelled when it was learned that he had been teased by a sibling, who threatened him with being gobbled up by the goblins. These goblins were at the time everywhere illustrated as a harbinger of Halloween. A few weeks later the boy returned with identical fears. With Halloween now past, the symbol seemed bizarre until I asked him if he had seen one of the goblins. He said he had. I asked him to draw what he had seen. He drew a picture of a bird with a striking resemblance to a turkey. He had confused the slang term for turkey (gobbler) with the gobbling goblins of Halloween. Thanksgiving, and its promises of gobblers to come, had reignited his fears, with reality supports in the form of pictures and promises of the coming of the "gobblers."

2.Long-term effects of the experiencing of oneself as small, passive, and vulnerable. Phobia undermines confidence. There is a trauma with lifelong implications involved in imagined humiliation while experiencing a phobic reaction in childhood. One's self-image in later life suffers from the experience of sensing oneself to be a passive object of aggression.

3. Premium given to the sense of reality over reality testing throughout life. In evaluating a phobic child it is necessary to determine if the break in reality testing implied by the existence of the phobia is limited to the current episode or is part of a lifelong pattern. The latter is pathological, indicating the presence of a mental fault that can permit symptom development unlimited by the constraints of reality. Such a lifelong pattern requires treatment that emphasizes reality testing. Phobias that are activated in the evening, at night, or under conditions of decreased sensory stimulation are less pathological than those that occur in broad daylight. The former occur during conditions of a decrease in the sensory guarantees of primarily autonomous functioning of the ego in relation to the id. Phobias in broad daylight indicate weakened reality testing. A lifelong pattern of weakened reality testing can be seen clinically in a history of failure to learn from experience, or an episode such as the following:

> A boy of six gazed in awe at some seabirds that sat upon the sea within easy reach of the sailboat in which he rode. Finally he spoke. "Look at the chipmunks," he said. The kindly skipper explained that those were seagulls. Later a fellow passenger heard the child mumble to himself, "They are chipmunks!"

4. Pathological introjects. The nature of the introjects involved in the projections from which the feared objects of the phobia are derived should be studied. One should study the behavior of parents and primary objects who may have been the models for introjects in early life. Their current behavior may be supporting and reinforcing a hostile, distorted object image as an introject. Family-oriented therapy is indicated in these cases. Study of the origin and maintenance of the introject is only half the study of the introject in latency-age phobia; one should also study the degree to which introjection of hostile projections (projective identifications) in early childhood has played a role. Such a process is an indicator of poor reality testing. When introjects wear the coloration of the aggressive drive to excess, there is the possibility that the original introjected object was falsely perceived. The fantasied (elaborated) persecutor is now falsely perceived as unduly hostile as a result of an old false perception.

These underpinnings are part and parcel of a chronic personality defect that just happens to be expressed through phobic symptoms in latency. Let us focus for a moment on a problem created by these unseen aspects of childhood phobia. Now that medication can be used to make anxiety manageable, psychotherapy is not always thought of for

childhood phobia. One should not use medication without evaluating the severity of the underlying personality defect and its future implications. The existence of frequent infection responsive to medication does not rule out the requirement that diabetes be considered in the differential diagnosis. On the contrary, it mandates such a differential diagnosis. Childhood phobia, with its tendency to be cured by any and all modalities (including the passage of time), likewise requires a differential diagnosis, including those diagnoses that presage crippling emotional conditions in adulthood.

I have had occasion to follow for as long as twenty years individuals with latency-age phobias. My impression is that the phobias of early latency when they are limited to night fears are quite normal and presage no severe pathology in adulthood. If the phobias are sufficiently charged with energy that actual changes in family plans are necessary, or if night phobias continue into the day, one should be on the alert for later depressive states and adolescent shyness. Night fears occurring in late latency and accompanied by great aggression and difficulty in shifting attention cathexes from inner fears and personal fantasies to the outside world presage borderline functioning in the adult, which will be manifested primarily in fear of close object ties in the early twenties. Yochelson (1976), in his study of the criminal mind, spoke about the typical childhood psychological adjustment of the adult criminal. "His [the criminal's] parents may remember that early in his life the criminal child had more fears than the other children; he Was the one who needed the night light the longest; he was the least tolerant of pain and the most afraid of the doctor. Criminal children fear thunder, lightning, water, heights, goblins—almost anything.. . . Many are so fearful of the water that they never learn to swim. . . . Although the fear is initially strong, running away is so deflating to the youngster's self-image that he decides to stand fast and try to hold his own. The fear is replaced by a desire to win and dominate" (p. 206). Yochelson describes how the victim becomes merely a pawn in the plans of the criminal, with little concern on the criminal's part for the feelings of the victim or the victim's sense of life or property.

The Role of the Therapist

The job of the child psychiatrist confronted with a phobia in a latency-age child is to respond to the parent's awareness of the child's symptoms and the effect that the symptoms have on current functioning. He must explain to the parents the effect of phobia on future skills and functioning, and interpret to the parents the less easily perceived implications of phobia for unconscious areas of functioning, subtle interferences with maturation, and cognitive impairments. For the immediately evident aspects of these conditions, the child psychiatrist brings to his work sympathy, support, compassion, and the mitigating

aspects of therapy. The occult aspects of phobic conditions require one to educate and inform the parent, and direct the therapy toward reconstructive techniques that will strengthen the ego, give the child insight, and improve his potential for the future.

The Differential Diagnosis of Childhood Phobia

Cognitive, physiological, and psychological factors contribute to the origins and times of onset of phobias and avoidance reactions. We will describe here those factors, as well as therapeutic approaches, differential diagnosis, and prognosis for phobic states during latency. In addition, we will consider the implications for maturational and developmental growth of the states that predispose a child to phobia formation.

Night Fears

"Night fears," probably the most common of childhood phobias, are the periods of fear that occur when latency-age children go to bed. They may begin at as early an age as 26 months, when the capacity to form psychoanalytic symbols (where what is represented and what represents is, as the result of repression, no longer connected in the awareness of the child) first develops. Night fears become most intense at 6 to 8 years of age. Then repression becomes stronger. Oedipal fantasies are repressed. The need to discharge drives must find other symbols for expression. For instance, a 6- to 8-year-old boy projects hostility that he feels for his father onto his father. This hostility is a manifestation of oedipal wishes. The father is then seen as a persecutor. Fearing the pain of being hated by his father, the child displaces the hostility from his father to symbols in the form of amorphous monster-like objects, which the child sets in the real world. In the most limited sense night fears occur only when the child is going off to sleep. Monsters, robbers, skeletons, goblins, and demons populate the world of these children. They want the night light on, the closet door open with the light on or shut. The hall door must be open, or the hall light or bathroom light must be left on.

The appearance of this type of phobia is directly related to the high sensitivity to sensory deprivation that typifies this age period. Eruptions of id-dominated material in response to loss of guarantees of the autonomous functions of the ego in relation to the id are possible at any age. At no time

is the process more sensitive to changes in stimulation than during latency. J. M. Barrie, in *Peter Pan,* immortalized this fact when he wrote, "Neverland . . . when you play at it by day with the chairs and table cloth, it is not in the least alarming, but in the two minutes before you go to sleep, it becomes very nearly real. That is why there are night lights." These phobias may therefore be considered normal for the most part. When occurring in the absence of other pathology, they serve as an indicator of cognitive maturational events, which for a brief time have provided a rather explicit conduit for the manifestation of psychosexual conflict.

Such phobias require a healthy precursor. Children have to have experienced introjection of lost objects. Projection of these introjects is a component of phobia formation. Such projection can occur as early as the second year of life. At the latest they should begin by 4 years of age. In childhood schizophrenia (see Bender 1947), it is not uncommon for such a process to begin only in the eleventh year; such a delay is pathognomonic of childhood schizophrenia. This evidence suggests that night fears in latency-age children, especially those in early latency, reflect a normal maturational process (the normal neurosis of latency). The absence of such symptoms suggests a consideration of childhood schizophrenia in the differential diagnosis.

Waking Phobia

When the child's phobic reactions occur when the child is fully awake—as in "I'm afraid to go in the water; I might [or will] be bitten by a fish or by a crab," fear of thunder, fear of robots, fear of shadows, fear of the dark, fear of lightning, fear of the wind—we are dealing with a process of greater seriousness than that suggested by night fear. The mitigating presence of an altered ego state introduced by the sensory deprivation implicit in darkness and aloneness is not present. What is present is a serious hypercathexis of persecutory fantasy to an extent that environmental reinforcements of reality testing are overwhelmed.

There are many phobic states that occur in latency-age children in broad daylight that do not involve fear of repression supported psychoanalytic symbols. In this section I limit the topics to deal with uncomplicated waking phobia, such as a fear of stairs, tunnels, bridges, seaweed, or people in masks. In uncomplicated simple phobia psychoanalytic symbols are involved. Fears based on separation, as in

symbiotic psychoses or avoidance maneuvers associated with psychotic delusions such as those that produce school avoidance fall into another category, which will be described in later sections.

The waking phobia that involves psychoanalytic symbols in childhood is similar clinically to phobia seen in the adult. Usually these states indicate an overstimulation of the child by the parents, caretakers, or other children. Latency-age phobia may respond rather quickly if parents are advised not to take the child into bed, not to beat the child, and not to walk around naked in front of the child. Taking showers or baths with children is also often involved when this symptom occurs. Such immediate pressures are related to the onset of these symptoms.

Why does this symptomatology appear with latency and disappear when adolescence comes on? This is the pattern in a majority of cases, without treatment and in spite of the persistence of seductive behavior on the part of the parents. The answer lies in the ego structure of latency. The "structure of latency" functions to a large extent through the creation of latent fantasies. These are the product of the projection of conflict-filled core fantasies that have been molded into occult representations through the use of masking symbols. These core fantasies are worked on through further displacement to produce manifest fantasies. The symbols of manifest fantasies have less valence for attracting affect. They can therefore appear in consciousness and be used for the discharge of drives by being communicated to another person, much in the way that talking to a therapist can calm emotional turmoil.

The structure of latency may be burdened with too much stimulation. The symbolizing function of the child may be immature or defective, producing symbols porous to the affect against which they are supposed to defend. These symbols appear in manifest fantasies associated with anxiety. When this happens, the affect-masking effect of the symbolizing and fantasizing function fails. Although the identity of the original feared object continues to be hidden, the affect associated with the original object persists. The persecutor and the persecuted of a masked story give way to new protagonists. The child as the persecuted one is returned from the zone of repression. The venue of the persecutory symbol is shifted so that the identity of the persecutor is hidden while the uncomfortable affect is reinforced. A raw tale of fury is produced. The discharge-oriented play fantasy of a peasant leader who kills a cruel king in a distant land is replaced by a lived-out fear of a persecutor whose victim is the child (as in the fear that the "dog will bite").

The structure of latency continues to play a role into adolescence, a role that is a far cry from its function in latency. The symbol representations through which it works shift from fantasy symbols to reality elements. This is one of the cognitive maturational changes that accompany the transition from latency to adolescence. The role of the structure of latency turns to future planning (a reality-oriented ego function). Regressions and phobic reactions involved in the fantasy function of the latency-age child are mobilized in the direction of object relations. Drive organization shifts for its drive discharge from fantasy objects to objects in the environment. Phobias may then be developed in relation to social situations, while the fantastic persecutors of latency lose their preeminent position. Phobias in early adolescence tend to give way to shyness, introversion, asceticism, or withdrawal. Adult phobias usually first appear during the late teens through the early twenties (Laughlin 1967, p. 566).

One may therefore expect latency-age phobias to clear with age. Laughlin quoted Menninger to the effect that "about twenty percent of college students have or have had phobias in early years which sooner or later disappeared spontaneously" (p. 566). Regression of the symbolizing function, and the prelatency fantasies that sensitized the child to the behavior of others, find different pathways for expression. They may even produce new phobias. In effect, the bottles in which psychopathology appears change during the shift from latency to adolescence; within the new bottles one finds the same old wine. If we take the view that the waking phobias of latency will heal with time and medication, we will probably be right. But what is gained in curing the phobia but not the child? Psychotherapy in latency has value. Latency is a good time to get to the ego defects and psychosexual sensitivities and fantasies that lie beneath the troubles of latency and can give rise to other forms of psychopathology in adolescence and adulthood.

In confronting a child with a waking phobia psychotherapeutically, one must be on the lookout for an overstimulating parent, a defective symbolizing function, a low level of anxiety tolerance, or a diminished stimulus barrier in considering the factors in the differential diagnosis. Treatment must be geared to the underpinnings of the diagnosis, as must the determination of prognosis. The primary technique for dealing with "waking phobia" is a play therapy technique that strengthens the symbolizing function.

Pavor Diurnus

Pavor diurnus, or day terrors, are waking fears that occur in individuals whose histories reveal the presence of night terrors *(pavor nocturnus)* before the age of 6, and sleep walking during latency. There appear to be at least two factors involved in their appearance in latency-age children. First, they occur during periods of psychological stress. Second, there is a physiological predisposition, as manifested in a disorder of arousal as described by Broughton (1968).

In cases of night terror the parents describe a peculiar type of nightmare characterized by hypermotility, confused automatic behavior, motor control that appears to be volitional, and awareness of the surround, with retrograde amnesia for the behavior and thought content during the attack. Kales (1969) did electroencephalographic studies of children during these attacks. He discovered in the EEG a hypnogogic hypersynchrony during rousal from fourth-stage sleep, signifying a disorder of arousal. A typical clinical history consists of an alternation of rare attacks with periods during which attacks come in series. The latter usually occur during periods of emotional turmoil. In latency, sleepwalking often starts with an accompanying decline in the night pavor. In most cases, by 9 or 10 years of age all symptomatology clears, including the immature sleep record on the EEG. In a small group of patients, the *pavor* continues unstintingly. For those with persistent *pavor,* memory for the dream content becomes possible. This has negative prognostic significance in adolescence. As adults, they may have sustained attacks or episodes patterned in bursts. In studies of the adjustment of these patients (Fisher 1970) there were reported difficulties in the setting up of appointments because of intercurrent psychiatric hospitalization.

Pavor diurnis is a disease that was well known in the nineteenth century. Macnish (1834) wrote of such waking terrors in adults, and Still (1900), publishing in *Lancet,* described day terrors in children. There were periods of extreme anxiety occurring during the waking period of a child's day, accompanied by hallucinated threatening figures. The last mention of it is a description by Ernest Jones (1931) of *pavor* states occurring during wakefulness. The probability is that the condition has recently been grouped with acute hallucinosis in childhood. I mentioned this in my book *Latency,* and apparently clinicians were thereby alerted to the condition. There soon appeared referrals for consultation with youngsters who had an early history of *pavor nocturnus* or sleepwalking and, later, phobic reactions

while awake, which contained *pavor-like* material. Many of the children functioned well between episodes. Youngsters who had definite *pavor nocturnus* and some episodes of *pavor diurnus* could be helped with dynamically oriented psychotherapy aimed at diminishing the seriousness of interference with function that derives from the presence of *pavor diurnus.*

Here is a classic example of *pavor diurnus.*

> Helen was 10 ½ when seen. There was a history of *pavor nocturnus* in early childhood. She said, "When I was younger I would wake up and walk downstairs. I started talking nonsense about my dream and running around." Although up she was not fully roused and had no recall for *pavor*-dream content or what she had done while walking about. Recall for *pavor*-dream content began at age 8. "More and more I remember the dreams since I was 8 ½." At 10 ½ she reported that during the day she got "these effects of things getting bigger and coming at me. My mother and father's face flashes up and gets bigger—it's kind of scary. If I don't fight them, the scary things continue into the night." She fights them by concentrating on other ideas. "It gets better 'cause I fight it. If I don't try to fight it it wouldn't get better." If she is concentrating, the images do not occur. She must work hard to keep the images out of her mind. For instance, once a visual image appeared in her head—a silver man on a playing field. He just stood there. He even had a shadow. "I made him friendly and walk around. He looked so creepy. I was frightened by the thought." She never has these images when she is having fun with friends or working in school. When relaxed, riding in a car, reading, relaxing at night without music or people to listen to, she has to expend continuous effort to keep from being overwhelmed by these affect-porous symbols that make her so anxious. She maintains a phobic avoidance of the situations in which she might experience such episodes.
>
> Another child's *pavor diurnus* consisted of a mouth that appeared in the wall and made fun of her.

Diazepam (Valium) obliterates fourth-stage sleep, and the elimination of arousal from fourth-stage sleep should be, and usually is, accompanied by a cessation of *pavors.* Some of the parents of children with *pavor diurnus* have reported good results with diazepam. I have seen improvement in a hospitalized 15-year-old girl with *pavor diurnus* and irritability and paranoid states while awake. All three of these symptoms cleared. She became less disturbed but on discharge was no less impaired in her ability to relate to others than before receiving medication.

The description in the case history of the need to concentrate to avoid the hallucinations is important. *Pavor diurnus* is an example of intact organs of perception being overwhelmed by intrusions of fantasy material. To avoid these intrusions the child is forced to struggle to maintain primary contact with external world realities. There is no sensory deprivation, as occurs in the case of night fears, that encourages an inward turning of the organ of consciousness. Rather, there is a faulty ability to rouse to contact with reality and defend against the intrusion of fantasy. The underlying problem here is more

physiological than psychological. Techniques to minimize strong affects of anxiety and depression are useful in helping these people maintain distance from the intruding affect-porous symbols that threaten to sap their efficiency, at the least, or even their sense of reality.

Phobic Reactions of Late Latency

Differential Diagnosis from Psychotic States

As the child passes from latency to adolescence, there is a period when persecutory fantasy accompanied by phobic reactions or phobic symptoms present difficult and far-reaching differential diagnostic problems. As reality testing becomes stronger, the symbols selected for fantasy formation by the structure of latency call increasingly upon reality elements from which they can weave their contents. The closer to reality the symbols are, the more likely are they to become fear producing when they (the symbols) attract underlying hostile wishes. The condition, in essence, does not differ from the regressions in the structure of latency that occur in early latency. The later regression is a product of any factors that impair the capacity of the structure of latency to diminish anxiety. Usually the manifest symptoms of the later regression take the form of fear of robbers, rapists, kidnappers, or murderers who are out to get the child. The symptomatology may expand to include a need for a companion, fear of school, or fear of shopping centers where the feared events might occur. Night fears, with the need for night-lights and the like, are rekindled. Typically these youngsters had night fears while younger, have many friends to whom they continue to relate well, and develop abstract thinking normally, with no thinking disorders. Regression in the structure of latency requires treatment that deals with underlying conflicts about accepting budding conscious sexual urges and ameliorating the poor symbolizing function that has been revealed.

Sometimes it is hard to differentiate these paranoid states, which present as phobic reactions and follow maturational changes and regressions in the structure of latency, from the schizophrenic diseases accompanied by persecutory delusions and phobic reactions that first appear at this age (adult schizophrenia of early onset and prepubescent schizophrenia).

Adult Schizophrenia of Early Onset

Adult schizophrenia of early onset may present with phobic symptoms, such as fear of persecution at parties, manifested by avoidance of social situations. These youngsters have thinking disorders and a flat affect. In the realm of object relations, they usually have had few friends during the latency years. Some have had friends but begin to have problems with object relations at this time. They often demonstrate engaging personalities in a psychiatric interview. For these, it is easy to confuse this state with regression in the structure of latency. Early onset schizophrenia has the same prognosis as the adult form of paranoid schizophrenia.

Prepubescent Schizophrenia

Prepubescent schizophrenia comes on after age 11. Typically the child has external persecutors, which may be responded to with phobic avoidance. Before this, the persecutors were within, as would be expected in a condition in which introjects are not projected until 11 years of age. There is a history of poor object relatedness; marked concrete thinking is evident. The feared symbols are bizarre. The primary modality of treatment is medication. An example of the symptomatology of a prepubescent schizophrenic episode follows.

> A boy aged 10, who avoided pizza because it gave him a bad stomachache and who often feared going to school, explained to me that in addition to the pizza allergy, he had pain in his "axis." The axis was a metal bar that fastened his heels together. The pain was very intense unless he directed his attention to his stomach, which then hurt instead. In addition, he had periods of "absence" while in school, during which he descended from his classroom 200 miles into the earth, where he sat with a group of other people while the devil talked to him. The stomach pain cleared up after one session. The father interrogated the child about my interview and, discerning that the "devil" had the face of a girl, who teased the boy while in the bus, instructed the boy to beat up the girl. He did.

Differential diagnosis between these conditions, any one of which can appear to be a phobia, is important because of the differing therapeutic indications and prognoses.

Phobic Reactions Related to Ethical Individuation in Late Latency

After about the age of 9, children begin to derive the contents for the aspects of the superego that control behavior from peers as well as from parents. The result can be marked conflicts between behavior

considered permissible during late latency and the superego contents that persist from early childhood. I like to call this aspect of late latency *ethical individuation.* During this period, reality influences and introjects both lay claim to control of ethical decisions. A phase-specific interface is introduced, and around it intrapsychic conflict can evolve. This is especially so for those who can form new wishes on the basis of new experiences, but at the same time are subject to strong reinforcements of the internalized introjects of early childhood. During this period, obsessions, transient tics, hives, night fears, and phobias occur at the time of heightened confrontations between peer pressure and parental introjects.

> A 12-year-old girl felt terror at the thought of the end of the session. She feared men intent on kidnapping her. I had to accompany her through the "phobic zone" to her parents1'car. This was accompanied by bad dreams, night fears, and continuous fear of kidnappers. I inquired into her recent activities. She had been induced to steal by her friends. This put her in conflict with the internalized dictates of her parents. She became overwhelmed with guilt. The kidnappers were her way of expressing guilt. She was able to address her conflict and the phobia disappeared as quickly as it had appeared.

Rarely are these conditions brought to a child psychiatrist de novo. They are of such brief duration that only the very sophisticated parent would consider them to be of any significance. If the phobic symptom appears in isolation, insignificance is probably an accurate appraisal. The therapeutic considerations involved in symptoms related to ethical individuation, including phobia, require the parents to lessen the effects of their influence through early introjects when appropriate. As in the preceding case, analysis of the conflict is both possible and fruitful.

These people, by dint of the balance that they strike between the demands of reality and the demands of their introjects, are prime candidates for conflict-ridden periods of adjustment during new situations. They tend to be symptom-prone rather than given to developing anxiety or acting out

Phobic States Associated with Maturational Moves in the Symbolizing Function

Because of the frequent developmental changes in the defenses and cognitive functions of latency, symptom changes often occur. For this reason, one must be on guard not to attribute a new symptom to the nearest stress.

> A child of 8 ½ was transferred from his public school to a parochial school. On arrival at the new school, he developed a phobic reaction to school attendance. When taken to school each day, he refused to enter the classroom. He insisted on waiting anxiously in the hall. Logic dictated to those who had worked up the case that the child's school phobia was a reaction to the move, the new environment, and separation from familiar

haunts. Investigation of his history, though, revealed that he suffered from chronic night fears, which had cleared completely with the onset of the school phobia. It was recognized at this point that rather than being an acute problem of school phobia, his phobia was of long standing. The symbol venue had changed, shifting from amorphous fantastic objects of fear to a specific external object of fear. The attention of the therapist could then be directed to the chronic stresses that underlay the symptomatology, once the chronic nature of the illness was identified.

This case illustrates the change of object chosen for symbolization and incorporation into a fantasy from an amorphous, internally conceived monster (the night fear) to reality elements used to actualize the fear and rationalize it with external reality supports. This shift in symptom often occurs. Most commonly, it gives rise to the agoraphobia of late latency-early adolescence. However, it occurs at its earliest with the cognitive shift in the nature of objects used as symbols, which occurs at 8& [In this regard, see also Anthony (1959) and Piaget (1945).] The move is necessary and normal, and presages a normal shift into adolescence. These patients must, however, be followed to be sure that they will move to the next step, which is the replacement of the fantasy-laden real people feared by reality-oriented real people. This is a normal step, but fixation at the point of transition to the feared real object is crippling.

Summary

Phobic symptoms, phobic avoidance reactions, and the persecutory fantasies that often hide beneath phobic behavior should not be merely noted in an evaluation. Differential diagnosis should be undertaken with an eye to the impact of the total pathology on long-range functioning and adult adjustment. Childhood phobia may be likened to the pulsing musical theme one hears in movies in advance of a shark appearing suddenly from the ocean depths. Sometimes it's just a false alarm. Sometimes the shark appears. If one were in the water, it would be a good idea to look around.