

## ONE-SESSION TREATMENT FOR SPECIFIC PHOBIAS

LARS-GÖRAN ÖST

Psychiatric Research Center, University of Uppsala, Sweden

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**Summary**—A rapid and effective treatment for specific phobias, in which the treatment is done in one single session, is described in detail. The treatment method consists of a combination of exposure *in vivo* and modeling. The short- and long-term outcome for a consecutive series of 20 patients are reported. Mean treatment time was 2.1 h and at follow-up after an average of 4 yr 90% were much improved or completely recovered.

### INTRODUCTION

Phobia is probably the psychiatric disorder that has attracted the greatest interest during the development of behavior therapy in the last 30 years. There are at present approx 50 variants (often minor) of behavioral methods described in the literature. The efficacy of many of these is also well documented (Jansson and Öst, 1982; Marks, 1987; Mavissakalian and Barlow, 1981; Öst and Jansson, 1987; Turner, 1984). A clinically significant improvement is usually achieved in 65–75% of agoraphobics and social phobics, and 75–85% in specific phobics.

Recent epidemiological studies (Robins, Helzer, Weissman, Orvaschel, Gruenberg, Burke and Regier, 1984; Wittchen, 1986) show that the prevalence of phobias in the general population is as high as 11% in U.S.A. and 13% in West Germany. The majority of the phobias in the general population consists of different specific phobias, although these are in the minority among persons seeking psychiatric treatment. This discrepancy may occur because many people don't think that it is possible to get treatment for a simple phobia and because they feel ashamed to admit to the extent of their problem. On the other hand, agoraphobia is usually so impairing that a greater proportion of sufferers seek treatment.

The purpose of the present article is to describe a rapid and effective behavioral method for the treatment of specific phobias and its results in a consecutive series of 20 patients. This treatment differs from traditional *in vivo* exposure in that the patient is presented with the whole hierarchy at a single session. In addition to help pushing the patient to the top of the hierarchy modeling is used when required.

### SPECIFIC PHOBIA

DSM-III and DSM-III-R (APA, 1980, 1987) use the construct simple phobia and define it as a residual category, i.e. the patient does not suffer from agoraphobia, social phobia or panic disorder. However, the word simple might convey the impression that these phobias by definition are simple to treat, while agoraphobia and social phobia are difficult. The problem with simple phobias is that the anxiety reactions are elicited by a circumscribed stimulus, which generally is not the case for the other groups of phobias. Thus, I will in this article use the term specific phobia in accordance with Marks (1969). Included in this category are all animal phobias (e.g. for snakes, spiders, rats, dogs, cats, birds, etc.) as well as phobias for enclosed spaces, heights, flying, blood/injury, etc.

### ASSESSING SUITABILITY FOR TREATMENT

#### *Behavior analysis*

As in all forms of behavior therapy, a thorough behavioral analysis has to be performed before the treatment starts. This consists of a topographic analysis of the patient's problem behavior, its onset and development, the situations in which it occurs, the factors that elicit and maintain the

behaviors etc. It is not until a behavior analysis has been done that it is possible to judge whether a one-session treatment is suitable or not. As the specific phobias are restricted and the patient usually does not have any other psychiatric problems an experienced therapist can do the behavior analysis in 1 hr.

*Which specific phobias are suitable?*

All animal phobias are suitable for one-session treatment. So far I have worked with phobias for spiders, dogs, cats, rats and birds. However, it seems likely that phobias for snakes, worms, different types of insects etc. would respond similarly to this type of treatment.

Of the other types of specific phobias I have so far only had the opportunity to try the method for injection phobia. However, it is probable that most of the other specific phobias, e.g. for heights, lifts, darkness, blood/injury etc. also are suitable. Flying phobia and claustrophobia might possibly be exceptions as the former group of patients often is characterized by a significant lack of knowledge about how airplanes function and the latter often concerns a large array of situations. This must be tested empirically before any definitive judgement can be made.

*Which patients are suitable?*

The first criterion is that the phobia should be **circumscribed** (monosymptomatic) and only concern one specific situation or object. The most important criterion, though, is that the patient is **motivated enough** to get rid of his/her phobia, to be prepared to tolerate a (possibly) high degree of anxiety during a rather long time. Furthermore, the patient (and his/her close relatives) must not have any positive consequences from the phobia, and there must not be any predictable negative consequences if the phobia is successfully treated. This has, however, never been the case for any of my patients.

Of the 25 patients with specific phobia reported in this paper I have chosen another form of treatment for two (one flying and one claustrophobic), while three have rejected the one-session treatment. These were one with phobia for worms and two injection phobics, who did not want to have such a rapid treatment and/or feared that the degree of anxiety would be too high during an intensive therapy session.

One factor that probably is responsible for the fact that so few reject one-session treatment is the knowledge that if this should not be successful, i.e. if the goal is not reached in one single session, one can continue with more sessions if needed. So far this has only been necessary in one case.

## TREATMENT GOALS

In regards to one-session treatment there are two different goals. The first goal is what the patient should manage in natural situations when confronted with the phobic object. Examples of these are that the injection phobic should be able to receive an injection or have a venipuncture without undue anxiety, and that the spider phobic should be able to catch a spider with a drinking glass and a piece of paper, and throw it out. Thus, it is not the purpose of the treatment to make the patient a "lover" of the animal that the phobia concerns, but rather to achieve a normal, non-phobic, relationship to it. This goal is agreed upon during the behavior analysis session.

The second goal concerns what the therapist wants to achieve during the single therapy session. As the treatment is so short and intensive it is desirable with a large amount of "overlearning", i.e. that the treatment takes the patients considerably beyond the goal described above. For example, this means that I want an injection phobic to have a large number of injections and some venipunctures, or a spider phobic to have one or two spiders walking around on the patient's hands for a while. I keep this in mind throughout treatment and do not explain it to the patient. Experience shows that if I explain this goal to the patient at the start of treatment it makes the treatment much more difficult. The patient tends, more or less continuously, to think about the "horrifying things" I am going to "subject" him/her to and is unable to concentrate on the small steps that gradually take the patient to the goal. It might perhaps seem unethical not to reveal my goal at the start of treatment, but my experience has been that 90% of the patients would have refused to start the treatment had they known this goal. Afterwards they are pleased that I had

helped them to discover that they could manage much more than they had dared to dream of in their “wildest imagination”.

## TREATMENT METHOD

The treatment method that I have been using in one-session therapies consists of **exposure *in vivo***, in most cases combined with **modeling**. These procedures are regularly used in behavioral treatments for phobias but the number of sessions is then generally considerably higher; often 4–8 for specific phobias, 8–10 for social phobia, and 8–12 for agoraphobia.

### *Exposure in vivo*

Exposure can most simply be described by the following: (1) The patient makes a commitment to remain in the exposure situation until the anxiety fades away and never escape from the situation during the treatment. (2) The patient is encouraged to approach the phobic stimulus as much as possible and continue to expose him/herself until the anxiety has decreased or completely disappeared. (3) When the anxiety has been reduced the patient is instructed to approach the phobic stimulus more closely, and stay there until the anxiety is decreased, and so on until the patient is as close as is possible. (4) **A therapy session is concluded only when the anxiety level has been reduced by 50% of its highest value, or completely vanished.**

Although the basic principles can seem deceptively simple, it takes an experienced therapist to help the patient carry out treatment in the correct way, particularly if the patient gets “stuck” on a task and cannot manage the next step.

### *Modeling*

Modeling means that a person, often the therapist, demonstrates to the patient how she/he is to interact with the phobic object. The patient gradually approximates to physical contact with the phobic object by touching the therapist as they touch the object, and gradually approximating to full contact. Later the patient interacts more and more on her own, with only the help of the therapist’s instructions and presence in the room. Finally, the therapist can leave the situation altogether and the patient interacts with the phobic object on his/her own, experiencing little or no anxiety.

### *Treatment rationale*

The rationale for the treatment methods must be adjusted to the characteristics of the individual patient’s phobia, and how it has developed from its onset, usually during childhood. In general one describes how the patient gradually has reinforced, and continued to maintain the phobia, through the avoidance and escape behaviors that are elicited by confrontation with, or thoughts of, the phobic situation. Also often included in the reaction pattern are different negative thoughts of a catastrophic nature, e.g. “I’m going to lose control, faint etc. if I don’t get away from this situation immediately”. The purpose of the treatment is to expose the patient to the phobic situation in a controlled way, and enable him/her to stay in the situation until realizing that the feared consequence **does not occur**. For example, the patient learns that, the anxiety gradually reduces, and after some time the patient can be in the phobic situation with little or no, anxiety. In the rationale one should also mention that the one-session treatment should be seen as a start and that the patient afterwards must continue on his/her own to carry out exposure to the phobic situations in everyday life in order to maintain or extend the effects of therapy.

### *Instructions*

The instructions given to the patient before the start of treatment are also very important. Firstly, it is emphasized that the treatment is a **teamwork** in which therapist and patient work together to “break down” the patient’s phobia. It must never get to the point where the patient views the therapist as an opponent that only wants to subject him/her to discomfort or anxiety for its own sake.

Secondly, the patient is instructed that the therapist will never do anything in treatment without first describing it to the patient, modeling it, and get the patient's permission (even if hesitantly given) to perform that part of the treatment.

The patient often fears that the treatment will lead to a very high level of anxiety, perhaps so high as she loses control over herself. If this is the case it can have a positive effect to inform the patient that a high anxiety level during the treatment is not a goal *per se*. Usually the patient will experience less anxiety than expected and, furthermore, the strongest anxiety reaction that she has ever had in a phobic situation will be her "personal record" after the treatment as well.

#### *Treatment time*

It is not possible to predict beforehand exactly how long a one-session treatment is going to take. I usually set aside one morning or afternoon (3 hr) and aim to finish treatment in this time. For the 20 patients (see Table 1) that have been treated so far the mean time has been 2.1 hr and the median 2 hr. It should be noted that the patients with animal phobias needed significantly [ $t(18) = 2.89, P < 0.01$ ] longer treatment time than those with injection phobia (2.4 vs 1.6 hr). In only one case (patient No. 5) did the session have to be concluded without reaching the goal; this particular patient was given a further three 45 min sessions.

#### *Video recording*

As the patients, during the treatment, go very far in confronting the phobic object and perform behaviors that most of them never have done before, some of the patients may afterwards experience the treatment as something unreal, a dream etc. To counteract this a video recording of the entire treatment is routinely done. If the patient so wishes she can return to the clinic after 1–2 wk to watch the parts of the tapes she wants to see. This helps, convincing the patient that what took place in the treatment was real and not "a dream", and that it was the patient herself that did it and not the therapist. The patient watches the videotape on his/her own, and no further treatment is given at this time.

#### *Maintenance of the treatment results*

The basic principle that the patient must follow in order for the treatment results to be maintained in the long run is in the future **never to escape from or avoid** confrontation with the former phobic object. Instead one should welcome every contact as an opportunity to once again demonstrate that this is a situation that one can manage with as little discomfort as anybody else. "As soon as you allow yourself to escape from/avoid a confrontation it is easy to build up an expectancy anxiety, regarding the next encounter, that is so strong that you start to avoid again, and so on."

Another component is used to generalize the treatment effect from the therapy situation to the patient's natural milieu. To do this the patient is given a homework assignment to carry out as soon as possible, in which they actively seek out and confront the phobic object. A person with injection phobia would have to contact the district nurse and visit her 2–3 times/week to receive different types of placebo injections. One with spider phobia has to take 1–2 spiders home and practice what they had done during the treatment session. A dog-, cat- or bird-phobic has to actively seek out situations in which a close contact with these animals is possible and practice the newly acquired skills. In this way the patient learns to handle the phobic situations in natural milieus without the safety and the control over the exposure afforded by the presence of the therapist.

### PATIENTS

In Table 1 the data from the 20 consecutive patients with specific phobia that I have treated with one-session therapy are presented. The patients were referred for treatment or applied themselves after reading articles in the local newspaper about my phobia treatment research project. All patients were females, which is consistent with previous studies of specific phobias. For example, Öst (1987) reported that 96% of those applying for treatment of small animal phobias were women. Their mean age was 25.1 yr (range 16–44) and the duration was on the average 17.9 yr (6–39). The

mean onset age was 7.2 yr, which is almost exactly the same as a group of animal phobics previously treated (Öst, 1978a). Consequently, this is a group of patients who have had their phobias for most of their lives and in whom a spontaneous recovery without treatment is unlikely (Agras, Chapin and Oliveau, 1972).

Table 1. Summary of performed one-session treatments

Pat No.	Phobia type	Age	Duration	Treatment time (hr)	Spec. pre*	Spec. post*	FSS pre	FSS post	F-up time (yr)	Outcome
1	Injection	24	20	2.0	5	2	130	111	7.5	3
2	Injection	18	12	1.5	5	2	197	147	7.0	3
3	Injection	16	8	1.0	5	1	142	120	4.5	3
4	Injection	20	14	2.0	5	1	271	152	4.4	3
5	Injection	22	13	2.0	5	4	167	158	4.3	1
6	Injection	22	17	1.0	5	1	154	120	2.0	3
7	Injection	27	21	1.5	5	2	169	131	1.5	2
8	Spider	40	34	2.5	21	10	159	132	7.5	2
9	Spider	16	6	2.5	24	6	195	127	7.5	3
10	Spider	16	7	3.0	23	11	88	83	7.0	3
11	Spider	30	22	2.5	28	4	172	123	3.3	3
12	Spider	30	25	3.0	26	14	99	89	1.3	2
13	Spider	16	10	2.0	16	3	200	174	1.2	3
14	Spider	28	16	2.0	29	7	127	103	1.1	3
15	Rat	24	9	1.0	18	7	121	121	7.0	3
16	Rat	30	25	3.0	28	10	148	120	1.0	2
17	Cat	28	21	3.0	5	3	160	145	4.3	1
18	Cat	24	15	1.5	5	2	165	132	0.5	3
19	Bird	27	24	3.0	5	2	108	93	6.5	3
20	Dog	44	39	2.0	5	2	155	134	1.3	2
Mean:		25.1	17.9	2.1	13.4	4.7	156.4	125.8	4.0	
SD:		7.4	8.5	0.7	9.7	3.8	40.1	22.6	2.6	

\*For Nos 1-7 and 17-20 the scale is 1-5; for 8-16 a 0-30 scale is used.

(Spec. = Specific phobia scale, FSS = Fear Survey Schedule. Higher scores = more phobic).

One measure of the severity of their respective phobias can be obtained from the pre-treatment assessment with the specific phobia scale (Spider Questionnaire; Klorman, Weerts, Hastings, Melamed and Lang, 1974). The spider and rat phobics are (except for patient No. 14) above the 95th percentile compared to a normal sample. For the injection-, bird-, cat-, and dog phobics there is no comparable specific scale, and for them the relevant item from the Fear Survey Schedule—III (Wolpe and Lang, 1964) has been presented. All of these patients give the maximum rating (5) at pre-treatment. There are, unfortunately, no Swedish norms for this schedule. However, it is clear that all the patients experienced strong subjective anxiety and impairment associated with their phobias.

## RESULTS

### *Immediate effects*

As shown in Table 1, on the specific phobia scale the patients have improved to a large extent. For the spider phobics the mean has decreased from 23.9 to 7.9, which is significant [ $t(6) = 7.96$ ,  $P < 0.001$ ]. The reduction of 67% is larger than obtained in a previous study (Öst, 1978b) using regular treatment (40%). For the injection-, bird-, cat-, and dog phobics the change on the relevant item of FSS-III is shown. This scale has a range from 1 = no fear at all, to 5 = maximum fear. The post-treatment assessment for the injection phobics show that 6 out of 7 rate no, or only a little fear, while the 7th only showed a marginal improvement. The mean for the group is 1.9, a reduction with 78% which is significant [ $t(6) = 7.85$ ,  $P < 0.001$ ]. The other animal phobics have also achieved a large improvement; on the average 65%.

On the general fear survey schedule the group as a whole has improved with an average of 30 points [38%;  $t(18) = 6.72$ ,  $P < 0.001$ ], which is in accordance with my previous studies (Öst, 1978b; Öst, Johansson and Jerremalm, 1982; Öst, Lindahl, Sterner and Jerremalm, 1984; Jerremalm, Jansson and Öst, 1986) of specific phobias in regular behavioral treatment. Thus, it seems as if the treatment has yielded a certain amount of generalization to other situations.

### Long-term results

The 20 patients described in the present article entered treatment over a 7-yr period. This means that the follow-up period varies between 6 months and 7.5 yr, with a mean of 4 yr.

The status of a patient at follow-up was classified in a 4-point scale (0 = unchanged, 1 = some improvement, 2 = much improved, 3 = completely recovered) on the basis of a thorough clinical interview.

Two of the patients (10%) showed only some improvement, 5 (25%) were much improved and 13 (65%) were completely recovered at the follow-up. Altogether 90% of the patients obtained a clinically significant improvement (Hugdahl and Öst, 1981) which was maintained at the follow-up after an average of 4 yr. This result is as good, or better than what has been reported for regular behavioral treatment across multiple sessions (Marks, 1987; Mavissakalian and Barlow, 1981; Turner, 1984).

### DISCUSSION

The results for the present group of 20 consecutive cases of specific phobia show that 90% of the patients were much improved or completely recovered after a mean of 2.1 h of therapy. These results are on a par with regular behavioral treatment where the treatment included multiple sessions. Thus, when it comes to clinical efficacy, it was not a disadvantage to reduce the number of sessions to one\*. Moreover, there were no drop-outs and only 3/23 patients did not accept the offer of a one-session treatment.

Often, when a new treatment, or a variation of a previous treatment is presented, the question is raised whether the treatment results only can be achieved by the therapist that has developed the method. So far three other therapists have treated another 9 patients with the one-session method. These patients had phobia for snakes, spiders, injections, thunder and lightning, and eating solid food, respectively. Eight of these have been treated successfully in a mean of 2.4 h. The results were sustained at follow-up after 6–8 months when the patients were considered completely recovered.

The tentative conclusion that can be drawn from this is that the method can be applied by therapists with the proper training and give as good results as the author has found. To be able to draw unequivocal conclusions about the efficacy of one-session treatment, in the short- and long-term, a controlled outcome study using properly trained therapist must be conducted. Such a study is now underway in our clinic.

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\*Remarkably similar results were independently obtained by Rachman and Lopatka (*Behav. Res. Ther.* **26**, 99–113, 1988) using participant modeling in the treatment of snake/spider phobic volunteers. Mean treatment time was 23 min only.

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