THE TREATMENT OF PHOBIC STATES BY BEHAVIOUR THERAPY

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SYNOPSIS

The techniques of Behaviour Therapy in the treatment of resistant phobic states is of recent development in Modern Psychiatry. This paper deals with the principles of Systematic Desensitization and Reciprocal Inhibition under deep muscular relaxation. Three cases of severe, incapacitating phobic states were treated by this technique with good remission of symptoms.

THE NATURE OF BEHAVIOUR THERAPY

Behaviour therapy is defined as the application of the principles of modern learning theory in the treatment of neurotic disorders (Eysenck, 1960). It defines neurotic symptoms as maladaptive conditioned autonomic responses. Their treatment consists essentially of the extinction of autonomic, skeletal and muscular responses of this type. The most important method used in counter-conditioning is that described by Wolpe (1958, 1961) in what is known as systematic desensitization by reciprocal inhibition under deep muscular relaxation. It has always been emphasized that behaviour therapy is purely symptomatic and is based on the theory that 'there is no neurosis underlying the symptom, but merely the symptom itself', (Eysenck, 1960). It would consequently follow then that the treatment of symptoms would result in the cure of the neurosis.

Wolpe, (1952) demonstrated that the induction and elimination of experimental neurosis in animals were possible, and that these conditions were persistent habits of maladaptive behaviour acquired by learning, and that their therapy is a matter of unlearning. The central constituent of the neurotic behaviour is anxiety, and the most effective way of processing unlearning is repeatedly to feed the animal while it was responding to a weak conditioned stimulus. If a response inhibitory to anxiety can be made to occur in the presence of anxiety-evoking stimuli so that it is accompanied by a complete or partial suppression of the anxiety response, the bond between the stimulus and the anxiety response will be weakened. The utilization of behaviour therapy in the treatment of neurosis was not taken seriously until the appearance of Wolpe's book on "Psychotherapy by Reciprocal Inhibition" in 1959.

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A basic premise of neuroses in this regard is that they are persistent, maladaptive learned habits of behaviour. The aim of behaviour therapy is always to change behaviour patterns which are acknowledged as undesirable by the patient. The principles deal essentially with symptomatic treatment, i.e., the elimination of the symptom, leaving other socially-orientated practices to revert the maladaptive behaviour, thereby curing the neurosis. Almost universally, anxiety is a prominent constituent of the neurotic reaction. Thus the elimination of the anxiety response habit seems to require the inhibition of the anxiety by a competing inhibitory response. The formal process is the establishment of conditioned inhibition through what is termed the "reciprocal inhibition principle".

SYSTEMATIC DESENSITIZATION BY RECIPROCAL INHIBITION

The method of systematic desensitization by reciprocal inhibition based on relaxation (Wolpe, 1958) is as follows:

1. A graded list of hierarchy of a patient's fears is drawn out. These include situations in which the patient feels anxious, the situations being graded from least to most anxiety-evoking.
2. The patient is put under deep relaxation with various techniques of muscular relaxation, particularly the variation of Jacobson's technique (Jacobson, 1938).
3. The conditioning commences by presenting to the deeply-relaxed patient the first item on the hierarchy. The patient is told to visualise an anxiety-evoking scene as vividly as possible and is also instructed to indicate if the visualisation of the scene causes any subjective feelings of anxiety. When the patient is able to visualise the scene a number of times without any anxiety, the next scene

up the hierarchy is presented and so on. The hierarchy is completed in this manner; desensitization is then complete. The situation dealt with will no longer be anxiety-evoking to the real life situation.

The basis for this technique is the fact that relaxation at the autonomic level is anxiety-inhibiting, thus when the hierarchial scenes are presented to the patient, the relaxation inhibits the associated anxiety by conditioning to that particular situation, thereby breaking the bond between the situation and the anxiety. The detailed steps in deconditioning are described by Wolpe and Lazarus (1966). Generally, systematic desensitization is the piecemeal breaking down of anxiety responses by employing the physiological state of relaxation which is incompatible with anxiety. This inhibits the anxiety response that the stimulus evokes. By repeated exposure to the anxiety-evoking response, anxiety eventually loses its strength and the patient loses his neurosis. The autonomic effect that accompanies deep muscular relaxation is diametrically opposed to the characteristic symptoms of anxiety. It has been experimentally shown that a stimulus that evokes a strong anxiety response may be presented as many as 20 times to the patient without the strength of anxiety diminishing in the least. By contrast, if the anxiety response is weak under relaxation with the presentation of the stimulus, the amount of subjective anxiety becomes less and less until it no more exists. Clinically there appears to be an inverse relationship between the magnitude of the anxiety a stimulus evokes and the ease at which the anxiety-evoking potential can be overcome by a given degree of relaxation.

The technique of systematic desensitization can only occur after a careful assessment of the therapeutic requirements of a patient. A detailed history must be taken of every symptom and every aspect of life in which the patient experiences difficulty, as well as careful scrutiny of his personal relationships and his work history.

CAUSES AND TREATMENT OF PHOBIAS BY BEHAVIOUR THERAPY

The causes of phobias which can be psychodynamically-orientated are said to be due to a basic fear of personal, sexual or aggressive activity and that the phobia fulfilled the dependency need at that time. Often it is seen that the phobia had to play a central role in the patient's life, determining his inter-personal relationships and binding them in a rigid and safe way of life. Psychodynamic theory and formulation may be useful for behaviour therapy in providing the stimulus situation assumed to be relevant that does not evoke observable behaviour. Some phobias can occur within the patient, without an externalized anxiety-evoking situation present. Such phobic fears which will be described in two patients in this paper are fears of one's own internalized feelings which come to consciousness and are beyond the voluntary control of the patient in that he is unable to suppress the phobic fear which he recognises as abnormal, irrational and not characteristic of himself. They are generally found together with other obsessive-compulsive phenomena and are so bound up and are so regarded as obsessive-compulsive disorders. Obsessional phobias are bound up with elaborate rituals and magical thinking and are very resistant to treatment.

Hollinghead and Redlich (1958) found that phobias accounted for 20% of all cases of neurosis in psychiatric treatment at an estimated rate of 0·5 per 10,000 population. However, Agras *et al*, (1969) made a sample survey of a community in the United States and found that the total prevalence of phobias was estimated at 77 per 10,000 population. Of these 75 per 10,000 were considered to be mildly disabling and 2 per 10,000 severely disabled. They found that common fears had a high incidence during childhood falling rapidly during adolescent and early adult life. Phobias are said to run a prolonged course and for most of the time are mildly disabling. Psychiatrists, however, were said to see only a small percentage of the phobic population i.e., 9 per 1,000 and these are usually severely-disabled patients.

Curran and Partridge (1955) said that phobic symptoms are notoriously resistant to treatment and their complete removal is rarely achieved. Paul (1966), Lang and Lazovik (1963) compared desensitization with short periods of interpretative psychotherapy and concluded that desensitization relieved phobias more effectively than any other treatment. However Gelder (1964) in the treatment of phobic disorders viewed it practical to send patients both for behaviour therapy and psychotherapy concurrently. Marks and Gelder (1966) in a controlled and comparative study of phobias between behaviour therapy and psychotherapy found that in the long run, there was no difference in the ultimate results by behaviour therapy or psychotherapy. However, patients undergoing behaviour therapy had reduction of symptoms at a much earlier stage in therapy than those undergoing psychotherapy. Behaviour therapy pursued more limited therapeutic aims that were mainly concerned with symptomatic relief, while psychotherapy often attempted a more fundamental re-organization of the personality of the patient

and was concerned more with the patient's emotional conflict and problems in a wider sense. Psychodynamic methods aid the patients in developing new ways of coping with problems of living in a broader perspective and they try to explore feelings and inter-personal relationships and in so doing help to modify presenting symptoms indirectly.

Later on, in a controlled study, Gelder *et al* (1967) found that symptoms especially presenting with phobias improved faster with desensitization than with psychotherapy. After six months, desensitized patients improved and changed significantly but the difference diminished later as psychotherapy patients improved but at a slower pace. Social adjustment was definitely greater with desensitization. There was no evidence of symptom substitution. The motivation of the patient in seeking treatment by desensitization is extremely important. Frank (1961) stated that the high motivation of the individual created higher expectancy in the cure of the illness, and this is an essential part of every psychotherapeutic transaction, regardless of whether the patient presents himself for behavioural or dynamic psychotherapy. The patient's faith in the therapist is a strong determining factor in persuading him to relinquish his symptoms in the powerful patient-therapist relationship.

Some patients while seeking help are ambivalent. Furthermore motivation sometimes fluctuates during treatment in ways which may have introduced important variables into the therapeutic situation. According to Meyer and Crisp (1960), poor motivation was often associated with:

(*a*) the emergence of new symptoms or the enhancement of untreated symptoms;

(*b*) the failure to effect improvement of target symptoms;

(*c*) the development of extreme dependency on the therapist;

(*d*) the development of poor patient-therapist relationship;

(*e*) the development of a hostile attitude to treatment situations and methods used.

CASE STUDIES OF THREE PHOBIC PATIENTS UNDER BEHAVIOUR THERAPY

Case 1 *(In Detail)*

HISTORY

A 30 year old unmarried, English-educated, Indian male, a technician was initially seen for severe phobic symptoms for the last three months. He was unable to walk from his home to the bus stop to board a bus to his place of work. In fact, each day was an ordeal going to and from work. He felt tense, anxious and panic-stricken each time he walked along the road. He was very conscious that people were looking at his genitals and thus tried to walk in a "swaggering" gait to prevent his genitals from knocking the sides of his thighs. He also harboured an obsessional phobic thought of being watched by onlookers and was unable to get rid of these anxiety-evoking thoughts. At the time of consultation, he was almost house-bound and paralysed with panic and anxiety.

After some probing, it became apparent that his symptoms commenced shortly after his parents had planned that he should get married as he was growing old. They had made arrangements for him to go to India to choose a bride. Although the patient objected to this, he found it difficult to displease his parents and protest openly. Furthermore, they had set the wheels in motion for the impending marriage which was due in six months. He experienced intense anxiety over this situation and was most distressed. He then made arrangements to go for a holiday to London and Europe prior to meeting his parents in India. This, apparently, was a move to delay the wedding. However, he was unable to link the relationship of his conflict over the marriage with his severely-incapacitating phobic symptoms. To make the situation worse, there was no specific girl in mind and he was to obtain the aid of relatives in India to find a suitable bride when he arrived. Till the time of his departure to India he had still hoped that things would work out right and rationalised that his sister had also entered into a matched marriage and everything had turned out well.

Clinically, he was an atheletic, masculine-looking Indian who was anxious and very tense. He wore a manila shirt which was not tucked in, stating that it partially hid his genitals from the public view. There was no clinical evidence of any homosexual tendencies or sexual deviation. He was a mild diabetic which was controlled by diet and this worried him excessively that he might become impotent. He was diagnosed as a case of severe phobic state and the treatment by behaviour therapy utilising systematic desensitization and reciprocal inhibition with deep muscular relaxation was explained to him.

A construction of a hierarchy of anxiety-evoking stimuli was made from the most relaxed to the most intolerable anxiety-evoking situation.

Hierarchy Constructed (least anxiety-evoking to maximal intolerance):

1. When alone in his bedroom reading in the middle of the night.
2. Watching television alone.
3. Watching television with one friend to six friends.
4. Walking into an empty restaurant.
5. Leaving his home when there is no one around.
6. Standing at an empty bus stop waiting for a bus.
7. Boarding an empty bus.
8. Crossing the road with someone on the other side watching him from the front.
9. Crossing the road with someone looking at him from behind.
10. Changing into pyjamas in his bedroom with windows closed.
11. Changing into pyjamas in his bedroom with windows opened.
12. Changing into pyjamas without wearing any underwear.
13. Waiting at the bus stop with a few people.
14. Boarding a half-crowded bus.
15. Entering a half-filled restaurant.
16. Walking into a crowded street.
17. Waiting at a crowded bus stop and the bus arrives late.
18. Boarding a crowded bus and sitting opposite a woman (he would rather stand).
19. Walking into a crowded restaurant.
20. Sitting at the front row of the church pew.
21. Giving a talk to an audience ranging from four to twenty persons (intolerable).
22. Leaving home where there are lots of people around, and walking to the bus stop which is crowded, the bus arrives late and he boards a crowded bus where he has to sit in front of a woman (most intolerable).

THERAPY SESSIONS

Eighteen sessions of systematic desensitization and reciprocal inhibition under relaxation were conducted. The sessions ranged three to four times a week at half-hour intervals. A couple of sessions were spent training in deep muscle relaxation. He was then taken through the constructed hierarchy of anxiety-evoking responses from least to maximal anxiety in imagination and subsequently in real life. After six sessions, he was able to go into town and wait at the bus stop without much anxiety. He started coming on time after a few sessions as he did not need to miss the crowded buses on the way to hospital. By the ninth session, he was able to sit at the second row of the church pew on Sunday. He felt better and happier although there was a feeling of panic coming on and off. During the twelfth session, he said that his phobic symptoms were only related to leaving his house where there were many onlookers. It was during his thirteenth visit, which was supposed to be his last but one (as he had booked an air ticket to go to Britain the following week) that he relapsed. He came in trembling, panicky and complained that he had a severe relapse of his symptoms. However, he was able to tolerate the entire hierarchy without anxiety. It was then interpreted to him that his behaviour was a reaction to termination in therapy. However he postponed his trip to Britain for another two months and continued coming for therapy at spaced-out intervals. Concommitantly supportive therapy was given. At the eighteenth session, he was symptom free and was ready to leave for Britain and then to India. Throughout the sessions, he was made to talk about his impending marriage and his anxieties were exposed and discussed. He was still apprehensive even at termination of therapy about the impending wedding but was however able to board the aeroplane without panic.

Case 2

History

A 21 year old Chinese university student, complained that he could no longer cope with his studies, as his mind was tense and overpowered by uncontrollable, terrifying thoughts. As a result, he found it difficult to sustain any form of concentration in his studies. For the last three years, he had experienced severe obsessional phobic thoughts. These symptoms were initially minimal, but when he entered the university, the obsessional phobic thoughts became more and more incapacitating until he was unable to concentrate in his studies. At the time of consultation, he could only study 30 minutes a day.

He experienced an irrational thought that the people over the other side of the earth were standing up-side-down and might lose their gravity pull and be flung out eternally and endlessly into the space. Furthermore, he was afraid that he himself might lose the earth's gravity and be thrown by centrifugal force into space and be lost forever. Each time these uncontrollable obsessional phobic thoughts occurred, he felt an intolerable anxiety and panicked. He had become so incapacitated by these symptoms that he became entirely paralysed by fear and anxiety. The thoughts

occurred the moment he awoke till the time he fell asleep at night, and were a repititive recurrence in his mind throughout the period of wakefulness.

He was diagnosed as an obsessional phobic anxiety state and in a very obsessional personality. Due to the urgency of his forthcoming examinations, he was immediately treated by behaviour therapy. The technique utilised systematic desensitization and reciprocal inhibition under deep muscular relaxation. A further technique of Implosion (flooding) was concommitantly used. He was taught deep muscular relaxation exercises, and a hierarchy of anxiety-evoking situations around a constellation of his fear of heights and falling and being lost in the universe was constructed.

Sixteen sessions of behaviour therapy were instituted ranging from three times a week and later at more spaced-out intervals when symptoms abated. He wast aken up the hierarchy of anxiety-evoking situations and felt much better immediately after the second session. In fact, after that session, he was able to study one hour a day. It was also decided to utilise the technique of implosion, i.e., flooding. By contrast to systematic desensitization, in flooding treatment, he was asked to enter the phobic situation, initially under relàxation and later without relaxation, and to experience the phobic fear at maximal intensity for a long period until he was no longer capable of experiencing fear. In successive sessions, he found it increasingly difficult to feel frightened in the phobic situations. By the fourth session, he was able to study five to six hours a day. Flooding technique was instituted at each session. By the seventh session, he was studying some eight hours a day and was no more terrified by the phobic thoughts, the frequency of which was drastically reduced. On follow-up, he never lost these thoughts completely but was able to manage them when they recurred. He had by then acquired the principles of flooding. It was interesting that through therapy, he had gradually begun to be less tense and less obsessional and some degree of personality change also occurred in the therapeutic situation.

Case 3

History

A 24 year old Chinese university student was referred with severe obsessional phobic symptoms which had dominated his life for the last four years. Since then, he had found himself checking and rechecking his name in the examination papers. This worsened and he found that he had to check and recheck taps, locks to doors, switches to electric lights, and even checking whether he had left his notes or his books in the lecture halls or in the library. The symptoms became so severe that he was unable to control them at all and became increasingly incapacitated by them. At the time of consultation, he was unable to study, had lost his power of concentration and was afraid that he might fail his examinations. The most crippling symptom of his obsessional phobic thoughts was that he had to check and recheck his books many times to see that they were not misplaced. He also developed obsessional ruminations during the day and night and this disturbed his concentration and caused insomnia. He would say that his mind kept on wandering beyond his control and he felt extremely tense and anxious and paralysed by his symptoms. It was decided to treat him with systematic desensitization and reciprocal inhibition under deep muscular relaxation as well as utilisingthetechnique of implosion.

Seven sessions of therapy were instituted twice a week. He was taken up the entire hierarchy gradually in a state of deep muscular relaxation. The technique of implosion or flooding was instituted and he was made to imagine at each level of the hierarchy the anxiety-evoking situation repetitively until it was no more anxious. This was carried on right through until he was able to reach the topmost rung of his hierarchy at the end of seven sessions. He lost all his obsessional phobic symptoms by the sixth session and was no more anxious and was able to study without the interfering thought. His concentration had recovered. He no more checked or rechecked and felt that his recovery was almost complete.

DISCUSSION OF TECHNIQUES

Phobic symptoms appear to be particularly suitable for behaviour therapy. Three cases of phobic states were treated by the techniques of systematic desensitization and reciprocal inhibition under deep muscular relaxation. The process of implosion (flooding) was utilised in two of the cases. All three cases had good remission of their incapacitating symptoms and were able to resume functioning at their previous levels. Although the first case presented with well-defined underlying psychodynamic constellations, and could have been treated by psychotherapy, behaviour modification was instituted due to an urgency of time as he had to leave for India within a few months. Besides, it was known that behaviour therapy produced quicker remission of symptoms than individual psychotherapy (Gelder and Marks, 1967).

No attempt was made to define the underlying psychodynamic causes for the symptoms of the second and third cases which were obviously related to their rigid obsessional personalities. Psychotherapy of the obsessional states have been shown by Salzman (1966) to be fraught with difficulties and results extremely poor. Due to the urgency of the second case brought about by oncoming examinations, behaviour therapy was immediately instituted. Characteristically, obsessional symptoms can never be completely eliminated either by behaviour therapy or psychotherapy.

The principles in the treatment of phobic symptoms were initially learnt from cases of "shell shock" in the First World War, where subjects affected were taken away from the military atmosphere. It was then found that if a deliberate effort was made to allow the subject to experience the fear without escaping from it, they improved much more quickly. It was important that patients in treatment experienced the fears and anxieties that initially caused them to fall ill. Malleson (1959) suggested that phobic patients should "not be comforted, protected or cossetted". In fact, they should be made to face, recall and if necessary react the occasions of their fears, which would enormously improve the prognosis.

The technique of implosion or flooding has been found to be an effective method for treatment of phobias (Boulongouris and Marks, 1969). This technique is to produce as much anxiety as possible and for as long as possible. There is evidence that the method of implosion may ultimately turn out to be more effective than systematic desensitization, which is only partially successful in certain severe obsessionals.

In any psychotherapeutic relationship including behaviour therapy one starts with an individual with a problem which may be regarded as deviant or in the form of a subjective distress. There is no doubt that the feelings in therapist-patient interaction greatly influence the course of treatment (similar to the transference reaction in psychotherapy). A multitude of important relationships develop between the therapist and the patient as behaviour therapy progresses, just as they do in many forms of prolonged treatment. Cooper *et al* (1965) emphasized that the intense feelings developed by patients undergoing behaviour therapy to their therapists must obviously be associated with improvement. This relationship is not an integral and necessary part of the desensitization process, and success with the technique cannot be attributed solely or even primarily to this factor (Krapfl and Nawas, 1969). In a phobia, the whole pattern of the patient's behaviour changes to accommodate the phobic symptom; and in consequence, if the symptom is removed, it is necessary for the patient to make new adjustments. Kraft (1969) felt that changes in the patient's life adjustment may be surprisingly far reaching in the behaviour therapy of target symptoms. It would appear that the symptom represents an outward manifestation of underlying psychopathology and that in the course of desensitization, not only is the target symptom removed, but at the same time, a change is affected in the dynamic causes of symptoms. Meyer and Crisp (1966) stated that patients showed a deterioration of their treated symptom when termination was imminent. This occurred in the second case and was probably related to the problems of dependency and termination. The similarities of behaviour therapy and psychotherapy have been discussed by many authors (Marks and Gelder, 1966; Sloane, 1969). Psychotherapists regard symptom change as only one aspect of improvement and may sometimes regard symptom change as only one aspect of improvement and may sometimes regard symptom removal as a false solution. Frank (1961) however, suggested that behaviour therapy merely speeded the natural process of recovery. Common to both approaches (Brady, 1967) are elements of warmth, tolerance, and non-judgemental acceptance by the therapist. These encourage relaxation in the patient. It must be noted that all therapies (behavioural or psychotherapeutic) involve a relationship and despite differing theoretical considerations and assumptions, common threads are present in both techniques.

The three cases of phobias treated have characteristics peculiar to Malaysians. The first patient underwent the anxieties of a westernized, educated Indian at being matched into marriage with a woman of a different socio-cultural background. the possibilities of a whole variety of psychological manifestations might occur from this conflicting situation. The other two university students came from Chinese backgrounds which demanded high expectations of their sons and they themselves originated from a high attainment sub-culture. The coalition of these two factors invariably caused much tension and anxiety and the development of phobic symptoms was only one of the many manifestations of this neurotic conflict.

CONCLUSION

The principles and techniques of behaviour therapy were discussed, especially Wolpe's method of systematic desensitization and reciprocal inhibition. The technique of desensitization and implosion was utilised to treat three severe cases

of phobias, of which two had severe incapacitating symptoms of obsessional phobic anxiety states. In all three cases, symptoms were alleviated almost completely in sessions ranging from 7-18. The inter-personal relationship between patient and therapist was also discussed as this was a potent factor in the success of behaviour therapy. Systematic desensitization and reciprocal inhibition under deep muscular relaxation, as well as the techniques of implosion have been shown to be an effective technique for the treatment of severe phobic states.

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REFERENCES

1. Agras, S., Sylvester, D. and Oliveau, D.: "The Epidemiology of Common Fears and Phobia." Comprehensive Psychiatry, 1, 151-156, 1969.
2. Brady, J. P.: "Psychotherapy, Learning Theory and Insight." Archiv. Gen. Psychiat., 16, 304-411, 1967.
3. Boulongouris, J. C. and Marks, I. M.: "Implosion (flooding)—a new treatment for Phobias." Brit. Med. J., 2, 721-723, 1969.
4. Cooper, J. E., Gelder, M. C. and Marks, I. M.: "Results of Behaviour Therapy in 77 cases." Brit. Med. J., 1, 1222-1225, 1965.
5. Curran, D. and Partridge, M.: "Psychological Medicine." Edinburgh, Livingstone, 1955.
6. Eysenck, H. J. (Ed.): "Behaviour Therapy and the Neurosis." London, Pergamon Press, 1960.
7. Frank, J.: "Persuasion and Healing: a Comparative study of Psychotherapy." London, 1961.
8. Gelder, M. C.: "Behaviour Therapy and Psychotherapy for Phobic Disorders." Paper read at 6th International Congress of Psychotherapy, London, 1964.
9. Gelder, M. C., Marks, I. M. and Wolff, H. H.: "Desensitization and Psychotherapy in the Treatment of Phobic States: A Controlled Inquiry." Brit. J. Psychiat., 113, 53-73, 1967.
10. Hollingshead, A. B. and Redlich, F. C.: "Social Class and Mental Illness." New York, John Wiley & Sons, 1958.
11. Jacobson, E.: "Progressive Relaxation." Chicago, University of Chicago Press, 1938.
12. Kraft, T.: "Behaviour Therapy of Target Symptoms." J. Clin. Psychol., 25, 105-109, 1969.
13. Krapfl, J. E. and Nawas, M. M.: "Client-Therapist Relationship Factor in Systematic Desensitization." J. Consult. Clin. Psychol., 33, 435-439, 1969.
14. Lang, P. J. and Lazovik, A. D.: "Experimental Desensitization of a Phobia." J. Abn. Soc. Psychol., 6, 519-525, 1963.
15. Malleson, N.: "Panic and Phobia: a possible method of Treatment." Lancet, 1, 225-227, 1959.
16. Marks, I. M. and Gelder, M. C.: "Common ground between Behaviour Therapy and Psychodynamic methods." Brit. J. Med. Psychol., 39, 11-23, 1966.
17. Marks, I. M.: "Fears and Phobias." London, Heinemann Medical Books, 1969.
18. Marks, I. M.: "The classification of Phobic Disorders." Brit. J. Psychiat., 116, 377-386, 1970.
19. Meyer, V. and Crisp, A. H.: "Some Problems in Behaviour Therapy." Brit. J. Psychiat., 112, 367-381, 1966.
20. Paul, G. L.: "Insight versus Desensitization in Psychotherapy." Stanford, Stanford University Press, 1966.
21. Salzman, L: "Therapy of Obsessional States." Amer. J. Psychiat., 122, 1139-1146, 1966.
22. Sloane, R. B.: "The converging paths of Behaviour Therapy and Psychotherapy." Intern. J. Psychiat., 7, 493-503, 1969.