Phobia: Fear and Loathing in Mental Spaces

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Abstract:
This article presents a general introduction to the modern idea of ‘phobia’ and its therapeutic treatment. Various treatment methodologies are compared and contrasted. Particular attention is given to the theoretical background to the Neuro-linguistic Programming Fast Phobia and Trauma Cure and a careful discussion of mode its application and the results obtained is given.

Keywords:
Phobia, fear, Neuro-linguistic Programming (NLP), NLP-FP/TC; Fast Phobia Cure, trauma Cure, anxiety, hypnosis, hypnotherapy, repression; psychoanalysis; extinction; desensitization; flooding; submodality; dissociation; future pacing.

“With nowhere,
To run,
And nowhere,
To hide,
We are forced,
To face,
The fears that,
We all,
Secretly hold,
Inside.”

D-Day (2005) Fear Within
It is instructive to begin with a commonly-acce-
pted definition of the term 'phobia,' derived 
from the Greek Φοβία meaning 'fear' or 'flight.' Gorkin (2002) quotes a dictionary 
definition of a phobia as "an exaggerated and 
often disabling fear usually inexplicable to the 
subject, having occasionally a logical but usu-
ally an illogical or symbolic object, and serving 
to protect the ego against anxiety arising from 
unexpressed aggressive impulses. Fear, dread 
and hatred often cluster together." Faulkner 
(1992) suggests: "May I propose a definition; 
Individuals that experience sudden and intense 
fear in the presence of a stimulus or on recall-
ing it, and/or being 'unable to put it out of their 
minds' have a phobia." Indeed we could go so 
far as to say that any fear, which disrupts nor-
mal day-to-day functioning could be classed 
as a phobia, at least in terms of resolution of 
the problem. For example, if an individual's 
fear of travelling on the Underground system 
in London is severe enough to interfere with 
a normal daily working pattern and cause her 
to make complex coping arrangements, then 
this disruption would probably be considered 
in the 'phobic response' category. According 
to D'Silva (2005), "Some therapists define the 
source of fear as the external object or situa-
tion the patient identifies as fearful, while oth-
ers find a deeper source within the patient – in 
the unconscious, in thoughts, or in physical 
sensations." Whatever the source of the phobic 
response, how might we identify its aetiology? 
Common symptoms of a person undergoing 
a phobic response are: dizziness, excessive 
sweating, facial blushing, mental and verbal 
confusion, palpitations, shortness of breath and 
sickness. Of course there are other symptoms 
depending on the individual sufferer, and gen-
erally several symptoms occur together.

McCabe (2005) states that "Phobias are quite 
common and occur in about one in every 10 
Canadians." In order to get a feeling for the 
ocurrence of such problems in the general 
population we can quote the US Department 
of Health and Human Services (1999) report 
Mental Health: A Report of the Surgeon Gen-
eral. This estimated the following figures for 1-
year prevalence of certain mental disturbances 
in the 18 – 45 age group (where here the term 
prevalence "refers to cases (i.e., new and exist-
ing) of a condition observed at a point in time or during a period of time."): any anxiety disor-
der 17%; simple phobia 8%; social phobia 2%; 
agoraphobia 5%; generalized anxiety disorder 
3%; panic disorder 2%; obsessive compulsive 
disorder 2%; post-traumatic stress disorder 
4%. Thus 'phobia' and 'anxiety' are the most 
common ailments reported. Gorkin (2002) 
go on to discuss two common classes of 
phobic response as typified in DSM-IV (1994). 
The first class is ‘specific phobia,’ previously 
known as ‘simple phobia.’ Here, the specific 
stimulus may be an object (banana, snake, spi-
der, telephone), a place (alone in a dark wood, 
in a church, high-up), or an activity (flying, 
receiving an injection). Exposure to the pho-
bic stimulus usually produces an immediate, 
severe and persistent anxiety response. This 
is characterized as being excessive and unre-
asonable, and may take the form of a situational 
bound or situational predisposed panic attack. 
Anticipation of the response can in itself lead 
to avoidance behaviour, which can also be 
debilitating.

The second type is ‘social phobia.’ Here the 
individual has a persistent fear that she may 
do something that will be embarrassing in a 
particular setting, when scrutinized by others. 
A good example would be an individual who 
is articulate on a one-to-one basis but who is 
unable to speak in public, or join in conversa-
tion in a social setting. McCabe (2005) gives 
a different categorization: "There are four main 
types of phobias: animal type (e.g., spiders, 
dogs, rodents), natural environment type (e.g., 
storms, lightening, water), blood-injection-in-
jury type (e.g., seeing blood, getting a needle, 
having a medical procedure), and situational 
type (e.g., enclosed places, flying, driving). 
Phobias that do not fit into these four categories 
fall into a fifth category referred to as 'other 
type' (e.g., fears of choking or vomiting)." The 
distinction between: anxiety, fear, and phobia, 
is described in the following manner by Litt 
(2000); "You are on a very high bridge with 
water below. You approach the rail, and look 
down. Feel a bit shaky in the knees? Yes, there 
is fear that you might fall into the water. Anxi-
ety that you might jump! If you were suffering 
from phobia, then you would not be on the 
bridge at all. Then there is existential anxiety: 
that is when you ask yourself, 'Why am I on 
this bridge anyway? What am I doing here?
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What's it all about?"

So, where does our modern-day idea of 'phobia' originate? In fact, as Litt (2000) discusses, it is Freud's interpretation of phobia, which still holds sway. Freud noted that as infants, both animals and children are exposed to many frightening and (at that stage) inexplicable or irrational events: many of these are potentially hazardous, even if they do not result in actual harm in that instance. Such psychologically charged events include fear of being abandoned; of being attacked by another creature; of sensing unexpected quick movement; of being alone in the dark, or in a thunderstorm, and so on. Freud's idea was that these fears are a natural part of the developmental process, and play an important role in animal self-preservation instincts in adulthood. However, as the intellectual faculties develop in humans, the childish instinctual fears should subside, as they are no longer necessary. Problems arise in cases where these fears do not decay; indeed when they persist, become more powerful, and become fixed as a 'phobia.' The notion is that in a phobic response a single highly traumatic event in childhood is 'forgotten' or 'repressed,' and yet the trauma stimulus still triggers the anxiety of the original event without arousing the whole traumatic memory. Boeree (2003) gives a personal example of this:

"As an adolescent, I developed a rather strong fear of spiders, especially long-legged ones. I didn't know where it came from, but it was starting to get rather embarrassing by the time I entered college. At college, a counsellor helped me to get over it (with a technique called systematic desensitisation), but I still had no idea where it came from. Years later, I had a dream, a particularly clear one, that involved getting locked up by my cousin in a shed behind my grandparents' house when I was very young. The shed was small, dark, and had a dirt floor covered with - you guessed it! - long-legged spiders. The Freudian understanding of this phobia is pretty simple: I repressed a traumatic event - the shed incident - but seeing spiders aroused the anxiety of the event without arousing the memory."

Moreover, to quote Litt (2000), Freud believed that "phobias do not occur at all when the vita sexualis is normal." This belief and the other apparatus of Freudian theory has resulted in the modern Psychoanalytic idea that in order to free a client from a phobia, one must uncover unconscious processes and expose repressed complexes. It is interesting that Freud (1919) himself commented: "One can hardly ever master a phobia if one waits 'till the patient lets the analysis influence him to give it up... One succeeds only when one can induce them, through the influence of the analysis to go about alone and to struggle with their anxiety while they make the attempt." Litt (2000) puts this labour-intensive methodology in context, commenting: "It is not unusual for patients who have instead sought psychoanalysis as a method for treating their phobia, have often turned up in my office after 5, 8, 10 or even 12 years on the Freudian couch still suffering from the same disorder they began with. I once had the audacity to ask - 'Well, after 10 years of seeing your psychoanalyst, you still complain about the original problem. What do you think of your analyst now?' The answer - 'I think he's wonderful.' Well, whatever it is, it's not psychotherapy."

However, psychotherapy has moved on, and we now have much quicker and more effective therapies. Essentially these therapies rely on the well-understood process of 'extinction of response' to a stimulus. Lady (2005a) gives the example of Seligman, who conditioned experimental rats to associate the sound of a buzzer with an electric shock: this caused them to jump over a barrier in their cage when they heard the buzzer. LeDoux (1998) explains the extinction phenomenon as follows:

'Especially important to Seligman was the fact that avoidance conditioning vanishes quickly if the animal is prevented from making the avoidance response and alternative solutions for escape or avoidance are not provided.... [If the barrier is replaced by a wall] preventing the avoidance response, the rat soon learns that the buzzer is no longer followed by a shock and begins to ignore the buzzer.'
The idea of extinction described above gives rise to two common behavioural cures for phobias: ‘imaginal flooding’ (or ‘implosion’) and ‘systematic desensitisation.’ These are similar in that they are both generally practised in mentē, using thought and imagination, but are otherwise quite different. Wolpe (1958) was the first to report good results with systematic desensitisation which uses formal deep-muscle relaxation and guided visualization to effect gradual extinction. The client has to maintain her relaxation when the phobic stimulus is visualized. Since relaxation and fear are incompatible, as Lady (2005a) explains, “The phobic response is prevented when the phobic stimulus is presented, so the subject soon learns to maintain a neutral feeling in the presence of the phobic stimulus.” So, a client who was afraid of the Underground might be dealt with as follows, for example:

OK, I want you to see yourself at the top of the steps to the Underground Station... Good... How do you feel?... Yes, nervous, a bit sweaty, heart beating faster. That's OK... Now, I want you to really focus on how you're feeling... your nervousness... how does it feel now... can you tell me exactly where you feel it in your body?... OK, your breathing... Hard to breathe... Now... Focus on your breathing... yes... That's right... Really concentrate on how it feels... So... How is it now?... A bit better... concentrate more... Good. OK, very good... So now you are through the turnstile... yes... that's right... there are lots of people... concentrate on your feelings... breathing... yes... What's happening now?... Sweating more... feeling cold sweat... OK... butterflies in your stomach... Yes... that's OK... So now just feel the feelings and watch yourself... Feel it... See what happens... Yes... That's right... the feelings are less, now... So you're on the escalator going... down... and... Yes... feeling a bit more calm... Good.

The therapist continues this visualization and attention to kinaesthetic sub-modalities until the client ‘boards the imaginary train,’ all the time learning subconsciously that she is not at the mercy of the fear. It is important that the client is helped to remain relaxed and control her emotions at all times. Finally, she sees herself on the train, which gradually moves off into a tunnel. The visualization together with relaxation is continued; at all times the therapist helps the client pay close attention to her physical and emotional states. The process is judged to be successful if on repetition, the client reports feeling ‘a bit shaky... but not terrified like before.’ In fact Hoffman (2005) takes this visualization idea to its current limits, explaining “...the effectiveness of VR [Virtual Reality] for medical applications. We have since treated about 20 clinical phobics with a success rate of approximately 85%...”. However, D'Silva (2005) warns: “But most therapists have found there is a gap between fantasy and reality. In other words, once the client has completed desensitisation treatment and undertakes to face the real object or situation, he is likely to have to move part of the way back down his list.” Gelder et al. (1973) discuss the method of imaginal flooding. This differs from systematic desensitisation as the therapist aims to make the images as vivid, realistic and fear-provoking as possible. Moreover, the client is not helped to relax: in fact she is pushed to experience the phobic stimulus and response at its worst, and thereby overcome it. D'Silva (2005) comments: “A number of researchers have compared desensitisation and flooding. They have found the two forms of treatment are about equally effective: Both reduce phobic anxiety and behaviour in people with simple phobias, but desensitisation is not as effective as flooding for agoraphobia. Although not well studied, neither method appears to be very effective for social phobias.” The Neuro-linguistic Programming techniques used to effect quick, painless and permanent phobia cure in a hypnotherapeutic setting are compared and contrasted with these approaches below.

The NLP Fast Phobia and Trauma cure (NLP-FP/TC), first described by Bandler (1986) and Andreas (1990), is a simple visualization that takes “… only a single session... less than fifteen minutes,” according to Lady (2005b) although up to three one-hour sessions may be needed, and the therapy is thus referred to as ‘brief.’ The NLP-FP/TC is described as a ‘content free’ method, as the client does not regress to infantile trauma, nor is there abreaction. As Lady (2005b) says: “When neutralizing a memory, the subject does not need to actually

European Journal of Clinical Hypnosis: 2005 volume 6 - issue 3
tell the therapist the details of the traumatic event." It is important to realise that as Lady (2005a) explains: "The NLP phobia cure does not have to do with any particular hypotheses of what phobias are or how they arise." Rather it is sufficient to understand the situational sources of anxiety and use this understanding to help unlearn obsolete responses and relearn new ones. Indeed the NLP-FP/TC can be used to treat simple phobias as well as to neutralize memories of traumatic incidents like such as abuse, combat experience, rape, and so on. An expanded example of this technique in operation is given below; this is modelled on that of Lady (2005c), who comments that "Unfortunately, since the technique is so simple I think people tend to think the brief descriptions... are incomplete," whereas of course exactly the opposite is true and it is the rapidity and simplicity of the intervention which is so useful! There are two steps to the NLP-FP/TC. The first step is essence Visual-Kinaesthetic Dissociation (Lady, 2005d) in which the client imagines (visualises) watching a film of herself confronting the object of her phobia. So, for example, with a fear of the Underground, then the film is not just about the Underground system, but rather it is a film of the client attempting to use the Underground and experiencing all the attendant difficulties. Moreover, the client must remain dissociated and be able to watch herself perform the phobic response. The following extract is an example of the kind of language used and is modelled on the script given in Lady (2005c).

OK, now... Imagine you're comfortable, relaxed... sitting in a nice warm cinema... That's right... It's not dark... Not too bright... Get your bearings... have a look around... Can you see where everything is... What it looks like... yes... High overhead... Behind you... Is the projector... The screen is clear in front of you... Not too close... Not too far away... Now I want you to imagine... Seeing a black-and-white photo of yourself... There... On the screen... It's You... Before... Watching a film... You are going to show...

Yes... Right... Now... But before... You can... Easily... Leave your body... Float up out of yourself... Up... Up... Into the safety and warmth... The projection room... And now you... Control the film... So... now... In charge... Of the shining beam of light... Of the pictures on the film... Yes... You can look far down below... And see... [name]... Sitting... Waiting... Watching herself... Comfortably waiting... For the film you are about to start... Looking at a picture... Before...

... You have the experience... The film is going to show... Good... Now... In a moment... The screen is going to show a film... All about [name]... Black and white... yes... Silent... This film will be in black and white... There's no sound... Can you even notice it flicker a bit?

And now... Yes... You have the power... That's right... To start the projector... All about [name]... This film... and you watch... [name]... as she sits... comfortable... right down below... looking up... at [name]... there on the screen... just... watching... you watching [name]... doing some experience... That's right...

It can of course be very hard for the client to remain dissociated even when told just to imagine watching a film of a trauma or phobic response. It is crucial for the NLP-FP/TC that the client is dissociated. The therapist must check for appropriate dissociation by asking: 'How did you feel when you watched that film?' If the client answers 'A little bit frightened,' then the therapist should check further: 'Are you sure you were sitting in your seat... Watching yourself... Or did you get involved in the film?' If the client has re-associated too early, then the therapist starts the visual-kinaesthetic dissociation again, using different imagery: he should be very attentive to the client's state and direct her appropriately to avoid re-association.

The second stage of NLP-FP/TC goes as follows. The traumatic part of the film is over, and the client has observed herself doing the phobic response at several levels of dissociation. The phobic stimulus has disappeared and she is safe, secure, calm and detached. The therapist now asks the client to re-associate with the film and see, hear, smell, taste and feel all appropriate aspects of the scene. All the criti-
We might ask, ‘does phobia amelioration have any side-effects?’ Well in general a client can be sure of a new approach to living her life together with a sense of joy, and feelings pride in her accomplishments. However, even when the method described above is executed exactly, there is still one complication that occasionally arises. Freud coined the phrase ‘secondary gain’ to explain this phenomenon, and it is described in detail in Jemmer (2005). It refers to the fact that some people prefer to keep their phobia since it serves a hidden purpose. In this case a side-effect of removing the phobia could be severe disappointment, or even the inception of a negative life-event. Let’s take the example quoted in Merlevede (2002): “‘secondary gain’ is the ‘hidden’, possibly unconscious, reason why a person acts in a way that may, to an external observer, appear to be self-defeating. For example, Joe Bloggs frequently, and apparently sincerely, expresses a desire to lose weight – but he never does...” Hunter (2005) expands on this idea by illustrating how Mr Bloggs might describe how he is experiencing an internal conflict, saying that “A part of me wants to get slim but something else inside me keeps me starving all the time!” That is, one facet or ‘part’ of the personality desires to reduce the food intake; this in conflict with a second part, which controls the desire to overeat. In general, there are several common causes for such a conflict: for example: authority imprint, overwork, past programming, self-punishment, unresolved past experience, personal or family problems, and so on. Hunter (2005) also makes the point that secondary gain could be important in a case like this, and Merlevede (2002) reaches the conclusion “... Why? Because Joe has an unspoken belief that he will be safe from mugging so long as he looks big enough to wrestle a bull.” Methods of dealing with secondary gain are discussed in detail in Jemmer (2005).

So, how does the NLP-FP/TC compare with other treatments? Lady (2005b) points out that the initial part of NLP-FP/TC is in essence classic desensitisation. He says: “... the NLP phobia techniques are refinements of known approaches in behavioural therapy... NLPers do not believe that the behavioural technique called Implosion or Flooding is the best approach for phobias, but they use a refinement of..."
it (the Compulsion Blow-out) to break obsessions and compulsions.” Thus in a behavioural approach the client learns deep relaxation which according to Lady (2005b) is “one of the least powerful of all internal states.” Only then is she asked to imagine the phobic stimulus; trying to maintain this relaxed state under such conditions can be very hard work! The most significant difference between NLP-FP/TC and other behavioural methods is the client’s sub-modal dissociation from the confrontation of the phobic stimulus in NLP-FP/TC. The client imagines watching herself doing the phobia indirectly, in a film, rather than imagining doing the phobia directly. Next the client floats ‘outside herself’ and watches herself watching the film; then she becomes further dissociated by becoming the projectionist who is controlling the film she is watching. She then changes the critical sub-modalities of the film itself (its colour, brightness, graininess, speed, tone, soundtrack, and so on).

In general these are ‘turned down’ (colour becomes monochrome, volume decreases, three dimensions are squashed to a flat-screen image, a comical soundtrack is applied, voices are made high and squeaky): another dissociative strategy. Although, a seemingly trivial distinction; “This seems to make a great deal of difference,” as Lady (2005b) points out. Moreover, Gallo (1995) comments that; “…this perceptual shift appears to be a primary causal factor in promoting relief from the trauma.” In fact, Lady (2005a) goes on to posit two reasons why this dissociation might be so important: “The first is that in having the subject imagine being out of their body, one is keeping them in a state where they will be unable to feel fear... The second possible explanation, though, is that it’s just a process of distraction. One is simply giving the subject a complicated task to do, one which is likely to hold the subject’s attention because it seems superficially related to the phobia.” However, as Gallo (1995) tells us: “It should be emphasized, however, that dissociation is a temporarily induced aspect of the procedure, as the patient is later directed to re-associate and maintain the ‘learning’s’ [sic] acquired during the dissociation phase.” This brings us to the second difference between therapies: the mechanism of the phobia cure. In behavioural therapy this is by extinction, and in NLP-FP/TC it is by memory-trace modification. Only when the film has run its course and the client has watched herself at several levels of dissociation, is she asked to re-associate. At this point of course, the phobic incident is over and she is safe. Then, she can ‘turn up’ the critical sub-modalities once again and reinforce the experience of neutral or pleasurable feelings of safety, survival and support. The whole process described above is then run backwards in mente; the film reel is ‘rewound’ if you like. It is crucial that this is done very, very fast, maybe in one second or so. This rewinding is what triggers the erasure of the phobic memory trace. During this process changes in one representational system may induce changes in another in the process of ‘transmodal reattunement’ as described in Gallo (1995): “For example, closer appearing images may entail a louder auditory component as compared to more distant appearing images... Shapiro cites the case of a Vietnam veteran... reporting that the auditory component of the memory silenced, the visual aspects becoming like ‘a paint chip under water,’ and affect calmed.” Faulkner (1992) remarks that; “NLP co-developer John Grinder was once asked what the difference was between the NLP Phobia Relief Method and Systematic Desensitisation. Without a hint of humour he replied ‘Six (6) months.’ You see, to use Systematic Desensitisation to relieve you of a fear of dogs would take about six (6) months while the NLP Phobia Relief Method takes less than thirty (30) minutes.”

Goodrich (1994) gives data on a 1992 study of the NLP-FP/TC applied to three groups of ‘simple’ phobics. The first group underwent NLP-FP/TC and were interviewed each week thereafter for six weeks. The second group was treated using accelerated progressive-desensitisation and interviewed. The third group provided a control and was just interviewed. Re-evaluation of the treatment was done at intervals of six months, a year and five years; levels of recurring symptoms were categorized as none, few, many and all. After five years the NLP-FP/TC group reported 90% none; the progressive-desensitisation group reported 35% none, 33% few and 32% many or all; the group that underwent no treatment reported 90% all. Although not published in an academic journal,
these results are posited by Goodrich (1994) as evidence of the efficacy of the NLP-FP/TC in treating ‘simple’ phobias, for, as he points out: "... Few of the ‘Major Players’ in NLP are primarily academics, so the idea of an academic journal has aroused relatively little interest... The upshot of the whole thing is: lack of publication doesn’t equal lack of evidence." Furthermore, Goodrich (1997) goes on to quote results on his personal use of NLP-FP/TC with 128 individuals. He states that of the 127 who completed the treatment, "ALL... experienced complete relief of relevant symptoms at that time, and at the time of a 2-4 week follow up... 104 of them reported a complete absence of such symptoms as of a 1-year follow up... of the 63 cases treated before January, 1992, 51 reported a complete absence of symptoms as of their 5 year follow up... informal contact with two people treated in 1989 indicates that they are still completely without relevant symptoms. In every one of those 127 cases, the process took less than one half hour. In most cases, far less.”

In conclusion, we agree with Faulkner (1992) in saying that: “Rearrangement of the structure of this stimulus-experience nexus becomes the domain of successful therapy.” Using NLP techniques and hypnotherapy provides an ideal way to do just this, and so provide a brief, painless, yet very effective and lasting phobia cure. The fundamental difference between the NLP-FP/TC and other methods of treatment is that in the former, change occurs on 'the inside:' to quote Faulkner (1992), “With NLP the internal map of the experience is changed directly.” About the only ‘drawback’ in Lady’s (2005c) view is that it has little dramatic impact: “Clients seldom say ‘Oh wow! This is incredible! I can’t believe I’m cured after having this awful phobia all these years!’... After all, the very worst that could happen to you in an elevator is that you’d get stuck for a little while, and that’s only inconvenient.” This is taken as positive proof of the efficacy of the NLP-FP/TC compared with other, more traditional techniques. In the words of Fear Poem by Joy Harjo, John L. Williams and Susan M. Williams (1994):

“I release you, my beautiful and terrible fear...
I release you. You were my beloved and hated twin, but now, I don’t know you as myself...
I take myself back, fear.
You are not my shadow any longer.
I won’t take you in my hands.
You can’t live in my eye, my ears, my voice
my belly, or in my heart my heart
my heart my heart…”

References:


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