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Degree you are working toward: Masters of Ministry and Christian Counseling

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Course Number & Title: or Name of Book From the Bible: PSY4031 Psychopathology

Book Title: Phobias: A Handbook of Theory, Research and Treatment

Author: Graham C. L. Davey

Begin/End Date of Enclosed Course: 1 JAN 2023 / 30 APR 2023

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PSYCHOPATHOLOGY PSY4031

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Text Read: Phobias: A Handbook of Theory, Research and Treatment
Graham C.L. Davey (1997) ISBN: 0-471-49220-5
451 pages in 3 sections and 20 chapters

Section I: The Nature and Description of Prevalent Phobias (ch 1) Social Phobia: a Cognitive Approach (ch 2) Agoraphobia (ch 3) Blood-Injury-Injection Phobia (ch 4) Animal Phobias (ch 5) Dental Phobias (ch 6) Water Phobia (ch 7) Height Phobia (ch 8) Accident Phobia (ch 9) Claustrophobia (ch 10) Atypical Phobias (ch 11) Specific Phobias in Children.

Section II: The Treatment of Phobias (ch 12) Rapid Treatment of Specific Phobia (ch 13) A comparison of Behavioral and Cognitive Treatments of Phobias (ch 14) The Use of Medication in the Treatment of Phobias.

Section III: General Theoretical Perspectives on Aetiology (sic., the author is British and many spellings in this book are British English) and Maintenance. (ch 15) A Conditioning Model of Phobias (ch 16) Evolutionary Models of Phobias (ch 17) Unconscious Pre-attentive Mechanisms in the Activation of Phobic fear (ch 18) The Match-Mismatch Model of Phobia Acquisition (ch 19) Information-processing approaches to phobias (ch 20) The Epidemiology of Fears and Phobias

INTRODUCTION: The word "phobia" is derived from the Greek word φοβος meaning fear, or terror, and originated from Phobos, the god who invoked fear in the hearts of their enemies. This text gave the reader a description of the different phobias as defined in the DSM III and DSM IV, which were the prevalent versions of the Diagnostic and Statistical Manual at the time the text was authored. The DSM III was published by the American Psychological Association (APA) in 1980, the DSM-III-R (revised) in 1987, and the DSM IV in 1994. The text then provided diagnostic criteria for the various phobias. The text discusses treatment of the phobias as well.

Social Phobia

The primary characteristic of social phobia is a debilitating fear of embarrassment or humiliation. In order to qualify as a phobia, the fear must be such magnitude as to be avoided or endured with considerable distress. (Because we all get "butterflies" which does not equate to a phobia.)

Social anxiety (which is not social phobia) is widely prevalent in the general

population.(and probably on the rise in 2023 when this is being written, post-COVID and in the throes of the social media generation and its aversion to social conduct. This sutdent will investigate this again later seeking some recent journal publications.) The difference between Social Anxiety and Social Phobia is a matter of degree: The Social Phobic's avoidance behavior will be greatly pronounced in contrast to the Anxious.

One study found that 10% of students reported difficulty in soucial situations. [Bryant & Trower, J.Br.Ed.Psych. 44:13-21 (1974)] In another study, almost one-third of male and female college students reported dating anxiety. [Arkowitz, et al., Counselling Psychologist 7:41-46 (1978)]

Social Phobia is equally prevalent in males as in females in most studies of clincal populations. [Amies, et al, Br.J.Bsych. 142:174-79 (1983)] There remains some suggestions that prevalence may skew slightly higher in women in the entire community. (considering the undiagnosed) [Chapman, et al., Social Phobia: Diagnosis, Assessment and Treatment (1995)]

Subtypes and Avoidant Personality

Social Phobia is separated into two subtypes: "general" and "specific." The DSM III included only the specific subtype, whereas the DSM-III-R and DSM-IV included the general subtype.

The general subtype has much overlap with Avoidant Personality Disorder (APD). APD is described as a "pervasive pattern of inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation that begins by early adulthood and is present in a variety of contexts. (DSM-IV, p. 662)

Most succinctly usmmarized, these diagnoses seem like a continuum from the unaffected to socially anxious, social phobic specific subtype, social phobic general subtype, and APD being the most affected by symptoms. [Watson and Fried, J.Consulting and Clin.Psych. 33:448-57 (1969)][Holt, et al., J.Ab.Psych. 101: 318-25 (1992)]

Treatment

The treatment of choice for the socially phobic is Cognitive-Behavioral Therapy (CBT). Exposure therapy is shown to be superior to no treatment. [Butler, et al., J.Cons.Clin.Psych. 52:642-50 (1984)], however CBT is the leading empirically validated form of psychological therapy. (p. 23) Social Phobias show an attentional bias toward threat stimuli. (Their focus and concentration is drawn to their fears.) [Asmundson and Stein, J.Anx.Disorders 8:107-17 (1994)]

The CBT is going to focus on breaking this cycle.

In comparison to pharmacological treatment, CBT patients tend to maintain their gains, whereas after a year 50% of those prescribed phenelzine had relapsed. [Heimberg, et al., 128th Annual Meeting of the Assn. for the Advancement of Behavior Therapy (1994)] The phenelzine response is immediately the same or slightly better than CBT, but the CBT is better in the long-term. Idem. For these reasons, it is suggested that the combination of the two is likely valuable. [Wells and Matthews, Attention and Emotion: a clinical perspective. (1994)] A diagnostic tool used to evaluate Social Phobia is the Fear of Negative Evaluation (FNE) Scale. [Watson and Fried, supra]

AGORAPHOBIA

In Greek, "αγορα" is the public square, and Agoraphobia is the fear of public spaces. The key features of this disorder are a fear of having a lack of an escape (the text uses the word "exit," but that seems to close to claustrophobia and ackward) and fear of being helpless while collapsed in public. Agoraphobia may be triggered by leaving home in some, shopping, crowds, public transportation (subways, buses, planes, etc.), and in some even being in "deserted places." The term "agoraphobia" was first used to describe anxiety that appeared in empty streets, crowded rooms, or open spaces -- and alleviated with accompanyment. [Westphal, Archiv für Psychiatrie und Nervenkrankheiten 3:384-412 (1871)]

It is suggested that agoraphobia may not exist as a distinct diagnosis, but rather is a complication of panic disorder. [Klein, Anxiety: New Research and Changing Concepts. (1981)] This aligns with what this student has read in moree recently published texts.

Agoraphobia is better defined a feature of panic disorder -- and a co-morbidity to other anxiety disorders.

Prevalence:

In the Epidemiological Catchment Area (ECA) study, a lifetime prevalence for agoraphobia was found to be 1.4 - 6.6% without panic and 1.7 - 2.6% with panic symptoms. [Weissman, et al., Psychopharmacology Bulletin 26:543-45 (1986)] This confusion in diagnostics of agoraphobia is discussed in the text at length. Agoraphobia is "not codable" in the DSM-IV but is defined as existing as a feature of panic disorder, or as agoraphobia without history of panic disorder.

Treatment:

Exposure therapy is used within the CBT framework. This comes to us

through the adaptation of Ivan Pavlov's classical conditioning. This technique is referred to as systematic desensitization. [Wolpe, Psychotherapy by Reciprocal Inhibition. (1958)] Another similar conditioning-related model is Barlows. "...an ancient alarm system, crucial for survival, with inappropriate and maladaptive learning and subsequent cognitive and affective complications." [Barlow, Anxiety and its Disorders, (1988)] The premise being that agoraphobia may be a set of adaptive characteristics important to man's survival, but have been exagerrated and gone haywire.

CBT seeks to identify the beliefs that instigate avoidance and escape behaviors and any attendant behaviors of seeking safety. [Salkovskis and Clark, Panic and Pobias. (1986)] An interesting example given was to have the patient watch while a therapist pretends to faint in a public place. The patient will see that members of the public actually rush in to offer help. One must be concerned that today, in 2023, with the decay of concern for our fellow man in this culture that that therapy technique may not still work... it may contribute to the patient's fears!

Blood-Injury-Injection Phobia

The DSM-IV classifies Blodd-Injury-Injection (BII) phobia along with the "Specific" phobias. In BII "the fear is cued by seeing blood or an injury or by receiving an injection or other invasive medical procedure." (APA, p. 406 (1994))

As with other specific phobias, to meet diagnostic criteria this fear must be unreasonable (and known to be unreasonable) by the phobic, avoided or endured with intense anxiety, distressing to the extent that it interferes with normal functioning, persistent (6+ months in <18 year olds) and consistent.

An important characteristic that differentiates BII from other phobias is that 70-80% of patients experienced fainting when in presence of the phobic stimulus. [Thyer, et al., J.Clin.Psych. 41:451-59 (1985)]

Prevalence:

BII occurs in 3.1% of the general population. [Agras, et al; Comp.Psych. 10:151-56 (1969)] Another found 4.5% in a sample of Canadian women. [Costello, J.Ab.Psych. 91:280-86 (1982)]

Treatement:

Because the vasovagal syncope is a prominent feature of injection phobia, (and BII generally, but so commonly associated to blood draws, etc.) the treatment teaches the patient to use "applied tension." This technique involves

flexing the major muscle groups as much as possible for 15-20 seconds and then relaxing for 30 seconds. This is done for 5 cycles. [Ost and Sterner, Behaviour Research and Therapy 25:25-9 (1987)] The literature contains an account of a 28 year old man who while watching a slide of a mutilated body after 75 seconds had bradycardia (30 bpm) and a 3-second long cardiac asystole. [Ost et al., Behaviour Research and Therapy 22:205-216 (1984)]

The treatment also includes exposure, to include imagined exposure, slides, and up to in vivo. These are worked up to incrementally. For example, an injection phobic would complete treatment at a blood donation center viewing others give blood and ultimately giving blood themselves.

ANIMAL PHOBIAS

Animal phobias are "specific" phobias wherein the feared stimuli are animals. The most common animal phobias are of spiders, bugs, mice and snakes. [Bourdon, et al., J.Anx.Disorders 2:227-41 (1988)] The proposition that there may be a predisposition to humans having a phobic response to these is reflected in the finding that "ugly, slimy, speedy or sudden-moving animals are experienced as less approachable and more fear-provoking than animals without these qualities." [Bennett-Levy and Marteau, Br.J.Psych. 75:37-42 (1984)] While fears of other animals exist, they are rare. Disgust and contamination fears are correllated to animal stimuli that induce the phobia. This is not the case for predator animals as objects of phobia. (eg. Shark, Tiger, Lion, Bear...) Idem. Indeed, by the diagnostic criteria, a specific phobia need be unreasonable, and thus a bear-phobia may not exist but in wildly rare cases, and would be extremely difficult to differentiate appropriate bear fear from bear phobia.

Prevalence:

Studies find the prevalence in general population for clinically defined phobias is 11% in the U.S. [Agras, et al., supra] Specific phobias make up a plurality, and of those 14% are animal phobias. [Barlow, Anxiety and its Disorders: The Nature and Treatment of Anxiety and Panic (1988)] Women are disproportionately represented in specific phobia studies. The literature suggests the gender disparity may be due to reproductive hormones as socio-cultural sex-role stereotypes. [Costello, J.Ab.Psych. 91:280-86 (1982)] There is little doubt this postulation would NOT pass muster in our 2023 culture of woke ideology and gender equity, but in 1982 the statement was fine.

Treatment:

There was (at the time of the writing of the text) no known effective pharmacological treatment for animal phobias. "No psychotropic drug has been found to be effective in the treatment of simple phobias." [Fyer, Simple Phobias. In D. Klein (ed), Anxiety (1987)]

CBT is the treatment of choice. Here again, exposure to the stimulus in a controlled setting is a CBT technique that is efficacious. For example, in the case of spider phobias, a spider's movement is a great trigger. Spider phobics tend to believe that spider movements are unpredictable. [Davey, Anxiety Research 4:299-314 (1992)] Thus, the treatment begins with therapist demonstrating a spider in a clear bowl, following it with a pen and then his finger, and then capturing it in a glass with a card. The patient follows the therapist's example. Then repeated with a bigger spider. Always the therapist emphasizes that the spider may be controlled and the spider's movements predicted. [Ost, Behaviour Research and Therapy 27:1-7 (1989)] This is a one-session treatment plan. This contrasts with the proposition that phobias are highly resistant to extinction. [Seligman, M.E.P., Behaviour Therapy 2:307-21 (1971)] In the spider therapy example, the patient is videotaped and provided with the recording for long-term reminders of the accomplishment.

DENTAL PHOBIA

3-5% of the adult population have a debilitating level of anxiety and fear of dental procedures. [Moore, et al., Behaviour Research and Therapy 29:51-60 (1991)] This is diagnosed by self-report questionaire. The most commonly used is Corah's Dental Anxiety Scale (DAS). [Corah, J.Dental Research 48:596 (1968)] Also available are the Dental Fear Survey (DFS) [Kleinknecht, et al., J.Am.Dental Ass'n 86:842-848 (1973)] and the Dental Belief Survey [Milgram, et al., Treating Fearful Dental Patients: a Clinical Handbook (1985)]

Etiology:

Well supported is the premise that Dental Phobia is a classically condictioned response to pain and negative experiences in dental care, à la Pavlov. [Lautch, Br.J.Psych. 119:151-58 (1971)]

Treatment:

Using conscious sedation via nitrous oxide is one technique to assuage dental phobia, [Veerkemp, et al., J.Dent. for Children 60:372-76 (1993)]

as is the sedative midazolam. [Kupietzky and Houpt, Pediatric Dentistry 15:237-41 (1995)] Perhaps other anxiolytic or sedative is appropriate (eg., Valium), but the text does not mention this.

Informative brochures as a behavioural therapy are effective. [Jackson and Lindsay, Br.Dent.J. 179:163-67 (1995)] Further treatment options are the gradational exposure as used in other specific phobias, patient encouragement, or hypnosis. [ter Horst, et al., Int.Dent.J. 43:265-78 (1993)][Kent and Blackhorn, The Psychology of Dental Care. (1991)]

WATER PHOBIA

The fear of water; not to be confused with "hydrophobia" which is a term for rabies coined by Celsus. [Grieve [trans.] Celsus, Aulus Cornelius: Of Medicine (1814)] Here, water phobia is an infrequent adult specific phobia marked by a refusal to bathe or shower. [Menzies, et al., Clin.Psych.Rev. 15:23-48 (1995)] Extreme cases where there is a refusal to wash their hair results in its removal.

While infrequent in adults, the fear of water and refusal to bathe is a prevalent phobia in children. [Miller, et al., Child Personality and Psyhopathology: Current topics. (1974)] Water phobia was more frequent than spiders, insects, dogs, heights, enclosed spaces, injection, blood, and 71 others considered, Only fear of snakes and rats were reported more in their sample of 7-12 year olds. Idem. One in twenty were unreasonably afraid of water.

Etiology:

Water phobia research suggests it to be mostly innate, an inference drawn from the young age of onset, and the low level of reports of Classical Conditioning (Pavlovian) influence. [Menzies and Clark, Behaviour Research and Therapy 31:499-501 (1993)] Water phobia may develop in children with no traumatic or adverse experiences with water.

Treatment:

In vivo exposure therapy is the successful route to eliminate water phobia. [Pomerantz, et.al., J.Beh.Ther.Exp.Psych. 8:417-21 (1977)] The initial fear response to water is argued to be a native evolutionary reaction. [Menzies and Clarke, supra] The therapy requires exposure. Habituation may require beginning with observant exposure, vicarious exposure and gradually moving to in vivo exposure.

HEIGHT PHOBIA

Acrophobia (Greek: ακρος "height" φοβος "fear") is the fear of heights. It was described at least as early as Hippocrates, and has been claimed to be the most common of the simple phobias. [Zutt, J.Nerv.Ment. Disease 116:789-93 (1952)]

Prevalence:

Fear of heights was found to be the third most common in general practice, [Burns, J.Int.Med.Res. 8(supp. 3):1-7 (1980)] 5% of all phobics and 2% of all phobics in treatment. [Agras, et al., Comp.Psych. 10:151-56 (1969)]

Etiology:

Fear of Heights is evidenced to be innate and evolutionarily valuable. The "visual cliff" experiment demonstrates this trait in human infants. A thin board is placed on a horizontal sheet of glass suspended above the floor. On one side a sheet of material is attached to the underside of the glass, so as to look shallow, some material laid flat on the floor to the other side of the board, so as to appear deep. Hence, a "visual cliff." 36 babies 6-14 months of age were tested, began on one end of the board. Their mothers would call them alternatively to the "deep" side and "shallow" side of the visual cliff. Of the 27 (out of 36) who never left the board, only 3 ventured to the "deep" side. Many simply cried. [Gibson and Walk, Scientific American 202(4): 64-71 (1960)] Experiments on other terrestrial animals (chickens, goats, and lambs) gave similar results. Even at 1 day old, no chick, kid or lamb ever stepped onto the "deep" side of the visual cliff. Idem. Other researchers have extended this work to cats, dogs, pigs and monkeys. Aquatic species such as ducks readily cross onto the "deep" side. [Emlen, Behaviour 22:1-15 (1963)]

Treatment:

As with water phobia just discussed, and many specific phobias, gradual desensitization and in vivo exposure is the efficatious treatment choice. One case study discusses treatment of a 40 year old male using binocular lenses in reverse to give the patient the visual experience of height. [Schneider, J. Beh.Ther.Exp.Psych. 13:333-36 (1982)] In one study, self-administered desensitization treatment worked better than that administered by an experimenter. [Schaap and Dana, Psych. Reports 23:969-70 (1968)]

ACCIDENT PHOBIA

The chapter discussed accident phobia primarily in the context of motor

vehicle accident (MVA) survivors, and their resultant specific phobia of driving in cars. The discussion was highly intertwined with PTSD. Due to the high amount of overlap between Accident Phobia with any other specific phobia and PTSD, the summary here would be mostly reptetitive.

CLAUSTROPHOBIA

The fear of enclosed places. (Latin: claustrum "enclosed place")

Prevalence:

One survey found that severe claustrophobia may affect as many as 2-5% of the population at large; incidence in clinics is low. [Marks, Fears, Phobias and Rituals, (1987)] This phobia is more common in women as compared to men. [Costello, J.Ab.Psycho. 91;280-86 (1982)][Kirkpatrick, Behaviour Research and Therapy 22:141-150 (1984)]

Etiology:

Claustrophobia, summarized from the text, is comprised of two mutally exclusive components that result in the same symptom: fear of suffocation and fear of restriction (of movement).

To differentiate these two fear components, experimenters used a questionnaire and 5 behavioral tests. The 5 behavioral tests were "breathing through a straw, donning a gas mask, standing in a closet, tied in a canvas bag, [and] lying on a shelf resembling a bunk bed." The questionnaire included items like handcuffing, hands tied behind your back, straitjacketing -- triggering restriction fears; and swimming with a nose plug, snorkeling, having a cold with a very stuffy nose, and having a pillow over your face -- triggering suffocation fears. In claustrophobics these triggers were associated to one another, co-occurring. In non-claustrophobics, restriction and suffocation fears operated independently. [Rachman and Taylor, J.Anx.Disorders 7:281-91 (1993)]

The idea of symbolic restrictive fear as a form of claustrophobia has been considered. The given example being a marriage wherein the patient felt she was "caught like a rat in a trap." [Wolpe, Psychotherapy by Reciprocal Inhibition. p. 99 (1958)] The text describes this as being "illuminating and even persuasive," but ultimately inconclusive.

Treatment:

The treatment for claustrophobia is performed like many of the simple phobias using exposure in gradations, and habituation leading to extinctionof the fear. Repeated exposures where the patient finds, "I did not suffocate,"

results in cognitive disconfirmation of the fear and fear modification. [Ost, et al., Behaviour Research and Therapy 20:445-460 (1982)] Claustrophobia may fall into a category of fears with obvious survival value, with early onset (suggestive of innate-ness) that Seligman called "prepared fears," [Seligman, Behaviour Therapy 2:307-20 (1971)]

ATYPICAL PHOBIAS

Not unlike the Psychopathology textbook (Castonguay and Oltmanns) for this course, the instant textbook also has a "grass-catcher" chapter on rare phobias. The author makes a similar joke at the expense of funny-sounding Greek-derived phobia names, stating that "sufferers of hellenologophobia (i.e. fear of "pseudoscientific terms") will surely tremble to contemplate many of the entities uncovered by Maser ["List of Phobias" Anxiety and the Anxiety Disorders, pp. 805-13 (1985)] in his search through the literature." (That hellenologophobia; helleno- "greek" logo- "word" phobia- "fear", is defined as a fear of "pseudoscientific terms," is hilarious!)

This chapter introduces us to fears of choking, vomiting, disease, flying, space (not outer-space, but open spaces/falling), noise, (...going more exotic) dolls, eye-patches and newspapers.

An interesting culturally-bound example given was Taijin-kyofu-sho (TKS) (Taijin- "strangers" kyofu- "fear" sho- "sympton") TKS is very common in Japan, (and rarely outside of Japan) 7% to 36% of patients receive this diagnosis, which is characterized by a fear of embarrassing others. (contrast: Westerners with SAD who fear public embarassment, of themselves) [Prince and Tcheng-Laroche, Culture, Medicine, and Psychiatry, 11:3-19 (1987)]

Biological predisposition:

Seligman (1971) proposed the concept of preparedness theory, stating that fears are genetically transmitted explaining modern man's fears of these stimuli that were threatening to ancient man. Expanding on this, "it is a remarkable fact that phobias are easily evoked by many of the greatest dangers of mankind's ancient environment, including closed spaces, heights, thunderstorms, running water, snakes and spiders." Of equal significance, "phobias are rarely evoked by the greatest dangers of modern technological society, such as guns, knives automobiles, and electric sockets." [Lumsden and Wilson, Behavioral and Brain Sciences 5:3 (1982)]

A very interesting observation made by the text is the difference in distribution of phobias across stimuli based upon the survey used. Where 40 stimuli from traditional fear scales were used in the survey, fear of snakes

was most prevalent. [Agras, et al., Comp.Psych. 10:151-56 (1969)] Whereas where a 133 item survey was used (which included a blank to fill in unlisted fears) and in this study womens' top fears were roller coasters and untimely death; for men the top fear was "punishment by God." [Kirkpatrick, Behaviour Research and Therapy 22:141-150 (1984)]

Another example describes a woman who was looking at a photo of a snake when the car she was riding in was involved in a car-crash. She did not develop an accident phobia of MVAs, rather she developed a phobia of snakes. [Marks, Psychopathology: Experimental Models (1977)]

In an attempt to induce a phobia in phylogenically irrelevant stimuli, researchers used captive-bred rhesus monkeys with no learned fear of snakes. Using videotapes edited showing wild monkeys expressing fear responses, a video showing monkeys expressing fear toward snakes and another toward a flower were created. Monkeys observing the snake video did develop fear of snakes, monkeys observing the flower video failed to develop fear of flowers. [Mineka and Look, J.Exp.Psych.: General 122:23-38 (1993)] We may conclude that phobias originate from an evolutionary-derived readiness to fear situations that threatened survival of our distant hunter-gatherer ancestors. [Marks, supra; Seligman, supra; Ohman, et al., Theoretical Issues in Behavior Therapy, pp. 123-179 (1985)]

Pharmacological intervention:

The use of anxiolytics in fear reduction has a long history. The text offers the example of soldiers who used alcohol prior to battle to boost their courage. [Keegan, The Face of Battle (1993)] The text does suggest that treatment with drugs may offer positive results in panic disorder and agoraphobia. We learned this in the Anxiety disorders section of our other text. Here the use of anti-depressants is said to reduce panic frequency. [[Mavissakalian, Br.J.Psych. 143:348-55 (1983)] The literature speaks to drugs used in the treatment of social phobia as well. Efficacy measured using MAOIs [Liebowitz, Clin.Neuropharmacology 16(Supp. 2):S83-8 (1993)], alprazolam [Lydiard, et al., J.Clin.Psych. 49:17-19 (1988)], benzodiazepines [Davidson, et al., J.Clin.Psych. 52(suppl. 11):16-20 (1991)], fluoxetine [Van Ameringen, et al., J.Clin.Psych. 54:27-32 (1993)], buspirone [Schneier, et al., J.Clin. Psychopharmacology 13:251-56 (1993)]. Drawbacks to pharmacology include side effects, risk of relapse, and lack of long-term efficacy. Many of these drugs have unwanted or even dangerous side effects. Examples include that MAOIs

May lead to high blood pressure. Tricyclics have the potential for suicidality and self-harm in overdose. [Arana and Hyman, Handbook of Psychiatric Drug Therapy (1991)] Most criticized are th benzodiazepenes which have a risk of dependency, withdrawl, and the potential for an "amnesic" effect which would result in a patient "forgetting" the skills learned in therapy. [Curran, Biological Psychology, 23:179-213 (1986)] This is balanced against rapid short-term efficacy with pharmacological treatments (some anti-depressants excepted due to a "ramp-up" period of a couple of weeks for efficacy) and the synergistic effects accomplished with medication and CBT combined. [Mattick, et al., J.Nerv.Ment.Disease, 178:567-76 (1990)]

CONCLUSION

The textbook used intthis class, Phobias: A Handbook of Theory, Research and Treatment by Graham Davey was slightly dated, published in 1997 and based upon the Diagnostic and Statistical Manual 3rd and 4th editions, along with research and publications, overwhelmingly from the 70's,80's and 90's. Notwithstanding, the text remains relevant today, and so the reading was valuable. As the opportunity arises in the remainder of this coursework, we will investigate newer journals on Phobias and compare to the reading that has been done, looking for any changes in the literature as to diagnosis or treatment. At first blush, the regular citation to the use of Cognitive-Behavioral Therapy in the treatment of the Phobias leads one to believe that this text continues to hold up. This is based on the continued overwhelming use of CBT up to the present day, 2023. Indeed, here in this student's immediate surroundings, the Buena Vista Correctional Facility, a prison in Colorado, the programs offered here for improving the prisoners' criminality are also based in CBT principles. For this reason one may infer that CBT's emphasis on changing maladaptive beliefs and behavior correction that is based in classical conditioning; if it can be effective in the penal environment for criminality it is reasonable that it continues to be the best course of action for remediating the fears found in phobics as well.