American Handbook of Psychiatry

PHOBIC REACTIONS

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e-Book 2016 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 3* Silvano Arieti

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the agoraphobic symptom may have a variety of remote meanings, including the idea of an open street as an opportunity of sexual adventure; the idea of leaving home; the idea that on an open street one may be seen and caught; the idea that some other person (usually a parent or sibling) may die while one is away from home; or the idea of being born. In a less symbolic sense, agoraphobia may also represent a reaction to "equilibrium eroticism," that is, to a sexualized pleasure in the sensations of equilibrium while walking.

Displacement is likewise a prominent feature of claustrophobia, a symptom often traceable to fantasies of intrauterine existence. According to Ferenczi, there is a close association between claustrophobia and the idea of being inside the mother; the fear of being buried alive is often a transformation of the wish to return to the womb. He also cites a case where claustrophobia and fear of being left alone in any enclosed space acted as a defense against masturbatory temptation. Observing that skin and chest sensations are particularly prominent in claustrophobic anxiety, Lewin attributes this fact to the fantasy of being inside the mother and to ideas concerning the tactile sensations and breathing of the fetus. This fantasy is also described by him as one of partial identification through oral incorporation.

These are but a few examples where displacement is prominent. It is actually a characteristic feature of most phobias. The assumption that the

choice of the phobic object is determined by displacement is consistent with the view that fears of early infancy affect the subsequent choice of the phobic object.

Concomitantly with displacement, projection plays an important role in the phobic symptom formation. “Little Hans,” as already indicated, harbored aggressive impulses against his father. These impulses he projected onto the object of his hostility, the father, thence displacing them onto the horse by which he feared would bite him.

One might say that the general human tendency to create the outer world in the image of the inner world is one of the prominent features of the phobic’s defense against anxiety.[9] However, although in phobia the ego structure is more severely impaired than in conversion hysteria, the projection in phobia is far less extensive than it is in psychosis. Unlike the paranoiac, the phobic remains capable of reality testing, and is usually aware that his anxiety is subjective rather than based on objective danger (Nunberg).

Identification and Regression

The role of identification in phobia has been described by many authors. Deutsch showed that the phobic fear of going out alone in the street is closely bound up with ambivalence, which frequently can be traced back to the

oedipal situation. In some instances of animal phobia (for example, the hen phobia described by Deutsch), analysis revealed the existence of an earlier identification with the animal, which subsequently became the phobic object.

In the case of "Little Hans," the realization that large animals have large "widdlers" became fused with his own wish for a large "widdler." This occurred by way of identification, thus paving the way for the replacement of the father by the horse in the phobic symptom.

The process of identification may also take a more primitive form. Thus, the idea of being devoured by animals, a common phobic fear in childhood, is based upon a regression to the oral stage of development. The classical illustration is the fear of being eaten by the wolf, described in Freud's paper, "From the History of an Infantile Neurosis." (The popular children's story of the "Little Red Riding Hood" probably derives part of its appeal from the reassurance it offers to the young child against this fear.) Moreover, the theme of oral incorporation also characterizes many phobias of adults. For instance, a male patient related his phobic fear of bridges to a fantasy of crossing into a dangerous country where he might be devoured by prehistoric animals. Since phobic reactions are indicative of regressive processes in the same measure as they place the person in a situation of infantile dependency, this regression is especially marked in phobic syndromes which restrict the patient's locomotion and make him continuously dependent upon a

companion.[10] But to some extent it is inherent in all phobias; they all impose some restriction of action not caused by objective reality. Viewed from this standpoint alone, regression would seem to be minimal where the phobic object is quite remote and easily avoidable, as in a phobia of some rare exotic animal. This general consideration, however, is not the only criterion for the existence of regression in phobic reactions.

Evidence of regressive features is frequently found in the symbolism utilized by the phobia. For example, in the case of "Little Hans," the repressed impulses themselves—sexual wishes toward the mother, death wishes toward the father—were predominantly of an oedipal kind, in keeping with the child's developmental stage. But his fear of being bitten by a horse contained, along with the castration symbolism, a strong oral-sadistic component characteristic of an earlier age.

Symbolism in Phobias

To understand the meaning of a phobic symptom we must delve into the complex and multifaceted structure of its symbolic content. Only thus can we uncover the real source of the patient's fear.

Coming back to the case of "Little Hans," we find that his fear was a result of a combination of many elements. He was not simply afraid of horses as such or of the street as such. He was afraid that a specific kind of horse

would bite him and that a horse would fall down in the street. But his phobia also included heavily loaded furniture vans and other vehicles that might cause the horse to fall; and at one point he was afraid, moreover, that a horse would come into the room and bite him.

Freud convincingly argued that this diffuseness of the boy's phobia was "derived from the circumstance that the anxiety had originally no reference at all to horses but was transposed onto them secondarily and had now become fixed upon those elements of the horse-complex which showed themselves well adapted for certain transferences." The idea of the falling horse represented a death wish against his father, while the idea of being bitten by a horse having some specified characteristics represented a punishment for this wish. On another level, which emerged only later, the heavy furniture vans represented pregnancy and the falling horse represented his mother having a baby.[11]

These ideas found their clear formulation in Freud's *Introductory Lectures,* where he compared the content of the phobia to the manifest content of the dream, characterizing it as a "facade." Lewin, using this view as a point of departure for his illuminating study of "Phobic Symptoms and Dream Interpretation", showed that the over-determination of the phobic symptom is the work of the primary process, as is also true of the dream fabric. He treats the façade of the phobia the way the psychoanalyst is used to

treat the manifest content of the dream. Indeed, as the case of “Little Hans” exemplifies, true phobias frequently consist of a condensation of various symbols which seem to be interrelated in a meaningful way. Moreover, as one of the authors has shown elsewhere, and as Jones had previously observed in his paper on symbolism, in the phobia (as in the dream) there is a certain affinity between the person and the symbols he chooses to express his unconscious imagery.

The following example is an illustration of phobic symbolism. An unmarried woman of twenty-six sought psychoanalytic treatment because of a fear of walking down a flight of stairs, an affliction from which she had suffered since adolescence. The clinical picture could be described as follows. When approaching the first step on her way downstairs, she became frightened and her legs stiffened, as though paralyzed. She could not move her feet. Clinging to the bannister, she would move her left leg with great effort, by lifting it first to the left, then to the right, before she could finally put her foot down on the step. Exactly the same procedure was then performed by the right foot, etc. Throughout her descent the patient’s eyes were centered on her movements, as though she were a child learning to walk.

Her phobia had first appeared at about sixteen, in high school, when a teacher had warned the class to be careful in walking downstairs, as the stairs were rickety and had caused some minor accidents. Since then, the phobia

had persisted continuously for more than ten years.

The patient had an only brother three years her junior, who apparently was favored by the mother. When he was very small, the patient had hated him, teased him, and often threatened to leave him in the woods at night. She also used to frighten him by telling him that he was not the real child of her parents but a foundling, and she felt gratified when the little boy would run crying and complaining about it to the mother. She remembered having been scolded and punished by her mother, whom she had feared and disliked since early childhood.

Nevertheless, she felt pity for the mother who, she believed, was being cruelly attacked by the father. When she was about eight or nine, she used to overhear conversations between her parents, and would not fall asleep until all noise had stopped completely. Many times she became frightened, felt anxious, wanted to scream, and wished her father would die.

At about six, she once walked into the bathroom and surprised the piano tuner while he was urinating. The man then showed her his erect penis, and she told him that she had seen the same thing before on her father. It is significant that in the early stages of her analysis, the patient found it difficult to remember having seen her father nude or having observed him in the bathroom; nor could she remember having indulged in masturbation before

the age of ten or eleven, when she started to masturbate regularly. However, she remembered an incident which apparently took place when she was about nine. She had been playing with some other girls and boys in an empty carriage that stood abandoned in the backyard of their house. A boy slightly older than she tried to put his hand under her skirt. She became frightened, wanted to jump down from the carriage, but for some reason felt unable to do so. However, in her state of fright, she somehow did leave her companions and went to complain to her mother.

When she was eighteen she worked as a secretary for a much older man who once attacked her from behind while she was standing near the files. She became frightened and left the office.

From that time on, there were several unsuccessful love affairs. One, with a young intern in medicine, lasted about two years. She hoped to marry him, but when he suggested a separation she accepted it without any protest or ill feeling; she understood, she said, that he could not afford to marry a poor girl because he needed money to establish himself in practice. She then had an affair with a much older man who likewise left her with some rationalization, which she again accepted. A third affair followed, with precisely the same pattern and the same outcome. In all these relationships she was completely frigid. As she put it, most of the time she would comply with the man’s insistent desire to have intercourse, and then consent to go on

with the affair only because she was very much afraid of being blackmailed.

The patient’s early jealousy of her brother persisted during adolescence; it became further increased when he was allowed to go to engineering school, whereas she had to renounce her own aspiration to study medicine. When he enlisted in the Air Force at the outbreak of World War II, she wanted to join the WACs or some other women’s military auxiliary, but she was forced to give up this project because of a sudden increase of phobic symptoms.

The conflict about her femininity and her identification with the brother was brought out in many revealing dreams during the analysis. Very often she dreamed of being pursued by men who threatened to kill her; she would flee from the man in fright, then gloat as he ran into a mortal danger, but she would finally rescue him from this plight.

At a certain phase of the transference situation, the patient had a dream in which she stood on a small, round platform at the top of a long, narrow, endless flight of stairs. The entire structure was suspended in mid-air in a vast, arena-like space. As she stood on top, she became frightened, nervous, heard a voice telling her to go down the stairs. She felt unable to move and, looking down, thought that nobody could walk down these stairs. But the voice was telling her to go down, to move. Finally, she figured out that by

sitting down she would gain more security: “If I were closer to the stairs, I would feel surer of myself.” She then imagined that there were railings, and very cautiously somehow she began to descend. She kept her eyes closed until she had moved down some distance. Opening them, she saw that the stairs were beginning to close up at the bottom and were growing nearer and nearer to her. Then she heard another voice, telling her to turn around and go back. She felt paralyzed and unable to release her hold on the rails. With great effort she managed to take her right hand off the rail and to grasp the other rail with both hands, attempting to turn around. She did not remember going up, but thought that somehow she had done so, for she remembered then lying on the platform at the top of the stairs and sobbing. At the same moment, the stairs seemed to twist like a snake, but they were stationary the rest of the time.

This dream, in which the patient’s phobic experience was minutely enacted, became fully understandable only through the analysis of another anxiety dream soon thereafter. This time no stairs appeared in her dream; the dilemma consisted in having to cross a bridge, but of being threatened with death if she did so. Her associations to this dream led to hitherto inaccessible childhood memories, including the recall of two decisive experiences at the age of five or six.

In the first memory, the patient remembered that she had slept in the

same bed with her parents. Half awake, she had witnessed intercourse between them. She remembered exactly how her mother had pushed her father away, saying to him: “Turn your back, it’s enough.” The father then had turned toward herself, put his arms around her, and touched her with his wet penis. She had been frightened, as if paralyzed, wanting to jump out of bed, to scream and holler at her parents, but being unable to do so.[12] This was all she could remember about this incident. But she immediately related the words spoken by her mother, “Turn your back,” to the dream in which an invisible voice told her to “Turn around and go back.” She was as paralyzed in the dream as she had been when lying in bed with her parents. It became clear that the movement of the stairs and the trembling of the platform represented the shaking of the bed during the parents’ intercourse.

The second memory concerned an incestuous game with her brother, which had taken place on several occasions near a window overlooking a bridge. While engaged in this forbidden sexual activity the little girl had guiltily looked through the window, watching lest someone should come.

Thus, the analysis of these two dreams showed that the bridge and the stairs were really interchangeable. Both were symbols crystalizing the conflict at the base of the phobia: desire and punishment for incestuous sexual pleasure.

This brief fragment from the patient's history and analysis has served to demonstrate the sadistic and self-punitive trends underlying the structure of her phobia. From a tender age she had harbored hostile and aggressive impulses, and the analysis revealed intense murderous wishes toward the brother, whom she had used in her incestuous play. Her guilt feelings and self-punishment were at the basis of her masochistic behavior.

The symbolism of the stairs, so often discussed by Freud, is especially transparent in the staircase dream supplied by Rank (and included only in Freud's last (1930) edition of *The Interpretation of Dreams).* It is interesting to note that the connotation of this symbol here is not static but kinetic, a concept described in Friedman's aforementioned paper. There, too, the bridge symbolism represents a dynamic process of crossing.[13]

Stairways and bridges seem to be closely connected and often used interchangeably. Both represent links (one vertical, one horizontal) between one place or condition and another. (For further relevant comments, see Friedman, Friedman and Goldstein.)

There are other sets of symbols presenting similar affinities; for example, all vehicles or all animals are respectively interchangeable. By the same token, an original monophobia may progressively spread to other objects belonging to the same associative or symbolic constellation.

Having noted before that virtually any object can become the object of a phobia, we may now add that any symbol can be used to express a variety of meanings. Taking the phobia of the elevator as an example, it may stand for a fear of the *claustrum;* it may stand for a fear of height; or it may, like any phobia involving means of locomotion, stand for a fear of sexualized sensations of equilibrium and space.

The foregoing considerations are of importance because they shed light on the obscurities behind the facade of the phobic symptom.[14]

While the psychoanalytic theory places considerable emphasis on symbolic substitution in phobic symptoms' formation, some authors, notably Rado[15] and Lief, stress the role of the "sensory context" in the acquisition of phobias. Indeed, phobic reactions may become attached to the "sensory context" of a traumatic experience, but upon closer scrutiny the latter may prove to be a precipitating rather than a causative factor. However, as previously suggested, there may well be some phobic reactions in which symbolic substitution plays a less prominent role and which correspond more closely to the model of avoidance learning.

Phobias in Children and Adults

Phobias "are *par excellence* the neuroses of childhood" (Freud). Indeed, there is scarcely a human being who has not, at some time early in life,

experienced fear of a phobic nature.

The case history of “Little Hans” is illuminating also because it demonstrates a typical causative factor which often gives rise to infantile phobias—the little boy’s castration fear. In girls we may find a corresponding factor in fantasies of previous injury to the genitals. Bornstein reports a case of this kind, where the child’s belief that her genitals had been injured produced a phobia as early as the third year of life.

Castration anxiety and its feminine counterpart, however, are by no means the only major source of childhood phobias. Symbolic threat of sexual attack plays an important pathogenic role in girls and in boys with passive homosexual tendencies. Moreover, phobic reactions in both sexes frequently originate in separation anxiety. Thus, Abraham reported a case of childhood agoraphobia that could easily be traced to the child’s desire to be with the mother, and observation which is corroborated by interpretations of agoraphobia by Weiss, Deutsch, and other psychoanalytic authors.

Separation anxiety seems to be responsible for a variety of phobic reactions which in recent years have received a great deal of attention under the general heading of “school phobia.” As suggested by Johnson et al., and corroborated by more recent studies, school phobia is a syndrome occurring under very definite circumstances which include: (1) “A history of a poorly

resolved dependency relationship between a child and its mother"; (2) an acute anxiety in the child, "produced either by organic disease or some external situation . . . and manifested in hysterical or compulsive symptoms"; and (3) a recent frustration or threat suffered by the mother, increasing her need to exploit the child's dependency relationship, with the result that separation from her when going to school becomes a traumatic experience.[16] However, separation anxiety is certainly not the only causal factor in school phobia,[17]

Because of the young child's identification with the important persons of his environment, we often find a predisposition to phobia in children of phobic parents. Hence the child psychiatrist may find it necessary to recommend treatment for his patient's parents in order to remove such pathogenic influences.

A childhood phobia may be a transitory disturbance or may continue into adult life. However, not all phobias start in childhood. In treating adult patients we are often confronted with the question whether the development of a phobic symptom actually represents a new disturbance or a reactivation of an earlier neurosis, a point that may be important in the choice of therapeutic procedures.

In a retrospective study of adult phobic patients, Marks and Gelder[18]

found that in the case of specific animal phobias the mean age of onset of the symptom was placed at 4.4 years, while the mean age of onset of specific situational phobias, social anxieties, and agoraphobia was placed much higher (22.7, 18.9, and 23.9, respectively). Because of the retrospective nature of the data these figures cannot, of course, be taken as representing anything more than a rough estimate of the age of onset. Moreover, the possibility cannot be excluded that those phobias which Marks and Gelder found to have a typically later onset may have been preceded by earlier related phobic manifestations that were either subsequently repressed, or not consciously connected with the later phobia. However, even after an allowance is made for this possibility, Marks and Gelder's findings corroborate clinical experience which indicates that animal phobias originate in childhood. It is of interest in this connection to note that the majority of the patients with animal phobias in Marks and Gelder's sample placed the onset of the phobia within the age range which corresponds roughly to the oedipal period. Some of the available evidence suggests that fears of large animals are especially prevalent in early childhood, and that, if anything, such fears tend to decline by the time the child has reached the age of four or five.[19] In the light of this evidence consideration should be given to the possibility that Marks and Gelder's subjects may have (on the average) developed their animal fears at an earlier age than their recollection indicates, but that the onset of the phobia tended to be retrospectively placed within the oedipal period because at that time

the fear may have acquired a new significance. (It should, of course, be noted that since the large majority of childhood animal phobias disappear spontaneously in the process of development, the cases studied by Marks and Gelder, in which animal phobias persisted for a number of years, are probably of more than average severity.)

Just as in the case of animal phobias, phobic fear of dental treatment in adults apparently also usually goes back to childhood. In a study of dental patients with dental phobias, Lautch found that in each of the thirty-four cases in his phobic sample there was a history of at least one traumatic dental experience in childhood. However, except in a few cases in which there was an earlier history of neurotic manifestations, two traumatic visits to a dentist were apparently needed for the development of the phobia. In the few cases with prior neurotic manifestations a single visit to a dentist was sufficient to establish the dental phobia. However, ten of Lautch's thirty-four control subjects (dental patients who did not have a dental phobia) also claimed a history of traumatic dental treatment in childhood.

Lautch's findings are particularly instructive in that they highlight in a statistical fashion the relationship between specific painful events and other factors in the development of dental phobia. On the one hand, it would appear —within the limits of Lautch's sample —that a traumatic dental experience in childhood is a regular (though perhaps not actually necessary) condition for

the occurrence of a dental phobia that persists into adulthood. On the other hand, Lautch's findings indicate just as clearly that such a traumatic experience is not sufficient for the development of the phobia. Since Lautch also found that dental phobics tended to have a lower pain threshold than did the control subjects, it is possible that this lower pain threshold contributed to their greater susceptibility to the development of the phobia as a response to the painful treatment experience. However, there is also the possibility (supported by some other aspects of Lautch's findings) that neurotic predispositions (possibly involving displacements from other areas) may have contributed to the formation of the phobic symptom. Finally, Lautch's findings suggest that repeated dental trauma may have a greater effect than a single such trauma in the development of the phobia.

It may further be observed that dental phobias differ from animal phobias in that relatively few of the children who develop animal phobias have had the experience of having been hurt by animals (though some of them, like "Little Hans," may have had the experience of being frightened by some event involving the subsequently feared animal). Moreover, a child who is hurt by an animal does not necessarily develop a phobia of that animal. Thus, Sperling reports a case of a two-year-old girl who was bitten by a dog and did not develop either a dog phobia or even a fear of the particular dog, but did develop (for other reasons) a spider phobia. Apparently the dog bite did not have in this case the kind of symbolic meaning that would lead to the

development of a dog phobia.[20]

Counterphobia

In some cases, a phobic fear is masked by an attempt to actively seek out the phobic situation. In its more moderate forms, a wish to face the phobic situation may represent in part a healthy desire to put the phobia to a test in the hope of mastering the fear. In its more extreme forms, however, the tendency to seek out the phobic situation represents an active attempt at denial of the fear, and it is also often tied up with self-destructive impulses, e.g., in the case of an individual with a masked height phobia who becomes a diver or a pilot. The term “counterphobia” has been used (e.g., by Fenichel and by Szasz) to refer to the condition which is characterized by such masking of phobic fears. It should be noted that the counterphobic is not satisfied with merely facing situations which the nonphobic individual does not fear, but rather seeks out situations involving real danger (which, however, fall along the same dimension as the underlying phobic fear).

Therapy

Psychoanalytic Approach

Except for the need for more active intervention at an appropriate stage of treatment, psychoanalytic therapy of phobias is guided by the same general

principles as is psychoanalytic therapy of other psychoneuroses. However, there is always some fluctuation and haziness in the manifest content of a phobia, and considerable probing may be needed before this manifest content can be accurately described.

In some cases of early childhood phobias it may be necessary for the therapist to include certain educational measures, such as explanation of the anatomical differences between the sexes, reassurance to the little girl that her sexual organ is intact, to the young boy that he is in no real danger of being castrated. In dealing with such infantile anxieties, the educational and the analytical part of the work cannot be rigidly separated. The cases reported by Bornstein' and by Sterba illustrate the need for some initial analytic work to determine precisely what the child fears or to establish a pattern of communication best designed to convey the needed reassurance.

Sometimes, symptoms can be eliminated by supportive measures alone. In some childhood phobias, for instance, such measures may consist essentially in accustoming the child gradually to the feared situation. Thus, it has been found that in some cases a child's fear of school can be gradually overcome if he is brought to the school every day but not forced to attend classes or to participate in any prescribed activities. Under these conditions "going to school," as such, becomes less threatening, and this decrease in the child's fear may then be extended to the specific object or situation on which

the phobia really centers.[21] However, in cases with a more deep-rooted disturbance such a simple procedure may not be sufficient. Moreover, one should be on guard against the error of assuming that compliance in school attendance is a sufficient indication that the phobia has been cured. As

Sperling has noted, the school-phobic child who attends school may develop substitute symptoms which sometimes take the form of psychosomatic complaints.

Particularly in the case of children who had previously attended school without such difficulty, the emergence of a school phobia can often be assumed to represent something other than a mere reaction to an unfamiliar school environment, although the latter feature may, of course, be involved in the child who has just been transferred from a familiar to an unfamiliar school setting. Moreover, the likelihood of a more severe disturbance which cannot be adequately treated through superficial measures becomes greater if there is evidence that the onset of the phobia has followed closely some traumatic event, such as actual or threatened object loss, or if there are some features in the family constellation which would tend to favor the development of a school phobia.[22] Psychological tests may also be helpful in distinguishing between the more superficial phobic disturbances which require a more basic type of treatment.

In children, as well as in adult patients, genuine phobias marked by a high degree of symbolic displacement require systematic psychoanalytic treatment. This method attempts to uncover the symbolic meanings of the symptom and to interpret changes in these meanings in terms of the changing transference situation.

Although the use of other techniques is sometimes imperative in order to provide early relief (e.g., from disabling phobias, as in the case of individuals whose fear of travel interferes with their ability to hold a job or even to undergo treatment), such symptomatic treatment does not necessarily obviate the need for a subsequent psychoanalytic exploration of factors which may have contributed to the phobia. This point is illustrated by a case reported by Kubie in which the emergence of a height phobia was precipitated by a homicidal fantasy which was directed against the patient’s wife. In this case the alleviation of the phobia (which was apparently accomplished by a non-psychoanalytic procedure) did not do away with the need for dealing with the patient’s hostility towards his wife. Without going into the details of the case it may be noted that the phobia first emerged while the patient was on a balcony of a chalet in the Alps, shortly after some events had taken place which had rendered obsolete his original motivation for his marriage, and that just prior to the experiencing of the phobic fear he had a fantasy of hurling his wife from the balcony. Thus, the hostile feelings towards his wife which were reflected in the phobia in a disguised form were

important not only from the standpoint of the genesis of the phobia but also in terms of the patient's current marital relationship. It would appear that problems of this kind—involving as they do complex and partly unconscious interpersonal attitudes—fall outside the scope of techniques which aim merely at elimination of the symptom as such.

In his paper, "Turnings in the Ways of Psychoanalytic Therapy," Freud stressed the necessity of exposing the phobic patient to the dreaded situation or object, and he warned that "one can hardly ever master a phobia if one waits till the patient lets the analysis influence him to give it up. He will never in that case bring for the analysis the material indispensable for a convincing solution of the phobia."

Therefore, it is often necessary for the analyst to intervene more actively and to insist that the patient brave the phobic situation. In this way, the full strength of the underlying conflict can be evoked in the associative material. Evidently, the analyst will await a propitious phase when the patient's positive transference may help to reduce the phobic fear. This more active intervention in the analysis of phobias constitutes an exception to the standard psychoanalytic procedure.

To give an example: An agoraphobic patient was referred to one of the authors (Friedman), after having been treated by several other therapists

over a period of several years. She had always been accompanied to their offices by her husband, and for a short time this arrangement was permitted to continue. But as soon as the transference situation appeared propitious the patient was requested to come alone. She complied readily, but had to telephone the analyst before each session to assure herself that he was expecting her. After a few months, she was even able to go unaccompanied to her place of work, although she still had to call the analyst very frequently to feel secure.[23] Her evident dependency needs and defensive devices, as well as the strong hostility underlying her dependency, could then be analyzed in the light of the transference situation. It thus transpired that the phone calls served to reassure the patient that her death wishes against the analyst as a transference object had not materialized. Her transference manifestations revealed the characteristic ambivalence toward identification figures which had been described by Deutsch, Katan, and other authors as among the basic factors in agoraphobia. It may be added that this patient's feelings of dependence displayed, in rather transparent form, a "linkage fantasy," whereby an identity between herself and the analyst (as symbolic parent figure) was asserted by magical means.

An adequate psychoanalytic approach to the interpretation and treatment of phobias must take cognizance of the fact that phobias are often multiply determined, and that an understanding of the origins of the phobic symptom often needs to be supplemented by a grasp (on the part of both the

therapist and the patient) of the role which the phobia plays in the patient's current functioning. Thus, a phobia may become intensified under conditions where realistic factors contribute to the general level of anxiety. It should also be noted that a phobia, such as a fear of heights, may play a self-preservative role in the case of a patient who has a self-destructive impulse to jump, and that when this is the case an increase in the strength of the phobia may reflect an increase in the strength of the suicidal impulse. In cases of this kind, the patient should not be encouraged to face the phobic situation until the therapist is reasonably convinced that the suicidal impulses are under control.

In some cases, secondary gains from a relationship of dependence on others—e.g., in the case of phobias which restrict the individual's locomotion —may contribute to the persistence of phobias whose origin is due to other factors. It is of interest to note in this connection that, according to the findings of a number of studies (for a summary see Andrews), dependence is a frequent characteristic of phobic patients. As the case on page 124 cited illustrates, the phobic need for dependence on others may also have a strongly hostile underlying quality.

Another type of contemporaneous influence consists in fluctuations in the patient's general level of anxiety. An existing phobia may become reactivated under conditions of stress. Fluctuations in the strength of a

phobia during psychoanalytic treatment cannot always be taken at face value as indications of changes in the severity of the disturbance. Thus, as Glover has noted, an apparent increase in the strength of a phobic symptom, after a date for termination of treatment has been set, may represent a transference reaction reflecting a wish for continuation of the therapy. As Glover points out, it may be necessary in cases of this sort to extend several times the tentatively set termination date until the patient is able to accept the termination without this type of reaction.

The length of time and amount of therapeutic effort needed for psychoanalytic or psychoanalytically oriented treatment of a phobia varies considerably. In some cases' the patient's acquisition of insight into the meaning of the phobia leads to the disappearance or substantial alleviation of the symptom, although further treatment may be needed to deal with the residual neurosis. In other cases a good deal of working through may be needed before the insight brings about a substantial alleviation of the phobic symptom. In still other cases, the phobias are extremely resistant to treatment. Among the patients whose phobias are so resistant to treatment there are some who have good intellectual insight into the origins of their fears.[24] In general, it would appear that the ease of treatment of a phobia is inversely related to its duration (and particularly to its continuity since childhood), as well as to the patient's over-all degree of disturbance. At least in the case of young children, prompt psychoanalytically oriented

intervention after the phobia has first made its appearance in response to emotional stress can sometimes result, as Sperling’s findings illustrate, in a prompt disappearance of the symptom. On the other hand, a phobic symptom may be extremely difficult to treat if it is part of a long-standing obsessive or schizophrenic pattern.

Since phobic patients realize the irrationality of their fears, direct suggestive therapy is not effective. Sometimes, it may even strengthen the patient’s guilt feelings, or intensify his hostility to the therapist or resistance to the treatment. And when such attempts at rational persuasion seem successful, this is usually due to rapport rather than to logical reasoning.

(For further material relevant to the psychoanalytic theory and treatment of phobias see Alexander, Eidelberg, Feldman, Fenichel, Freud, Little.)

Behavior Therapy

In contrast to psychoanalytic and other dynamic approaches that view neurotic symptoms as a function of inner conflict, the behavior therapy approach—at least in its more orthodox forms—views neurosis as essentially nothing more than a set of maladaptive habits. Although there are important differences among these orthodox exponents of behavior therapy both with regard to the learning theories they espouse and the specific therapeutic

procedures they favor, they all share a view of the therapeutic process as involving either unlearning of maladaptive habits, or as learning of new habits that would render the maladaptive habits ineffective. Most of them also reject the notion of displacement, and regard insight on the part of the patient as irrelevant to the success of the treatment. Although they grant that psychoanalytic treatment can sometimes result in symptom alleviation, they maintain that this is due to the operation of principles of learning which are accidentally built into the procedure (e.g., to "extinction" of fear responses, which presumably takes place when thoughts which previously gave rise to anxiety are verbalized without punishment), rather than to anything specific to the psychoanalytic approach.[25] The behavior therapy approach to phobias has by now become the subject of a voluminous and rapidly growing literature. (For an extensive bibliography see Eysenck and Beech.)

One of the techniques of behavior therapy widely used in the treatment of phobias is the technique of *progressive or systematic desensitization* developed by Wolpe and derived in part from his earlier experiments with cats. This technique is based on the assumption that fear of the phobic object can be reduced by confronting the subject with a succession of objects representing increasing degrees of phobic threat under conditions of deep muscle relaxation, which presumably inhibits anxiety. (The notion that deep muscle relaxation inhibits anxiety is derived by Wolpe in part from Sherrington's concept of reciprocal inhibition which, however, originally

referred to pairs of antagonistic muscles, rather than to emotional states.)

In the usual desensitization procedure the graded intensities of phobic threat are presented indirectly by asking the subject to imagine relevant situations or objects (stairways, bridges, etc.), or (sometimes) by showing the subject pictures of such situations or objects. Sometimes, however (e.g., in the case of subjects who have difficulty in complying with the instructions to visualize), real objects are used—a procedure known as desensitization *in vivo.* The (real or vicarious) graded series of objects—or a "hierarchy," as it is called—presumably corresponding to different intensities of the subject's fears is usually established on the basis of interviews with the subject and/or of the subject's questionnaire response obtained prior to the initiation of the desensitization procedure. Before the initiation of the desensitization series, the subject is also taught the technique of deep muscle relaxation. Sometimes, hypnosis or a drug is used to help the patient reach the relaxed state, but neither is essential to the procedure. Some findings, e.g., suggest that muscular relaxation is also not essential for desensitization, but that desensitization is favored by a psychological state of calmness.

Inasmuch as the procedure rests on the assumption that the experiencing of the previously feared situation under conditions of no anxiety (or, more precisely, minimal anxiety) is the crucial factor in the elimination of the phobic fear, the subject is instructed to interrupt the presentation

whenever the anxiety becomes too disturbing. When this happens, the therapist shifts to a less disturbing item. This procedure is kept up (often in a series of sessions) until the patient can face with relative freedom from anxiety the most disturbing item in the hierarchy.

Sometimes, more than one hierarchy is used either to deal with several symptoms (each of which is treated separately) or to deal with several “dimensions” of fear involved in a given symptom, as determined in the interview. Thus, if a patient is afraid of steep stairways in narrowly enclosed areas the fear of steepness may be dealt with through one hierarchy and the claustrophobic aspect through another hierarchy.

As a rule, at least when the procedure is carried out for research purposes, an attempt is made to minimize the role of therapist-patient interaction. In some cases, this has involved the use of tape-recorded instructions in lieu of a live therapist during the desensitization sessions.

In recent years, a vast literature on desensitization has accumulated and various modifications of the procedure have been introduced, in addition to the variations already noted. Thus, in lieu of muscular relaxation, Lazarus and Abramovitz have used a procedure which involves instructing the subject to imagine pleasant objects in alternation with the items in the anxiety-arousing series, on the assumption that pleasant moods will reduce the anxiety level

aroused by the feared object. The desensitization procedure has also been adapted to group therapy. Behavior therapy techniques based on principles other than desensitization have also been employed. (For discussions of other techniques of behavior therapy, some of very recent origin, see Rachman, Marks, Wells, Gurman, Orwin, Edlund, Lang, Migler and Wolfe.)

Exponents of behavior therapy, such as Eysenck, have emphasized the link between behavior therapy and learning theory in claiming for the former the status of an approach solidly based on science.[26] However, as critics of behavior therapy (e.g., Breger & McGaugh-) have pointed out, there is no one generally accepted theory of learning. Moreover, the assumptions of learning theory typically utilized by behavior therapists often represent oversimplified or outdated models, and their use of analogies based on animal experimentation is often questionable in its applicability to human neurosis.[27]

Critics (e.g., Locke) have also pointed out that the procedures of behavior therapy are much less behavioristic in fact than they are in principle. (In this connection see also Wilkins, Wilson and Davison, and Grossberg, Andrews.) For instance, the behavior therapist relies on the patient's introspective accounts to determine the nature of the phobia and to establish the fear hierarchy, and except when *in vivo* procedures are used, he also relies on imagery, rather than on manipulation of external physical variables, to

provide the hierarchy of “stimuli.” Moreover, except in special instances, he uses the patient’s reports rather than direct physical observation or physiological measurement to evaluate the degree of relief from anxiety. It has also been noted, e.g., by Weitzman, that such verbal reports are used by Wolpe primarily to provide data about the subject’s psychological state, rather than as an indirect way of obtaining information about physiological manifestations of anxiety. Moreover, case reports by behavior therapists indicate that they occasionally resort to persuasion and to educational measures which, strictly speaking, fall outside the scope of behavior therapy as usually defined. This line of criticism does not necessarily imply that the procedures as such are objectionable. It does imply, however, that whatever effectiveness these procedures might have may be due to factors other than those envisaged in the theoretical formulations of behavior therapists.

The available evidence suggests, moreover, that the psychological processes involved in imagining the object suggested by the therapist are in reality much more complex than the behavior therapist assumes. In theory, the patient is supposed to turn on the image when he is instructed to do so by the therapist, and to hold it until he is instructed to turn it off; but Weitzman’s findings suggest that the patient’s imagery under these conditions tends to undergo continuous changes, somewhat in the nature of free association. It thus appears possible that, at least in some cases, progressive desensitization produces significant psychological effects for reasons that are not necessarily

related to the rationale of the procedure.

The effectiveness of a therapeutic procedure is, of course, not always dependent on the validity of its theoretical underpinnings. In the case of behavior therapy, a considerable degree of success in short-term treatment of phobias has been claimed in various research reports, although some of these reports, e.g., Evans and Liggett, indicate that certain kinds of phobias, such as agoraphobia, have been more resistant to this form of treatment. One of the claims frequently made in this connection is that in the large majority of cases symptom removal has not resulted in the substitution of some other symptom.[28]

Although in some of the studies behavior therapists have made a special effort to minimize the effects of patient-therapist interaction, the possibility cannot be excluded that transference, as well as patient expectations of successful cures, may have played a role in some of the favorable outcomes. It should be noted in this connection that an impersonal attitude on the part of the therapist does not necessarily prevent the patient from creating fantasies in which the therapist is endowed with a special significance.

Moreover, in evaluating the reports of successful treatment of phobias by behavior therapists it is important to bear in mind that the selective factors that make up the patient population with which they deal are often

quite different from those operative in the selection of patients for psychoanalytic or other dynamically oriented forms of therapy. In a number of studies the behavior therapy patients were students whose phobic symptoms were discovered by means of questionnaires administered to college classes, and many of whom would probably not have sought treatment for these symptoms if they had not been offered such treatment as research subjects; moreover, in some of the studies, the phobias dealt with (e.g., snake phobias) were such as to have little, if any, maladaptive significance in the subjects' environment. In contrast, the phobic patients studied by psychoanalysts and other dynamic therapists are generally individuals who have actively sought treatment (or, as in the case of young children, have been brought to treatment) because of disturbing presenting symptoms. Consequently, it is to be expected that the latter group would tend to have a larger proportion of individuals with more severe disturbances that may require more complex treatment. It may also be conjectured that those college students who accept the offer of treatment tend to have favorable expectations of the outcome of treatment, and that this itself contributes to a positive result.

In the light of some of these considerations it would appear that whatever success is achieved in the treatment of phobias through the use of progressive desensitization can be reinterpreted in cognitive terms, and also in terms that allow for the operation of unconscious processes. (Thus, it may

be supposed that the reassurance gained through the experiencing of the phobic object in a protected setting is operative both on conscious and on unconscious levels.) As regards the role of free associations, Weitzman's findings clearly indicate that the processes of desensitization cannot be adequately understood without taking such associations into account, but considerably more research will need to be done in order to determine (a) to what extent such associations contribute to the therapeutic process; (b) whether there is anything specific to the desensitization procedures which contributes to the value of free associations in this context; and, (c) assuming that the answer to the preceding question is in the affirmative, whether anything can be done to develop new techniques that would make optimal use of such findings.

Implosive Therapy

In contrast to desensitization, which involves gradual habituation to the anxiety-arousing situation under conditions where the subject is presumably protected against the impact of the anxiety, the implosive or "flooding" technique'" involves the use of massive exposure (though usually in imagination rather than *in vivo*) to the phobic object (or to the presumably repressed fear objects which the phobic object is assumed to represent).

Implosive therapy is usually classified as a form of behavior therapy

because its rationale is derived from a learning-theory model. However, unlike the more typical behavior therapy approaches, the implosive therapy approach also makes use of some psychoanalytic concepts, including the distinction between the manifest and the repressed objects of anxiety. In line with the foregoing, the implosive approach also rejects the behavior therapists' claim that a neurosis consists merely of the symptoms.

The learning theory model underlying implosive therapy is that of extinction of traumatic avoidance reactions. As used in conditioned-response literature, the term "extinction" refers to a decrease or disappearance of a previously conditioned reaction as a consequence of presentations of the conditioned stimulus without the unconditioned stimulus. In the case of avoidance reactions, the unconditioned stimulus is a noxious stimulus, such as electric shock. With minor modifications, the foregoing definition of extinction would also apply to the "instrumental" learning situation in which the noxious stimulus is contingent on the completion of some act by the subject. According to experimental findings with animals, learned avoidance reactions are extremely difficult to extinguish under conditions where the animal is free to avoid or escape the situation in which the noxious stimulus was originally administered; but (with some exceptions which are not as yet well understood) extinction tends to proceed much more easily if the opportunity for avoidance is blocked and the animal is, so to speak, forced to subject its fear to "reality testing."

While the principle of extinction of anxiety responses appears simple when stated in an abstract fashion, its application to concrete clinical situations presents some complications. In the first place, there is, as in the case of desensitization, the question as to whether the image evoked in response to the therapist's instructions is functionally equivalent to an external phobic object. (On the analogy of Weitzman's findings with respect to desensitization, it seems plausible to conjecture that the instructions given in implosive therapy similarly tend to give rise to a chain of associations in which the visual image does not necessarily remain stable.) It may also be noted that, according to some findings, e.g., Barrett, implosive instructions occasionally give rise to "run-away" imagery which continues beyond the therapy sessions. Moreover, even if one disregards the foregoing problem, it may be difficult in practice to draw a sharp line of demarcation between anxiety-arousing experiences which might theoretically be expected to lead to the "reality testing" of existing fears, and those which might lead to the development of new fears. In this connection Bandura has drawn a distinction between imaginal evocation of the phobic object as such, and imaginal evocation of disastrous consequences of an (imaginal) evocation of the phobic object or situation. (This distinction may be exemplified, in the case of a stairway phobia, by the difference between the subject's being told to imagine that he is walking down a steep stairway, and his being told to imagine that he is falling from the stairway or that the stairway is collapsing.) Bandura

suggests that the latter type of imaginal evocation may have the effect of extending rather than reducing the fear, particularly if the noxious consequences had not previously been envisioned by the subject, and he notes that the procedures used in such evocation resemble closely the procedures used in aversion therapy.[29] Of course, the therapist who instructs the patient to imagine the phobic object might find it difficult in some cases to prevent the emergence of imagery representing noxious consequences of the phobic situation.[30]

Similarly, it has been conjectured by some investigators that instructions to imagine the phobic situation along with the fear reaction and its somatic accompaniments may be quite different in its effects from instructions which specify the phobic situation but not the fear and its somatic accompaniments (see page 130). Actual studies which have utilized instructions intended to arouse highly noxious imagery, including imagery involving somatic accompaniments of fear, have yielded conflicting results.

Staub has attempted to reconcile these conflicting results by citing evidence which suggests that flooding procedures tend to be more effective with longer intervals of continuous exposure to imaginal stimuli. He conjectures that longer exposure exerts this effect through reduction of the intensity of the physiological accompaniments of the fear reaction during the exposure interval, and through providing the human subject with an

opportunity to realize that the adverse consequences are not forthcoming. While Staub’s argument deserves serious consideration, there is reason to believe that it involves an oversimplified view of the processes involved in implosion. Thus, as already noted, it is by no means clear that the duration of the imagined stimuli can be controlled through instructions with any degree of precision. Moreover, Staub’s formulation takes no account of individual differences in reactions to implosive instructions. However, other interpretations of the conflicting results are also possible. It is perhaps of relevance to note that the main negative results thus far were obtained in a study which dealt with the spider phobia, while some of the positive results came from studies using other phobias, such as the snake phobia. Perhaps the deeper level of regression in the spider phobia is the factor that accounts for the negative results.

By way of summary, it can be stated that the implosive technique offers some interesting possibilities for further research, but that as of now the factors that make for success or failure in implosive treatment of phobic symptoms have not been sufficiently elucidated. In addition to the factors already mentioned, the role of the patient’s attitude towards the therapist and towards the imaginal task, as well as of subtle factors in patient-therapist interaction, needs to be systematically explored.

Modeling and Related Techniques

This procedure consists in having the phobic subject observe another person (the "model") perform the phobic act (e.g., playing with a dog, in the case of a dog phobia) in a fearless manner and without aversive consequences. One of the major assumptions underlying this procedure is that such viewing results in a "vicarious" extinction of the fear.

As already implied, some of the key concepts used by proponents of modeling, e.g., the concept of extinction, are derived from conditioned response terminology. However, since the postulated fear reduction in the observing subject is presumably mediated by a change in attitude towards the feared object, rather than by direct extinction of the avoidance responses, the modeling procedure can be more adequately classified as representing a cognitive rather than a behavioristic approach. (Of course, as already noted, the behavior therapy approaches are also not consistently behavioristic). It should, however, be noted that some of the major proponents of modeling share the behavior therapists' opposition to the concept of symbolic displacement as applied to neurotic symptoms.

As in the case of desensitization, the modeling procedure often involves a progression from the less feared to the more feared act. A less gradual exposure to the phobic stimulus would presumably result in an increase rather than a decrease of anxiety.

Insofar as modeling involves providing the subject with visible evidence that the feared object is not in fact dangerous, it may appear to represent a form of persuasion, which, however, is implicit rather than explicit. Such a view, if it should turn out to be correct, would run counter to clinical experience which indicates that persuasion is largely ineffective in the treatment of phobias. However, the evidence suggests that something other than persuasion, in the usual sense, is at least in part involved in the treatment of phobias through modeling. One reason for this supposition is that most adult subjects are already convinced of the irrationality of their phobias by the time they come for treatment. It thus appears plausible that the visual factor involved in the experience of seeing the phobic act performed by another person without adverse consequences has an effect over and above its rational function of providing evidence that the feared act is not dangerous. Perhaps something in the nature of empathy or identification is involved here.

The available evidence' suggests that modeling can be quite effective as a means of alleviation of some phobic fears, such as fears of dogs in children, and that its effectiveness can be enhanced when it is used in conjunction with other techniques, such as desensitization or physical guidance of the subject in the performance of the feared act.

A procedure known as contact desensitization and utilizing a

combination of modeling, desensitization, and physical aid in the performance of the phobic act, has been developed by Ritter, who has used it with some degree of success in the alleviation of acrophobia in a nonpatient sample. Ritter's findings indicate that physical contact with the experimenter while facing the phobic situation was a significant factor in the success of the procedure. In this connection, it seems plausible to assume that the physical contact may have had for some of the subjects psychological significance beyond that of physical protection against the danger of falling.

Ritter's study is of considerable interest because it is one of the very few systematic studies indicating that a space phobia can be alleviated by a procedure that does not involve exploration of the origins or individual meaning of the fear. However, Ritter herself explicitly avoids the claim that her procedure has succeeded in eliminating the phobia.[31]

Existential Therapy

In sharp contrast to learning-theory approaches, which view human personality in strictly deterministic terms, existential psychiatry places a great deal of emphasis on man as a free and responsible agent. In spite of this wide difference in theoretical starting points, the best known technique for the treatment of phobias to have come out of the existential school—Frankl's method of *paradoxical intention*—bears a considerable resemblance to

implosion, and more specifically to the type of implosive therapy that involves imagining disturbing consequences of the phobic situation. However, while implosive therapy typically makes use of imaginal presentation of the feared object, the method of paradoxical intention is usually applied *in vivo*.[32]

The technique of paradoxical intention consists essentially in having the patient make a voluntary effort to magnify his fear reactions, such as sweating or acceleration of the heart rate, in the phobic situation. Frankl makes the assumption that the attempt to augment physiological reactions will fail, but that in making the attempt the patient will attain a greater distance from his phobic symptom, and that he will derive a therapeutic benefit from his ability to laugh at himself in this situation. (Frankl credits G. W. Allport with the notion that the patient's ability to laugh at himself represents the first step toward the cure of neurosis). In part, Frankl's rationale is also based on the (correct) assumption that phobic anxiety is increased by the effort to resist it. One of the examples of this approach is provided by a patient of Gerz, who feared a heart attack, and whose fear was relieved after he was told by the therapist to try to accelerate his heart rate so as to produce a heart attack.[33]

Frankl recognizes that the method of paradoxical intention is not applicable to all phobias, but he insists (and here there is a definite parallel to behavior therapy approaches) that the success of the method is not dependent on the personality of the therapist or on a correct understanding

of the history of the phobia. He reports, however, that recall of the traumatic events sometimes occurs *after* the technique of paradoxical intention has brought relief.

It would appear that Frankl's method is primarily applicable in those cases where the phobia is not so severe as to prevent the patient altogether from facing the phobic situations, and apparently also in some cases, e.g., fear of a heart attack, in which the phobic object is internal and thus cannot be avoided. On the other hand, it may be conjectured that there are some phobias in which the application of the method would be quite dangerous. For instance, encouraging an acrophobic patient to amplify his fears while he is walking down a steep stairway might well lead to a loss of control, which in turn might result in falling. Such a procedure would be especially contraindicated in cases where there is reason to believe that the acrophobia is overdetermined by unconscious or preconscious suicidal tendencies. As a general rule, paradoxical intention should not be applied in those cases where there is reason to believe that loss of control resulting from the amplified fear reaction would represent a realistic danger to the subject.

Although other existential therapists have also dealt with phobias, there is no one theory of phobias, or of treatment of phobias, that could be said to characterize the existential school as a whole. One theme which is encountered in the writings of several existentialists and phenomenological

psychiatrists involves the notion that a phobia, such as a claustrophobia or an agoraphobia, reflects the individual's way of perceiving visual space, and, in a more general way, of seeing his relationship to the world. While some of these authors interpret this relationship in terms that are at least broadly consistent with psychoanalytic notions of symbolic representation, others, especially Boss, reject the notion of symbolic displacement, and maintain that there is no real distinction between the symbol and that which is symbolized. On a more concretely empirical level, Colm, who makes extensive use of psychoanalytic concepts, has presented some interesting insights, e.g., concerning the role of parental insecurity in the genesis of phobias in children, and has also outlined some of the implications of these insights for the therapy of children's phobias.

Hypnotherapy

The use of hypnosis in the treatment of phobias includes a variety of techniques, which may be thought of as ranging on a continuum from those aiming more or less exclusively at symptom relief (with little or no reference to the genesis of the symptom) to dynamically oriented approaches, which include measures directed at symptom relief, but which place this aim in a broader context. At one end of this continuum are techniques that utilize the therapist's authority to reassure the patient against the phobic fear or to command the patient to perform the feared act. At the other end of the

continuum are the approaches that involve intensive exploration of the genesis of the symptoms and seek to facilitate the development of insight. The development of techniques of hypnotic age regression has contributed significantly to the range of techniques available for intensive hypnotherapy. In contrast to the techniques that rely primarily on authoritative suggestions, these more intensive techniques may require a much more prolonged effort, at least in some cases, although the time involved would still be considerably below that required for psychoanalytic treatment.

In addition to hypnotic therapies proper hypnosis is also used as an adjunct to other techniques in the treatment of phobias, e.g., as a means of uncovering repressed material for subsequent use in the waking state, or as a means of inducing a state of relaxation.

Hypnotic treatment that relies primarily on authoritative suggestion or on positive transference can sometimes produce prompt and spectacular results. But as long as the underlying conflict remains untouched, the patient is prone to develop a new phobic symptom.[34] However, according to clinical reports thus far available, the more dynamically oriented forms of hypnotherapy tend to result in more durable improvement, including symptom relief.

A detailed description of a dynamically oriented hypnotherapy of a case

with phobic symptomatology has been published by Freytag, whose volume includes an introductory comment by Erickson. A detailed discussion of Freytag's procedure would fall outside of the scope of this presentation. However, since one of the features of her procedure involves the use of desensitization, it will be instructive to compare her use of desensitization with systematic desensitization as used by Wolpe, discussed earlier.

The significant common feature of the two procedures is that they both involve gradual exposure to phobic stimuli of increasing intensity under conditions of reduced anxiety, with provision for interruption of the series whenever there is an increase in the anxiety level. One of the major differences between the procedures is that in Wolpe's technique desensitization is the major focus of the therapy, while in Freytag's approach desensitization is a technical device which is used when an appropriate situation presents itself, but which has meaning only within a larger context that includes hypnotic regression, etc. A second difference consists in the fact that instead of using a prearranged hierarchy Freytag applies the desensitization procedure to material which emerges in the hypnotic trance, and which is presumably significant in relation to the genesis of the phobia.[35] A third difference is that in Freytag's procedure the desensitization is applied to hallucinated material rather than, as in Wolpe's procedure, to images, which, one gathers, are clearly distinguishable in their phenomenal qualities from perception of reality. (As previously noted, Wolpe occasionally uses

desensitization *in vivo.* The *in vivo* technique does not, however, always permit the same degree of control by the therapist as does the hypnotic procedure. For instance, it would not be feasible to have a patient with a bridge phobia walk through a series of bridges of various lengths.) As Erickson points out in the introduction to Freytag's book, hypnotically induced hallucinations are less subject to artifacts due to the subject's attitudes than are waking images produced as a result of instructions. To use Erickson's example, a subject who is told to imagine that he is cold while the weather is hot in reality might experience the request as artificial or absurd, but this problem would not arise for the subject in a deep trance, who would feel the cold temperature as if it were really there. A fourth point of difference pertains to the role of post-hypnotic amnesia; one gathers from Wolpe's case reports that he makes no effort to induce amnesia for the treatment. On the other hand, post-hypnotic amnesia plays a major role in Freytag's procedure. In this connection, Freytag expresses the view that the amnesia makes it possible for the patient to avoid a good deal of unpleasant experience which would otherwise be associated with psychotherapy.

The results reported by Freytag and by Erickson are quite impressive. However, since very few studies dealing with intensive psychoanalytically oriented hypnotherapy of phobias are thus far available, the range of applicability of the method still remains to be determined. (One may note here that Freytag's patient had had some psychoanalytic treatment before

entering hypnotherapy. Although this treatment apparently had not brought about a major alleviation of the symptoms, it may very well have contributed to the subsequent progress of the hypnotherapy.) The fact that a deep trance is required for this approach would, of course, preclude its application to patients who are unable or unwilling to attain such a trance. Moreover, further research is needed to explore the possibility of undesirable side effects, such as the development of excessive dependence on the therapist, in this form of treatment. Also, the advantages and disadvantages of posthypnotic amnesia as a feature of intensive hypnotherapy of phobias represent a problem which is in need of further investigation. One may wonder whether the insight attained in the trance can become optimally utilized if it is dissociated from the conscious personality. In the case described by Freytag the treatment took place entirely while the patient was in the trance state, except, of course, for the initial explanation of the procedure and for the procedure involved in getting the patient into and out of the trance at each session. However, this is not necessarily always the case in psychoanalytically oriented hypnotherapy. Sometimes, for instance, recordings of material obtained in a trance and then subjected to post-hypnotic amnesia are played back to the patient while he is in the waking state.

(For a recent study utilizing hypnosis in the reduction of phobias see Horowitz.)

Closing Comments

A wide range of techniques is now available for the relief of phobic symptoms. However, even though symptom relief obtained through short-range measures may lead to more general therapeutic benefits, such as an increase in ego strength, it does not obviate the need for more intensive dynamically oriented therapy in many of the cases where a deeper longstanding disturbance is involved. On the other hand, as Kubie's previously cited case illustrates, the use of short-range measures to relieve a severely disturbing or disabling phobic symptom is not inconsistent with subsequent psychodynamic exploration of the meaning of that symptom.

At the moment, the practical knowledge of techniques that can be used to alleviate phobic symptoms outstrips the theoretical understanding of how the various techniques work. To be sure, there is no dearth of theories which attempt to explain how these techniques work, but, even apart from the specific criticisms that have been advanced against some of these theories, the very diversity of the techniques that apparently work in some cases leads one to suspect that the reasons for whatever effectiveness some of them might have may be quite different from those postulated by some of the theories. Thus, we know that phobic symptoms have been successfully treated both by techniques that attempt to minimize anxiety in the presence of stimuli resembling the phobic object and by techniques that involve

massive exposure to anxiety-arousing stimuli. And, to complicate matters still further, we also know from at least one study that administering an electric shock while the subject imagines the feared object can also lead to the mitigation of a phobic symptom. While it would be tempting to ascribe the apparently successful use of these various methods to the “placebo” effect involving interaction with the therapist, and perhaps also to the expectation of success, such a conclusion is rendered unlikely by the findings of various studies which utilized “pseudo-therapy” control groups. These control group data indicate, on the whole, that little or no improvement occurs when the interaction with the therapist involves no attempt at treatment. (Of course, the nature of the problem precludes the use of a double-blind design in which neither the therapist nor the subject would be able to differentiate between the experimental and the control procedure.)

The phobic patient, more than any other neurotic, can become a faithful ally of his therapist in the struggle against his ego-alien and tormenting symptom. His need for dependency and protection, and his will to recover, offer excellent chances for successful treatment, if it is undertaken in the early stages of the illness. But only the therapist’s skill and understanding of the dynamics will enable the patient to overcome his resistance and to give up his neurotic defenses.

The ambivalent struggle of an agoraphobic patient, as she anticipated

her first unaccompanied visit to her therapist's office, was expressed in the following verses:

Which Epitaph Shall Be Mine?

She couldn't try

For fear she'd die;

She never tried

And so she died.

or

She couldn't try

For fear she'd die;

But once she tried Her fears—they died.

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Notes

1 The term “claustrophobia” was introduced in the same yar (1877) by Raggi.

2 Limitations of space prevent a more detailed exposition of Janet’s hypotheses, which originated in Charcot’s theory of the hypnoid states of hysterical patients.

3 Quite apart from these differences in interpretation, the available evidence suggests that some fears which typically manifest themselves at particular developmental stages cannot easily be reduced to the traumatic avoidance model. One is the fear of visual patterns which simulate the danger of falling. The available findings indicate that this fear is typically present in an intense form in sighted human infants by the age of six months. Some of the evidence suggests that this fear reaction is not yet present in the two-month-old infant who—as far as can be determined from behavioral and physiological indications—typically reacts to a similar optical pattern with curiosity rather than fear. Since some

animal species display a fear reaction to comparable optical patterns within a day after birth (without the benefit of experience of the kind envisaged by the conditioned avoidance model), a plausible case can be made for the assumption that maturation plays a role in the development of this fear reaction in the human infant. However, there is reason to believe that improved cognitive grasp of the properties of perceived space also plays a role in the emergence of this fear. It should, incidentally, be noted that the six-month-old infant's fear of the danger represented by the visual pattern is quite realistic, though in the experimental situation the infant is protected against the actual dangers of falling by a transparent surface.

It may be conjectured that this early fear of the dangers of downward extension is one of the factors which may contribute to the subsequent development of height phobias in some persons.

4 Problems of differential diagnosis of phobias by means of the Rorschach test are discussed by Schafer, by Klopfer and Spiegelman, and by Deri.

5 Von Monakow derived the appellation of this acute anxiety state from the Greek kakon = evil.

6 In a volume published in 1956, Laughlin noted that syphilophobia, common in the 1920s, had since become extremely rare and was by 1956 being encountered only in association with schizophrenia; and that, in contrast, the frequency of phobic fears of cancer had apparently risen. These changes, he pointed out, seem to have paralleled changes in the relative danger from the two diseases, and also have reflected the greater publicity "recently" (as of 1956) given to cancer. On the other hand, he notes that the popularity of some phobic objects—water, heights, closed spaces, open spaces—had apparently remained unchanged during the same period.

In the interval since the publication of Laughlin's remarks, VD rates had again risen, and in response to the rising VD rates anti-VD educational efforts have become intensified. During the same period, beginning approximately with the publication of the Surgeon General's 1957 statement on the subject, wide publicity has been given to the relationship between smoking and cancer. Whether these factors have had an effect on the incidence of syphilophobia and cancerophobia is a question that cannot be answered at this time. It can, however, be stated that water, heights, closed spaces, and open spaces still remain among the frequent phobic objects.

7 Dixon et al.2i& (1957) maintain that it is "both incorrect and misleading" to consider phobias as isolated symptoms, and that "any apparent specificity of the complaint may in fact be due to unconscious displacement." While the statistical analysis presented by these authors is highly interesting and instructive, exception must be taken to their conclusion that the phobia is not a distinct entity. The fears dealt with in their study seem to be symptoms of various clinical conditions.

8 Actually the fear that a horse might fall reflects the hostile feelings more closely than does the fear of being bitten by a horse. However, here also the hostility is masked through projection.

9 According to Fenichel, even "the physical state of sexual or aggressive excitement" may be projected and experienced in sensations of equilibrium and space. (Whether this kind of projection can still be characterized as anxiety hysteria seems doubtful.)

10 It may be relevant, in this connection, to note Abraham's comment that the fear of walking in the street usually occurs in persons who are also afraid of being left alone indoors. The common feature of the two situations is seen in the fact that "the unconscious of such patients does not permit them to be away from those on whom their libido is fixated," and that "any attempt by the sufferer to defy the prohibitions set up by his unconscious is visited by an anxiety state." Thus, in the cases covered by Abraham's generalization, the term "agoraphobia" describes only one aspect of the manifest phobic picture.

11 Freud's interpretation of "Little Hans's" phobia in terms of symbolic displacement of oedipal strivings has been challenged by Wolpe and Rachman and by Bandura who interpret Hans's fear of horses, as well as phobias in general, in terms of conditioning. The general position of the Wolpe and Rachman paper is also applied by Rachman and Costello to several other psychoanalytic studies of childhood phobias (specifically, to the studies by Bornstein. and by Schnurmann).

This is not the place for a detailed critique of Bandura's, Wolpe and Rachman's, and Rachman and Costello's formulations. A brief comment is, however, in order. Noting that "Little Hans" was afraid of one horse pulling a heavy vehicle but not of two horses pulling such a vehicle, Bandura attributes this difference to the greater similarity of the former to the external conditions present in the traumatic situation, i.e., the occasion on which "Little Hans" saw a horse fall. While Bandura assumes that on the occasion in question the vehicle was driven by one horse, a reference to Freud's paper indicates that the vehicle was reportedly being driven by two horses on that occasion. Thus, at least with reference

to this one variable (number of horses pulling a heavy vehicle), the data show exactly the opposite of what one would expect if the degree of similarity to the traumatic situation were the only relevant factors.

12 This dream and its interpretation were previously reported by Friedman in a paper on bridge symbolism.

13 Gerhart Hauptmann, in his book Griselda, makes use of the symbolism of stairs, giving it also a sexual meaning. This was cited by Reik in The Secret Self.

14 For a theoretical formulation stressing other symbolic meanings of fear of heights, see Bergler.

15 Rado, S. "Emergency Behavior, with an introduction to the dynamics of conscience," in P. Hoch and J. Zubin Anxiety New York: Grune & Stratton, 1950. pp. 150-175.

16 Katan has suggested that a mild form of agoraphobia may be considered a normal phenomenon in the development of the adolescent girl.

17 An interesting manifestation which at one level might be regarded as a school phobia, but which in reality was merely a reactivation of an earlier and more idiosyncratic phobic structure, is reported in Freud's case history of the "Wolf Man." This patient, while in school, developed a fear of a teacher who was quite critical of him and whose name happened to be Wolf. As the patient had had a wolf phobia (or, more precisely, a fear of a picture of a wolf drawn in a particular position) in early childhood, the teacher's name apparently reactivated some of those early fears. Even much later in life the patient reacted with panic when he consulted a dentist named Wolf.

School phobia, which represents a genuine anxiety reaction to the school situation, should be carefully distinguished from other personality factors which make for poor school attendance. The available evidence suggests that in the large majority of cases school truancy is due to a combination of interdependent factors, including in varying degrees a low level of interest in school learning, a low level of achievement motivation, a lack of basic skills needed for meaningful participation in school work, and to oppositional attitudes toward the authority figures represented by the school. Sometimes, the pattern may be complicated by drug use (and by participation in a drug subculture which draws much of the individual's attention away from normal school activities) or by glue sniffing (in the case of younger children). In contrast, the school phobic child tends to be above average

in intelligence and average or higher in achievement. There are, however, some cases of school phobic adolescents whose achievement level is extremely low, though their intelligence may be average or higher.

18 Marks, I. M. and M. G. Gelder. “Different Ages of Onset in Varieties of Phobias,” Amer. J. of Psychiatry, 12 3 (1966), 218-221.

19 It should be noted that the time interval dealt with retrospectively in this study extends to the period before television came into use, and there is a possibility that the visual experiences provided by that medium may have altered to some extent the developmental pattern of fears in young children.

20 For a historically interesting study of fears in young children see Fackenthal.

21 It may be interesting to cite here the following passage from Locke: “Many children, imputing the pain they have endured at school to their books they were corrected for, so join these ideas together, that a book becomes their aversion, and they are never reconciled to the study and use of them all their lives after; and thus reading becomes a torment to them which otherwise possibly they might have made the great pleasure of their lives.”

22 For evidence relating school phobia to a depressive family constellation see Eisenberg; for evidence relating school phobia in older children and adolescents to object loss see Tietz.

23 In a somewhat similar vein, Deutsch mentions an agoraphobic patient who, in a state of positive transference, was able to go unaccompanied to the analyst’s office, and whose fear of walking alone was considerably attenuated with respect to the analyst’s neighborhood.

24 Since phobic symptoms are usually multiply determined, and since, in principle, the therapist can never be certain that all the determinants of a phobia have been explored in a given case, the question as to whether the patients have acquired insight into the origin and meaning of the phobia can only be understood in a relative sense. Moreover, in some of the cases described by J. H. Friedman50 and by Sperling,114 where a relatively brief period of therapy was needed to interpret the symptom to the patient, one may assume that no attempt was made to explore the meaning of the symptom in an exhaustive fashion. Thus, it would appear that a necessarily selective interpretation given in the course of brief treatment can in some cases be effective in dealing with a phobic symptom. Of course, it is likely that positive transference may also have contributed in

these cases to the success in the treatment of the phobia.

25 The foregoing characterization of behavior therapy approaches does not apply fully to implosive therapy, which is classified by its originator as a form of behavior therapy, but which does entail the notion that the original source of phobic avoidance may be repressed.

26 In the recent formulation by Eysenck and Beech, the claims with respect to the status of learning theories are considerably toned down. Instead, the emphasis is placed on the tentative nature of many scientific hypotheses, which serve as useful working models but soon become obsolete after they have served their purpose in giving direction to experiments.

27 Quite apart from the general problem of generalizing from animal to human subjects, there are some more specific problems which apply to the generalization from animal experiments to behavior therapy techniques. In Wolpe's animal experiments on desensitization, food was used to counteract anxiety in the presence of the objects on the phobic hierarchy. It is an open question to what extent the procedures used to induce relaxation in humans are comparable to the feeding of the experimental animals. It may, however, be of historical interest to note that in an early study which utilized what today would be called desensitization in dealing with fears of young children72 food was in fact used in a manner somewhat analogous to that of Wolpe's animal studies. Of course, the fact that the human subject in a typical desensitization experiment is a voluntary participant who has some advance information about the procedure makes for conditions that are very different from those of the animal studies.

28 It has often been maintained, both by psychoanalysts and by behavior therapists, that psychoanalytic theory would lead to the expectation of symptom substitution in cases where a pathological manifestation is removed through treatment which is directed at the symptom rather than at underlying causes. Thus, behavior therapists have often cited the low incidence of symptom substitution in their studies as evidence against psychoanalytic theory, while psychoanalytic critics have often expressed skepticism concerning behavior therapy on the ground that apparently successful treatment directed against specific symptoms is bound to lead to the emergence of other symptoms. However, Weitzman has recently presented several arguments in support of the view that psychoanalytic theory is in fact quite consistent with the notion that symptom removal may bring about more general therapeutic benefits (e.g., that improved mastery of the environment resulting from an alleviation of a phobia may result in increased ego strength). It has also been argued that the objections originally

raised by Freud against treatment aimed at the symptoms rather than at underlying causes were focused primarily on a specific kind of treatment in which symptom removal was brought about through the therapist's authority, and that the same considerations need not necessarily hold when symptom removal or alleviation is brought about through some other means. In this connection, it may be suggested that insofar as a therapeutic method brings about personality changes other than symptom alleviation or removal, it cannot be considered "merely" symptomatic, even if it ostensibly deals only with the symptoms. For other relevant comments, see Yates, Bookbinder, and Camoon.

29 In this connection, a further distinction can be made, however, between imagined noxious consequences which were truly unfamiliar to the patient, and those which had been repressed or suppressed but are significantly related to the origins of the phobic fear. Evocation of material of the latter type could possibly be helpful under some conditions, provided that the patient's ego strength is sufficient to withstand the emergence of such potentially threatening content.

30 The rationale of implosive therapy must be carefully distinguished from that of Freud's previously mentioned recommendation that the phobic patient be confronted in vivo with the phobic situation. Freud saw such a confrontation primarily as a means of utilizing the anxiety thus elicited, as a means of evoking associations which would help in understanding the origins and meaning of the phobia. The implosive therapist utilizes the massive evocation of the phobic imagery as a means of reducing the anxiety. Moreover, while Freud advocated the exposure to the phobic situation only under conditions where the degree of phobic fear had already been reduced through therapeutic work, in implosive therapy the imaginal presentation of the feared object is initiated as soon as possible after the preliminary interviews.

31 The previously mentioned procedure of getting a school-phobic child gradually accustomed to the school setting may be considered as involving features of desensitization, modeling, and guided participation. Of course, when the child is exposed to the natural school setting, the operation of these factors cannot be controlled to the same extent as under experimental conditions.

32 While Frankl's approach is known as "logo-therapy," it is usually classified as representing the varieties of existential therapy.

33 It is one of Frankl's and Gerz's contentions that instructions to accelerate the heartbeat, etc., do not represent a danger because these automatic functions are not subject to voluntary control. In view of recent findings which indicate that autonomic functions are to some extent subject to voluntary control, it may be best to reserve judgment on this point.

34 As it has been previously noted, there are good theoretical reasons for assuming that under some conditions the removal of a symptom without exploration of its etiology would not necessarily lead to symptom substitution. However, such substitution is particularly likely to develop when the symptom removal is based on authoritative suggestion or on positive transference.

35 These differences are not explicitly discussed by Freytag, but they emerge quite clearly from a comparison of Wolpe's and Freytag's procedures.