Phobias are very misunderstood in today’s culture. Many people do not understand what they are or where they come from. In fact, even many scientists struggle with understanding where phobias come from or what they are. With the limited knowledge on the origins of phobias, it is no surprise that phobias are commonly thought of as incurable. It stands to reason that something so complex and misunderstood would have no possible cure or options for treatment. Psychologist Kate B. Wolitzky-Taylor and colleagues reaffirm this notion by reporting “many perceive their phobia as untreatable, or are unaware of effective and available treatments” (1023). What Wolitzky-Taylor and her colleagues are saying is that people with phobias do not think that they will ever get rid of their phobias or just do not know of any treatment options. However, a variety of treatment options are available and being studied that have been shown to make an impact on those individuals who suffer from phobias. In this paper, I will give a brief overview of what a phobia is and what has been discovered about the source of phobias. I will also discuss what researchers are discovering about the treatment options available and which of these options they say are most successful.

In addressing the topic of phobias, psychologists have done extensive research on both the definition of phobias and their origins. Gavin J. Andrews, Professor and Graduate Chair of the Department of Health at McMaster University in Ontario, Canada, studied the effects of phobias, specifically acrophobia, or the fear of heights, on human behavior and everyday life.
Andrews concludes that acrophobia is about more than just the fear itself but has more to do with the perception of what is feared. Another group of psychologists discussed the multiple factors involved in the generation of a phobia. Thomas H. Ollendick of Virginia Polytechnic Institute and State University’s Child Study Center, Neville J. King a member of the faculty of Monash University in Canada, and Peter Muris of the Department of Medical, Clinical, and Experimental Psychology at Maastricht University in the Netherlands, assert what phobias are and what induces them in children in the journal *Child and Adolescent Mental Health*. The authors conclude that many factors can lead to the development of a phobia, and treatment should be focused on addressing all of these factors.

Treatment options for phobias are also currently widely researched by psychologists. Ad de Jongh and Arjen van Wijk of the Department of Behavioral Studies at The University of Amsterdam, and Manda Holmshaw and Wilson Carswell from the group Moving Minds Psychological Management and Rehabilitation in London, researched travel based phobias and compared two treatment options through experiment in their article in *Clinical Psychology and Psychotherapy*. The authors conclude that travel based phobia should be looked at as treatable, with two treatment options showing clear signs of symptom reduction. Another group of psychological researchers from both Virginia Tech and Stockholm University in Sweden, again led by Thomas H. Ollendick, studied the effectiveness of one-session treatment on children and youth ages seven to sixteen in their article in the *Journal of Consulting and Clinical Psychology*. The authors conclude that although more research needs to be done, one-session treatment appears to be both valuable and proficient in the treatment of phobias. A final study found in *Clinical Psychology Review* by Kate Wolitzky-Taylor, Jonathan Horowitz, Mark Powers, and Michael Telch, all of whom are from the University of Texas at Austin’s Psychology department,
provides an analysis and efficacy of the multiple treatment options available for phobias. Many treatments were studied and the authors conclude that exposure-based treatments were the most successful. When treatment lasted over multiple sessions, it showed a higher success rate as well.

Looking at the research available, I was excited to see that the research supported my view, that phobia treatment is available and can be very beneficial to those who suffer from phobias. Having reviewed the research that I found, I will now give a brief introduction to phobias: what they are, as well as what causes them. Following this introduction, I will discuss treatment options and their efficacy by first, looking at trauma-focused treatment for those suffering with travel phobias, second, reviewing one-session treatment and its effectiveness, and third, looking at the other treatment options out there and which of these options are the most successful.

In order to fully understand the treatment of phobias, phobias must be first understood. In his article, “Spaces of Dizziness and Dread: Navigating Acrophobia,” Gavin J. Andrews discusses what a phobia is. Andrews describes a phobia as “an irrational fear” (307). By irrational fear, Andrews means that the fear is without reason. What is being feared is not necessarily causing any harm or danger, but the fear still persists. This fear can manifest itself via physical and psychological symptoms. The physical symptoms may include for the individual “shortness of breath, rapid breathing, irregular heartbeat, sweating and nausea” (307-308), and the psychological symptoms may present themselves through emotions such as “panic, fear, dread and anxiety” (308). These symptoms show that phobias are not just an internal struggle but can be exhibited externally as well.
Specifically, Gavin Andrews discusses such external struggles; he interviews ten self-described agoraphobics to better understand how a phobia impacts them on a daily basis. The interviews had a few important issues that the author wanted to make sure were touched on, but for the most part, those being interviewed were allowed to discuss their phobia at large. Some of the points were if there was a specific height at which they began to sense their phobia kick in, what symptoms they began to experience, strategies to cope with encountering something high, and how they dealt with their phobia on a day-to-day basis. All of these points are discussed to understand the phobia better as a whole. For instance, one interviewee, a 35 year old housewife name Gale, discussed her own understanding of the irrationality of her phobia, explaining “It’s not about chances or risk. I might know deep down that something is probably safe, but it doesn’t stop it [the fear] occurring” (qtd. in Andrews 312). In other words, despite knowing that she is safe and away from harm, Gale is still affected by this fear. Another interviewee, a 59 year old office worker named Jake, responded to his emotional reaction, claiming “It’s a fear that won’t go away, stays there while you’re up there, occupying your thoughts and restricting other thoughts” (qtd. in Andrews 312). Jake’s point is that the fear takes over, leaving him little room for coherent thought.

Based on these (and other) interviews, Andrews concludes in his study that “acrophobia is far more about how height is perceived and negotiated by people, both in the moment and throughout life” (315). The author’s bottom line is that phobia is not simply about being afraid of something, but rather, it is the perception of what someone is afraid of. For example, it is not that someone is afraid of the stairs, elevator, or rooftop, but rather, a fear or perception of falling from them that causes the anxiety. Another example would be that people are not necessarily afraid of the physical dentist, but rather, what the dentist represents to them—pain, torture, or
soreness. Due to these perceptions, phobias prove to be quite complex and difficult to understand, and they form powerful emotions in the brain.

This emphasis on the tie between perception and phobias is shown further by Thomas H. Ollendick, Neville J. King, and Peter Muris in their article, “Fears and Phobias in Children: Phenomenology, Epidemiology, and Aetiology.” Ollendick and colleagues discuss the complexities of phobias and how they are created. One study that the authors consider in their discussion of the development of phobias deals with both adults who were phobic and not fearful of dogs. The authors’ findings show that while some in both groups had negative experiences with dogs, “they had very different expectations about the consequences of an encounter with a dog” (101). The study showed that while 100% of those with dog phobia expected injury or fright when coming in contact with a dog, only 14% of those who were non-fearful expected the same result. What this study shows is that there is a difference in how a potentially phobic situation is perceived. I was unable to find any research articles explaining why some individuals are more susceptible to developing a phobia and others are not in my limited time for research.

Ollendick and his colleagues do, however, review factors that may potentially develop phobias in children by reviewing the work of other psychologists and researchers in the field. While no one has a firm grasp on exactly what causes a fear or phobia, there are some contributing factors worth noting. Some of the factors mentioned by the authors that may lead children to develop a phobia include environmental factors such as having an experience that frightens them, seeing another kid react in a phobic way, or hearing or reading about fears (100). A phobia may develop from only one of these factors, or from multiple factors. There is no way to predict which factors will affect an individual. The authors also focus on whether genetic
factors play any part in phobia occurrence. According to Ollendick and colleagues, Kendler et al. found that agoraphobia (the fear of public places) was more likely to have ties to genetics, while specific phobias (like the fear of dogs or the fear of heights) were the least likely to have genetic ties. Social phobias (fear of social situations) fell somewhere in the middle of agoraphobia and specific phobias. Agoraphobia has the lowest environmental influences associated with it, while specific phobias have the highest amount of environmental influences, leading Kendler et al. to believe that agoraphobia is more linked to genetics than other types of phobias. However, according to Ollendick and colleagues, while genetics may incline a child toward being more fearful, external factors, such as overprotective parents, fearful situations, or shyness, play a much larger role in how a phobia is obtained. The authors conclude that “inasmuch as any one specific phobia is acquired and maintained through such complex processes, treatment approaches will likely need to address these dimensions before evidence-based treatments can be fully realized” (104). In other words, because of the multifaceted origins of phobias, all aspects will need to be considered before treatment can be based on research findings alone.

Now that a foundation has been laid on what phobias are and where they come from, we can at this time discuss and better understand treatment options and how they can be beneficial. Ad de Jongh and his colleagues agree with Ollendick and colleagues that many factors should be addressed in phobia treatment. In their article “Usefulness of a Trauma-Focused Treatment Approach for Travel Phobia,” Ad de Jongh and his associates discuss research performed on specific treatment options for those suffering with a travel based phobia brought about by trauma. In this study, de Jongh and his colleagues studied two experimental treatment options to see how they compared to the preferred method of treatment, *in vivo* treatment (coming in
contact with your phobia). The two methods of treatment being studied were Trauma-Focused Cognitive Behavioral Therapy or TF-CBT (discussion and processing of a traumatic event with a therapist to make it less distressing) and Eye Movement Desensitization and Reprocessing or EMDR (using controlled eye-movement to reduce the anxiety of a particular situation). In both of these treatments *in vivo* take home assignments were given to the patients to perform between sessions, in which they were expected to perform exposure tasks and face conditions that would normally cause them fear. These tasks were all performed without the therapist’s help. The researchers found that both TF-CBT and EMDR showed significant improvements in the patient’s anxiety, demonstrating that these treatments are feasible options. Focusing on the trauma that caused the phobia, rather than just facing the phobia proves to be helpful in battling phobias.

While these treatment options show vast improvement in phobias, it can take weeks or months to see any improvement. Another available option, one-session treatment, has been proven to show improvement after one three hour session. Ollendick, as well as a new group of researchers from Virginia Tech and Stockholm University in Sweden, studies the effect of this treatment in their article “One-Session Treatment of Specific Phobias in Youth: A Randomized Clinical Trial in the United States and Sweden.” One-session treatment is a mixture of different treatments condensed into one three hour treatment. Treatment includes informing the patients about their phobia, gradual *in vivo* exposure, as well as learning to understand and deal with the anxiety that comes with encountering the phobia. The researchers conclude that one-session treatment proved both valuable and proficient despite needing more research on this particular treatment. These findings confirm my point that treatment options are available that can make an impact.
While I have only shown two treatment options, there are a variety of other options available to meet anyone’s personal needs. In their article “Psychological Approaches in the Treatment of Specific Phobias: A Meta-Analysis,” Kate B. Wolitzky and colleagues point out the many options that are available for treatment, as well as comparing their effectiveness. The researchers broke the treatments up into three categories: exposure, non-exposure, and placebo treatment. Exposure treatments include treatments such as *in vivo* exposure (coming in direct contact with the fear), imaginal exposure (imagining contact with the fear), and systematic desensitization (teaching to relax while imagining the fear) (1023-26). Non-exposure based treatments include Progressive Muscle Relaxation (teaching to tense and relax certain muscles to help put the patient at ease) and cognitive therapy (discussing what causes the fear to help lessen the fear) (1024-26). Placebo treatments include treatments not known to be actively effective in phobia treatment such as pleasant imagery (thinking happy thoughts) and free association (speaking free flow to access the unconscious) (1027). Wolitzky-Taylor and colleagues found that after comparing the efficacy of the three different types of treatment, exposure based treatment proved to have the greatest and most long-lasting effect. This means those patients treated with an exposure based treatment saw the most improvement and also had the longest longevity. *In vivo* treatment, specifically, outperformed the other modes of exposure treatment. The researchers also found that those treatments that happened over multiple sessions showed longer lasting results than the one-session treatments, meaning that in follow-up, those who had attended multiple sessions were more likely to still be phobia free than those who had attended only one session. However, the research also showed that any treatment is better than no treatment at all, citing that those in active treatment were 84% better off than those who had no treatment at all (1029).
After reviewing the research of Ollendick, Andrews, Wolitzky-Taylor, de Jongh, and all of their colleagues, I feel that treatment is very important to help in phobia recovery. Everyone is different, so I do not know if I can say which treatment would work the best. Every situation is diverse. No two people are the same, so I do not feel like there is a “one size fits all” type of treatment. I will say, however, that if I were to have a phobia, the treatment I would find the most helpful would be the trauma-focused treatment outlined by de Jongh and colleagues. I feel that focusing on facing the origin of your phobia would be the most beneficial because you are treating the root of the problem, instead of just the symptom. I also feel that by making the phobic responsible for exposing him or herself to what is feared really puts rehabilitation in their hands. It makes them a part of the treatment process, instead of just a recipient of treatment.

The findings of all of these talented men and women challenge the preconceived notion that phobias are unable to be treated. The researchers and psychologists I have used in this paper all seemed to agree that while there was still much research to be done to better understand phobias, treatment was possible. With treatment comes a new lease on life, not being held back by fear. Fear no longer is in control, the individual is, which makes me wonder: why would anyone not seek phobia treatment?
Works Cited


