The Successful Treatment of Specific Phobia in a College Counseling Center

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Specific phobias are highly prevalent among college students and can be quite debilitating. However, students often do not present for treatment for phobias and, when they do, often do not receive effective treatment. This article will present a case study of the effective treatment of specific phobia using cognitive-behavioral therapy with an emphasis on in vivo exposure. It will provide a template for how to conduct this efficient and effective therapy and suggest several benefits of incorporating this treatment into the repertoire offered by a college counseling center.

KEYWORDS case study, exposure therapy, specific phobia

Specific phobias represent the third most prevalent of all mental disorders, with 10%–12% of the population experiencing them over the course of their lives (Kessler et al., 2005; Stinson et al., 2007). A recent study suggests that up to one-third of college students report significant phobic symptoms and that many of these students are interested in seeking treatment for them (Seim & Spates, 2010). Many people consider specific phobias to be a relatively benign disorder, as avoidance of the phobic situation typically allows the sufferer to steer clear of any anxiety symptoms (Choy, Fyer, & Lipsitz, 2007). However, phobic anxiety can be debilitating and avoidance behavior can lead to significant social and occupational problems (Stinson et al., 2007). Indeed, the course of specific phobias is typically chronic and unremitting if...
left untreated (Goisman et al., 1998), and yet specific phobias are also among
the most treatable of all mental disorders (Choy et al., 2007). A compre-
hensive review of the treatment of specific phobias indicates that exposure
therapy represents the most robust treatment for specific phobias, with some
studies demonstrating a response rate of 80%–90% (Choy et al., 2007). Clients
receiving this treatment show dramatic reduction in anxiety symptoms, gains
that can be quite enduring, and recent research has demonstrated specific
underlying neurological changes associated with successful exposure treat-
ment for phobias (Hauner, 2010). Nevertheless, only a minority of therapists
in college counseling centers espouse a cognitive-behavioral theoretical ori-
etation (Varlami & Bayne, 2007). This article will present a case example of
the successful treatment of specific phobia in a college counseling setting.
Our goal is to demonstrate the straightforward nature and effectiveness of
this type of treatment and thereby to encourage its wider adoption in college
counseling centers. As Seim and Spates (2010) point out, colleges are ideal
settings for the treatment of specific phobias, as a wide variety of resources
are available for counselors to use in developing exposures.

CASE DESCRIPTION

History

When she presented for treatment, Claire was a 19-year old Caucasian first-
year student who suffered a lifetime fear of elevators. Virtually as long as she
could recall (at least to age five), she was simply terrified of riding an ele-
vator. Claire could not point to a specific traumatic event that produced her
fear—it had just always been there. Despite popular conceptions, this lack
of a specific nuclear memory is quite common among people with specific
phobias, and direct traumatic conditioning is neither necessary nor sufficient
for the development of phobias (Mineka & Sutton, 2006). Additionally, many
people who are exposed to direct or observational traumatic experiences do
not go on to develop phobias (Mineka & Sutton, 2006). Claire reported that
she was a shy, timid, well-behaved child, and felt great reticence to speak up
about her fear, despite having very warm and loving parents. She recalled
one uncharacteristic experience when her family was in an airport, lugging
large suitcases after a long flight. Young Claire pleaded with her parents
not to take the elevator and she finally had a melt-down. Her parents were
embarrassed by this and her mother said, “Please keep it to yourself, people
will think we’re abusing you!” Claire quickly bottled up her fear, endured the
elevator ride with extreme distress, and felt quite ashamed. In adolescence,
Claire recalls having had a panic attack when forced to ride an unavoidable
elevator in a subway station while on a class field trip. Peers taunted her
about it for the remainder of the trip.

Claire began using an elaborate series of avoidance behaviors, finding
a variety of excuses not to ride elevators. For example, when a family friend
was going to be showing some artwork at a local museum, Claire went on-line before the opening to look through a floor-plan of the museum to determine how she might navigate the event without riding an elevator. Claire’s caring parents were concerned about her phobia, which was a distinctive and unfortunate problem for an otherwise well-adjusted, if shy, child. They arranged for a series of therapists who tried a variety of techniques, including play therapy, psychoanalysis, and hypnosis, but nothing was successful. Claire also tried a course of sertraline (Zoloft) for her phobic fear. Although the medication initially gave her some confidence to attempt riding elevators, Claire reports that it did not impact her experience of anticipatory anxiety. As a result, Claire became even more anxious about riding elevators, interpreting her anticipatory anxiety as a sign that the medication was not working. The side effects of the medication also began to interfere with her daily life, rendering her drowsy and apathetic. As she told me, “It failed to calm me down whenever I was anxious or afraid and it made me too calm whenever I was already relaxed.” A very smart child, Claire reported that she would sometimes tell the therapists that she was doing better in order to avoid meeting with them, even though her fear remained as strong as ever.

When Claire entered college, she took a work-study job in the college library, a beautiful building where she loved spending time. However, it quickly became clear that the job would involve moving books with a cart from floor to floor on one of the elevators. Embarrassed and ashamed, Claire confided in her boss at the library about her phobia. Her boss graciously understood and Claire resolved to return to treatment for her fear. In her first therapy session, she described the history of her problem. She reported no other psychological or psychiatric conditions during a diagnostic interview and portrayed a smooth adjustment to college. She scored high in anxiety sensitivity (scoring a 90 on the Anxiety Sensitivity Index [Peterson & Reiss, 1992]), suggesting that she held beliefs that anxiety experiences have negative consequences (Reiss, Peterson, Gursky, & McNally, 1986). Claire was aware of a range of severe limitations imposed by her elevator phobia. For example, she reported social discomfort with friends during the first few weeks of college, feeling pressure to find excuses for her avoidance of elevators, such as “I’m being healthy by taking the stairs.” Even more dramatic, when Claire was asked to imagine that upon graduating from college she was offered her dream job, with every perfect quality except that it was on the 60th floor of a building, she responded that she would likely turn it down if her fear remained as strong as it currently was, and this was why she was so committed to overcoming her phobia now.

Treatment

The approach to treatment was cognitive-behavioral and heavily grounded in in vivo exposure therapy. While we did not strictly follow any one
treatment manual with Claire, our work was heavily informed by several manuals (e.g., Craske, Antony, & Barlow, 2006) and we recommend that therapists adhere to one when first practicing exposure therapy. The first session began with psychoeducation about the nature of specific phobias. Claire was told about the prevalence of phobias, in an effort to normalize her experience. It was explained to her that her particular fear of elevators combined two especially common fears (heights and enclosed spaces) (Seim & Spates, 2010). A broad literature suggests that it is much easier to develop phobias to stimuli that may have held evolutionary significance as dangerous. One theory (the non-associative account of fear acquisition) suggests that fears of evolutionarily relevant stimuli are innate, generating phobias without requiring any unusually negative experiences (Mineka & Sutton, 2006). While elevators themselves were not an issue for our evolutionary ancestors, elevators do involve two evolutionarily prepared fears: heights and enclosed spaces. The treatment approach of exposure therapy was described, Claire was given some reading about its methods and efficacy, and a homework assignment was developed for her to survey the elevators on campus to determine which ones would be easier or harder to ride.

During the second session, a hierarchy of campus elevators was collaboratively developed by Claire and the therapist, rating each elevator in difficulty from 1–100. Claire’s job was to imagine how hard it would be to ride each elevator under the easiest possible conditions (which for Claire meant during the day, with other people, while holding her cell phone). As is generally true with specific phobias, the qualities that determined each elevator’s placement on her hierarchy were highly idiosyncratic, involving size, speed, perceived age, light quality, presence of a window, volume of traffic in the building, clear presence of an inspection document, and particular noises. In addition, each elevator was rated as more difficult when ridden alone, at night, or—worst of all—alone at night.

During this second session Claire was taught tools to encourage herself to follow through with the exposure practice. In the treatment of any specific phobia, it is important to identify key barriers, which tend to be idiosyncratic and personal and not always obvious, to interacting with the feared stimulus. In Claire’s case, the most feared thought—the one that arose automatically when she confronted elevators—was that she would become stuck, have overwhelming physical symptoms of anxiety, and not be found for days. Note that she was not afraid that the elevator would fall; she was focused on being stranded in the small space. Identifying this fear allowed us to focus on her specific concerns and to develop tools suited to her needs.

On the behavioral side, a deep, diaphragmatic breathing exercise was employed to reduce the physiological discomfort that being anxious induces. Often clients want medications to reduce the physical symptoms of anxiety, but Claire had already tried medication without ameliorative effect. Further, with exposure therapy, an embodied experience of anxiety is
actually necessary for successful counter-conditioning to take place (Choy et al., 2007). Medications are therefore not recommended in conjunction with exposure therapy (Choy et al., 2007). A breathing exercise helps mitigate discomfort, but not eliminate it, and so can be used as a tool for reducing barriers to engaging in exposure exercises.

On the cognitive side, Claire was given a homework assignment to do research into the actual likelihood of becoming stuck in an elevator. This homework assignment was itself somewhat anxiety provoking, as it forced Claire to read in the unfiltered domain of the internet about elevators getting stuck. She came across several horror stories during her search, and used the breathing exercise to calm herself physiologically while reading these accounts. Claire was unable to find a solid scientific report, but uncovered estimates suggesting that an elevator will become stuck in one out of every 10,000–100,000 rides (we could not verify these statistics). Since this was an enormous range, we focused on the more frequent estimate (one out of every 10,000 rides), which meant that if Claire were to ride an elevator once a week, it would take roughly 192 years for her to be stuck in one, and if she rode daily it would take over 27 years to get stuck. Claire also did some research into elevator construction and maintenance in order to learn how the machines actually work, which yielded a series of strategies recommended by elevator companies for what to do if stuck in an elevator. These facts allowed Claire and the therapist to collaboratively develop a balanced rebuttal thought to use when her automatic negative thoughts arose: “There is a one in 10,000 chance that I will get stuck in this elevator, and even if I did, I have a series of steps to follow to get out.” Two of the most common cognitive distortions that accompany anxiety are the over-prediction of negative outcomes and the belief that it would be catastrophic should the feared event actually occur (Beck, 1995). The balanced rebuttal specifically targeted each of these cognitive distortions.

With her behavioral and cognitive tools well-practiced during homework, Claire and I set out in the third session to ride elevators for her in vivo exposure. We started near the bottom of the hierarchy, with an elevator rated a 20/100 in difficulty. This first time, we rode the elevator one floor up together and then got off. Each time Claire rode an elevator, whether with me or on her own for homework practice, she generated three ratings of her Subjective Units of Distress (SUDS; e.g., Wolpe, 1958) from 1–100 (100 being the highest anxiety): anxiety before the ride, peak anxiety during the ride, and anxiety after the ride. For this first ride, Claire’s highest anxiety rating was 76/100, which she later noted was lower than expected. She trembled visibly, hyperventilated, and tightly clutched her cell phone in her pocket—this was one of the most anxiety-provoking things she had forced herself to do in years! Interestingly, her highest anxiety rating came prior to the ride; during the actual ride her anxiety peaked at 60/100, and it dipped to 22/100 after the ride. Over time it became clear that this was a relatively robust pattern; Claire’s anticipatory anxiety was almost always higher than
her anxiety during the ride, and she always experienced relief after the ride was over. Discovering this was reassuring to Claire, reminding her that the actual experience of riding the elevator was never as uncomfortable as the anticipation of it. During this first session of in vivo exposure practice, we spent the full time riding the same elevator together, one floor at a time. We did this about 15 times, giving Claire breaks in between rides to do the breathing exercise, repeat her balanced thoughts, and get an occasional drink of water. For homework, Claire was asked to repeat the exercise as often as she could manage. In addition, she was to undertake one full “session on my own,” wherein she would devote 45 minutes to her exposure practice, as if it had been a complete therapy session. She recruited a close friend who knew about her phobia to accompany her on these rides. Claire was also encouraged to make the task more challenging by riding more floors or by riding alone, with her friend waiting for her. Claire was asked to create a practice record to track every exposure practice. The record had six columns labeled: Date, Name of Elevator, Anxiety Before (1–100), Peak Anxiety During (1–100), Anxiety After (1–100), and Notes. The Notes column recorded how many floors she had ridden and with whom.

When Claire returned for her fourth session (the second of exposure practice), she had ridden the elevator 21 times in the intervening period. She had managed to go up to two floors at a time with her friend, and several times had ridden one floor alone. During this session and every one that followed, the first few minutes were spent discussing Claire’s homework practice, reinforcing the use of the behavioral and cognitive tools, and planning for the current session. The remaining time of each session was spent riding elevators, saving a few minutes at the end for debriefing and homework planning. Every time, Claire entered her three anxiety ratings in her record. Over the course of the treatment, Claire demonstrated the expected patterns: her anxiety rating steadily decreased over the course of repeated rides (in-session habituation), and specific elevators were rated as easier at the subsequent session than they had been at the prior session (between-session habituation). Each session started with the hardest exposure Claire felt she could manage—as high on the hierarchy as possible. Sometimes this meant a new, harder elevator, sometimes riding more floors, sometimes riding alone. As a general rule, the sessions were treated as opportunities to move significantly up the hierarchy, while homework practices were treated as opportunities to master the gains made at the last session through repetition. As expected, Claire found that each jump up the hierarchy rendered all elevators lower on the hierarchy much easier than before. She also experienced generalization effects: elevators similar to ones on the hierarchy that she had not already ridden became gradually easier.

During our 9th session, something unusual occurred. We were in the library where Claire worked. The daunting elevator that had originally brought Claire into treatment had turned out to be a middle-of-the-hierarchy
challenge, and we were ready to tackle it. As we turned the corner to approach it, we saw a bright red sign on it reading “Do Not Ride: Elevator Maintenance in Progress.” I was disappointed that we would not get to use this session to practice on this meaningful elevator, while Claire was relieved to have a reprieve. We moved to another elevator in the building, slightly lower on Claire’s hierarchy. From this elevator we could see the door to the first one, and as we got off at each floor, we encountered the maintenance workers who were riding the other elevator one floor at a time as well.

After about 15 minutes, we began to get odd looks from the elevator workers, wondering why we were trailing them and what Claire was writing down after each ride. I asked Claire if she would be willing to go talk to the elevator workers, to get some information first-hand from the people whose job is to maintain elevators. At first she hesitated, but then she agreed—if I would make the first connection. When the two men learned what we were doing, they were effusive and supportive, explaining to Claire that they were working on this elevator because it had stopped responding to the call button on the third floor, but that it had never gotten stuck. They held the door open and allowed us to lean into the elevator shaft so they could point out the machinery and explain how it functioned, describing and comparing different types of elevators. They also described the layers of safety mechanisms and how the call boxes worked. Most of all, they praised Claire for taking on her fears and reassured her that elevators are extremely safe. After about 10 minutes, we let the workers get back to their job and we retreated to the library stacks to debrief our conversation. This serendipitous meeting helped renew Claire’s commitment to our work (which truthfully had not lagged). Over the course of the next few sessions and homework periods she pushed herself even harder than before.

In total, Claire and I met for 16 sessions spread over six months (with time off for winter and spring breaks), with 13 sessions devoted to \textit{in vivo} exposure practice (the first two sessions were spent taking a case history and preparing her for the exposures and the last session debriefing the entire treatment). Claire also did an impressive amount of homework between sessions. Over the course of our treatment, Claire took on progressively more challenging exposure experiences. At the conclusion, she went from being someone who had ridden elevators rarely and always under intense duress, to someone who had taken 842 elevator rides. She rode every elevator on her hierarchy, including the most difficult one, which she rated at 70/100. By the end, her anxiety on the most difficult elevator peaked at 4/100—a dramatic reduction since her first rides. She also took several practice rides with additional challenges, designed to surpass the circumstances she might naturally face. For example, she completed several rides without bringing her cell phone, an object that had served to reassure her that if she did get stuck, she would be able to call for help. The purpose of this exercise was not to run through a likely or realistic scenario, but for Claire to demonstrate
to herself that she did not need her cell phone to successfully navigate an elevator ride. It is worth noting that Claire’s progress was not simply linear and upward; she did have some setbacks and off days. Yet her commitment to treatment and belief in the model allowed us to successfully manage these challenges.

During our final session, at the end of the academic year, Claire positively beamed, her pride in her accomplishment barely containable. She described feeling like a more solid adult, and framed the therapy as an important component of developing a mature identity at college. She also described how our work together had generalized beyond her fear of elevators, for example reporting saying to herself after completing a week of final exams, “these exams are no big deal now that I’ve conquered my fear of elevators!” Indeed, she described a new attitude towards anxiety, noting that whenever she found herself afraid of something in the future, she would try to approach the source of her anxiety and do the thing she was afraid of, now that she understood that avoidance reinforces anxiety while exposure ultimately reduces it. This increase in a client’s sense of personal agency following therapy has been associated with good outcomes across treatment approaches (Adler, Skalina, & McAdams, 2008). Claire also recorded a nearly 35% drop (from 90 to 59) on a re-administration of the Anxiety Sensitivity Index (Peterson & Reiss, 1992), confirming her diminished fear of anxiety-provoking experiences. She committed to practicing the exposure exercises in the future in order to maintain her gains and was highly optimistic in her ability to do so. When I asked whether she would take a dream job, even if it were on the 60th floor of a building, Claire enthusiastically responded, “definitely!”

**DISCUSSION AND RECOMMENDATIONS**

Claire provides a striking case example of the treatment of specific phobias using cognitive-behavioral therapy with an emphasis on in vivo exposure. While phobias are quite prevalent in college students (Seim & Spates, 2010) and in the general population (Kessler et al., 2005; Stinson et al., 2007) and exposure therapy has an enormous amount of empirical support for its efficacy (Choy et al., 2007), a minority of therapists working in college counseling centers and mental health clinics adopt a cognitive-behavioral theoretical approach to treatment (Varlami & Bayne, 2007). We present Claire’s case with two hopes: (1) that therapists working with college students will appreciate how straightforward and effective exposure therapy for specific phobias can be, and (2) that therapists will be able to use Claire’s case as a template for the implementation of exposure therapy (ideally in conjunction with one of the many available, more
detailed treatment manuals) with college students who suffer from specific phobias.

It is important to note that Claire’s case was remarkably straightforward. She reported no other significant psychological or psychiatric problems, was highly motivated for treatment, and was willing and able to complete an impressive amount of homework in between sessions. The relatively uncomplicated nature of Claire’s treatment was what initially made us choose to present her case. While treatments for specific phobias, like those for most psychological problems, are most effective with relatively straightforward cases, exposure therapy can also be quite successful regardless of complicating factors (Choy et al., 2007). Clients may present with additional complaints, they may want to discuss other issues, new information may suddenly appear (such as prior abuse, a substance abuse problem, a romantic breakup, deeper-than-expected self-esteem deficits, etc.), they may “forget” to do homework assignments or resist them due to anxiety, and they may have setbacks and grow discouraged. With each of these complicating factors, the treatment model can still be quite effective.

Therapists faced with such complications should first assess to determine if the specific phobia continues to warrant primary attention. The treatment model is more effective the more frequently exposures are undertaken, so if complicating factors are impeding exposure practice, they must be addressed first. For example, a severe depression might make it very difficult for clients to find the motivation to complete homework assignments, or a substance abuse problem might lead them to undertake exposures only when intoxicated, thus blunting the necessary anxiety response. In such instances, the additional psychological or psychiatric problems may need to be addressed prior to treating the specific phobia.

If clients want to discuss additional issues that are not interfering with exposure treatment, therapists may decide to see the client more frequently, alternating the focus of the session—for example one session of in vivo exposure practice, followed by one session in the office focused on other issues. If the specific phobia is not connected to other issues, another option would be to add a second therapist to the treatment team, allowing the client to focus purely on the specific phobia with one therapist and other issues with the other.

Another common barrier to treatment is client resistance to undertaking the exposures, either in session or for homework. Indeed, drop-out rates are higher in exposure therapy than in many other therapeutic interventions (Choy et al., 2007). Thus, it is vital that clients have a solid understanding of the treatment rationale prior to undertaking the first exposure and may need frequent reminders throughout treatment. The treatment manual by Craske and colleagues (2006) offers strategies for anticipating and addressing such concerns. It is very important that the therapist not push clients too far beyond their comfort zone, especially toward the beginning of treatment.
A good approach to sessions is to move clients one step beyond what they would feel comfortable doing on their own. This may result in very slow progress, which can be frustrating for the therapist, but it will facilitate treatment compliance and ultimate success.

If clients forget or resist completing exposures for homework, the focus of treatment should shift to overcoming barriers to treatment. True forgetting is possible, and so it may help for clients to place visual reminders in places they're unlikely to miss, such as wearing a rubber band loosely around the wrist, which is unlikely to provoke potentially uncomfortable questioning from peers. If clients fail to complete homework assignments because of resistance, the expectations for weekly practice may need to be scaled back significantly or exposure sessions may need to be scheduled more frequently. There is strong evidence that prolonged exposure sessions are especially effective (Öst, Brandberg, & Alm, 1997), so a several-hour session less frequently is another option. As a general rule in cognitive-behavioral therapies, when clients fail to complete homework assignments, the subsequent session should be used for completing them before moving on (Beck, 1995). This allows therapists to examine barriers to homework in vivo and prevents moving too quickly through the treatment model, thereby potentially missing opportunities for the approach to work. Completing unfinished homework also reinforces for clients that sessions are “wasted” if the homework remains undone. Homework non-compliance should not be treated as a failure on the part of the client, but rather as an opportunity for the therapist and client to work together to overcome a problem the client is having. Once clients begin to see some progress, they may be more willing to undertake exposures on their own. Indeed, exposure therapy for specific phobias is often increasingly rewarding for clients as they begin to see their former fears recede in a concrete and measurable way.

Exposure therapy can also be quite gratifying for the therapist. It is a relatively uncomplicated treatment to administer (although the idiosyncrasies of each individual presentation do demand flexibility and creativity), quite different from the general practice of many therapists. It is remarkably effective if one adheres to the treatment model, producing concrete and tangible outcomes. Practicing exposure therapy moves therapists out of the office and gives them the opportunity to observe and shape clients’ behavior in their ecological context.

From the systemic perspective of the college counseling center, using exposure therapy for the treatment of specific phobias serves several functions. It de-stigmatizes a prevalent and potentially debilitating on-campus problem that typically goes untreated. It also raises the public profile of the counseling center by bringing its work out from behind closed doors and into the campus community. Finally, it promotes the counseling center as a multi-dimensional service provider poised to meet the full range of the student body’s mental health needs effectively and efficiently.
NOTE

1. Identifying information, including the client’s name, has been modified to protect the client’s confidentiality. The client has read and approved of this representation (and chose the pseudonym).

REFERENCES


