“Lay beliefs about phobias” 25 years later: Conceptually Replicating and Extending Furnham
(1995), on the Treatment of Phobias, in 2020

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Abstract

Following a change in the professional atmosphere over the last several decades, there has been mounting interest in furthering clinical understandings of client and layperson preferences within psychotherapy. Curious about lay beliefs about phobias in particular, we sought to replicate a 1995 study by Adrian Furnham in order to examine how beliefs by laypersons regarding phobias have changed in the 25 years from 1995 to 2020. Situating our results against a backdrop of research suggesting that people prefer therapist directivity, we find not only that that psychotherapy preferences have changed since 1995 but that in 2020, there is support for a gentler, more relational approach to psychotherapy and behavioral change. While people do indicate a desire for directivity and therapeutic techniques provided by the therapist, there is an indication in our data that they wish for these to be positive and blended with less directive methods, as seen in person-centered therapy approaches.

**“Lay beliefs about phobias” 25 years later: Conceptually Replicating and Extending
Furnham (1995), on the Treatment of Phobias, in 2020**

Following a change in the professional atmosphere over the last several decades, there has been mounting interest in furthering clinical understandings of client and layperson preferences within psychotherapy (Swift et al., 2019). *Client preferences* simply refers to the way in which the person wishes to experience psychotherapy. Psychotherapists work in myriad ways, within various *modalities*, to affect change within the client and these have various theoretical origins, backgrounds, and viewpoints: Some are *psychoanalytic*, considering the unconscious; others are *behavioral* and reject the unconscious and most inner experiencing, while still others are, for example, *humanistic* or *existential* and focus on the very personal and subjective experiences of Being itself.

Questions as to the “true” nature of personhood, including those asking whether or not, and to what extent, individuals have free will and can choose their actions (or are, rather, behaviorally dictated by deterministic external forces); whether heredity or the environment (nature or nurture) play a bigger role in influencing the person; whether or not the traits which define people are more unique or universal; and whether or not people can change their own personalities, abound within the different modalities (Ellis et al., 2008; Engler, 2008) and are important to psychotherapy insofar as the *whole* of the *person* entering the therapy room needs to be understood by the therapist. Generally, however, the historical perspectives on personhood, from a purely scientific standpoint, are unrelated to psychotherapeutic process and based most primarily on anecdotes and the clinical observations and wider professional and personal experiences of the individual theorists (Ellis et al., 2008).

Recent research underscores the value of modality-client match and client preference accommodation within the therapeutic relationship, and this area is growing (Swift et al. 2019). Studies find significant effects of client preference accommodation and shared decision-making on the extent to which clients drop-out of therapy and to which they experience positive outcomes (Lindhiem et al., 2014; Swift et al., 2018; Windle et al., 2020; although, see Cooper et al., 2021 for some considerations). Psychotherapy so conducted, focused on relationality, reciprocal collaboration, and preference accommodation between therapist and client, is often termed *pluralistic* (Cooper & McLeod, 2010).

Most recently, Cooper and Norcross (2016) empirically established that clients have preferences for therapist directiveness (versus non-directiveness, actively guiding and interpreting, or not guiding and interpreting, the client; one can consider cognitive-behavioral and person-centered modalities examples); emotional intensity versus emotional reserve (pertaining to therapist style and temperament); past- versus present-focused orientation, referencing whether the therapist encourages discussion of prior or present-moment experiencing; and warm support versus focused challenge (again relating to therapist style). They found, and this has been replicated in further research on the subject (Cooper et al., 2019; Cooper et al., 2021), that clients tend to have a preference for emotional intensity and therapist directivity (whereas mental health professionals tend to prefer client directivity for themselves; Cooper et al., 2021).

Rationale for the Present Study

Curious about lay beliefs about phobias in particular, we sought to replicate a 1995 study by Adrian Furnham in order to examine how beliefs by laypersons regarding phobias have changed in the 25 years from 1995 to 2020. With respect to the first half of our conceptual

replication (Bolton et al., 2021), we found that people today believe the development of phobias is predicated on one's personality; traumatic events; psychoanalytic and behavioral-learning associations; genetic and biochemical influences; cognitive style, such as tendencies to catastrophize; and cultural and social factors. Many of our results—4 of 5 potential themes—reflect Furnham's (1995) original findings. Here, we report our findings with respect to participant beliefs on the psychotherapeutic treatment of phobias.

Method

The 202 mostly White (66.9%), mostly female (75.2%), mostly young-to-middle-aged (66.7% 18-41), and mostly American (65.8%) participants are described in detail by Bolton et al. (2021). Generally lacking in psychological or mental health education (88.1%), they were recruited through social media for an approximately 15-minute, Qualtrics-hosted survey. As reported by Bolton et al. (2021), the participants first responded to a series of simple demographic items. Following this, they were asked to endorse the extent to which they agreed with statements relating to the origins of phobias (Bolton et al., 2021). A second series of statements, shown next (Table 1), concerned the treatment of phobias. Data are available online at: <https://osf.io/5rtpn>

Table 1. List of Statements Regarding Phobia Psychotherapeutic Treatment.

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1. Phobias are incurable.
 2. Phobias can be treated by using drugs which stop anxiety.
 3. An individual with a phobia needs to be helped to come to terms with the real underlying, unconscious source.
 4. Merely understanding why you are phobic will not necessarily cure you without doing something about it.
 5. A phobic person needs to familiarize him/herself with, or gradually get used to, his/her feared object or situation in order to be cured.
 6. A method whereby an individual is gradually introduced to his/her feared object or situation, first in his/her imagination and then in reality, would be an effective treatment of a phobia.
 7. The only way to cure a phobic individual is to confront him/her directly with his/her fear. As an example, a claustrophobic should be shut in a cupboard until eventually his/her fear subsides.
 8. If a phobic individual sees someone else coping well in his feared situation and practices imitating this behavior, then he/she will soon learn to do the same.
 9. Group therapy, where people practice treatment methods and talk through their fears together, is particularly helpful for people who suffer from a fear of unfamiliar situations and open spaces.
 10. Phobics can be helped to cope with their fears by hypnotherapy.
 11. Homeopathic medicine can offer a cure to phobic people.
 12. People with phobias could be helped by courses in acupuncture.
 13. The best treatment for a phobic individual is to be held in a state of unconditional positive regard, accepted exactly as and for who she or he is as a person.
 14. The best treatment for a phobic individual is a non-directive, empathic approach in which the therapist does not tell the client what to do but rather guides the individual in their own learning and thinking, through a journey of self
 15. The best treatment for a phobic individual is a stance of unconditional empathy and respect.
 16. Phobia treatment should focus on increasing awareness of the emotions related to the phobia.
 17. Phobia treatment should focus on enhancing the ability of the phobic person to regulate, control, cope with, and process her or his emotions.
 18. Phobia treatment should focus on positively transforming and changing the emotions related to phobia.
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Materials

Assessment of Phobia Treatment Beliefs. To measure lay-participant perceptions of phobia treatment preferences, we used the 12 items Furnham (1995) originated, based on notions of phobias (that they are incurable; that they are treatable with medication) as well as theoretical formulations of therapeutic change. These included psychoanalytic, cognitive, and behavioral perspectives. To expand the study and engage with a wider breadth of treatment preferences, we wrote 6 new items, 3 each, face-valid for principles of emotion-focused therapy (EFT) and overarching person-centered approaches (PCA) to therapy. EFT is a process-based model similar to, but much less directive and different in intent than, cognitive-behavioral therapies. Participants indicated the extent to which they agreed with these statements on a Likert-like scale from 1-5 (*strongly disagree* to *strongly agree*).

Person-centered, or more colloquially Rogerian, approaches to therapy, were originated by Carl Rogers (1951, 1957) and are rooted in the assumption that distressed individuals have an innate capacity for growth and will be able to address their difficulties for themselves and in their own way if they can explore them with a psychotherapist who is warmly and accurately empathic, accepting, and genuine (or congruent).

Although today there is a recognized family of person-centered approaches rather than just one person-centered way of doing therapy (Sanders, 2012), Rogerian styles of therapy, especially in the more classical forms, are known for their non-directivity and for the therapist's empathic reflections. The person-centered therapist sees psychotherapy most primarily as a meeting of two persons—a meeting of which personal change and growth is a byproduct for the client, who is recognized as being at the start of therapy in a state of intrapersonal incongruence,

where there is a discrepancy between the individual's ideal sense-of-Self and their actual, real-world experiencing (Bohart, 2021; Rogers, 1957, 1961/1995).

Emotion-focused therapy is an offshoot of Rogers' work (Greenberg et al., 1993). Emotion-focused therapists strive to work from a place of empathy, acceptance, and congruence, providing these "core conditions" to allow a sense of psychological safety by which the client can feel free to take steps towards growth. Emotion-focused therapists, however, are not entirely non-directive: They offer, from a basic Rogerian stance and while giving the client freedom to choose engagement with any particular "intervention," certain experiential techniques meant to positively transform the client's maladaptive or distressing emotions (Greenberg et al., 1993; Timulak, 2015; Timulak & McElvaney, 2018). As clients in more classical and even other experiential Rogerian therapies tend to open up internally and to others and grow in authenticity (see, e.g., Rogers, 1961/1995; and Gendlin, 1978/2007), so too do clients in EFT, while also tending towards resilience and self-compassion (Timulak, 2015; Timulak & McElvaney, 2018).

Results

Exploratory factor analysis as used by Furnham (1995; as in Bolton et al., 2021, we used principal axis factoring, varimax rotation, and a factor minimum-loading cutpoint of .4) determined lay-participant perceptions of phobias in this study. As in Bolton et al. (2021), we report the primary factor loadings and then a subsequent factor solution which is most parsimonious and interpretable. Unlike in that paper where we grouped and analyzed the sample based on formal knowledge of psychology and mental health, factor communalities above 1 prevented analyses from running when participants were grouped by psychological knowledge/education. The first EFA is shown next (Table 2), followed by the final, reduced-item

analysis in Table 3. Items in both cases were suitable for analysis based on the following diagnostic criteria common to factor analysis (Watkins, 2018).

First EFA

- Determinant: 0.002, indicating a lack of multicollinearity
- KMO score of .72
- Significant chi-square (Bartlett's test of sphericity, $\chi^2 = 949.34$, df: 153, $p < .001$)

Second EFA

- Determinant: 0.007, indicating a lack of multicollinearity
- KMO score of .75
- Significant chi-square (Bartlett's test of sphericity, $\chi^2 = 741.14$, df: 66, $p < .001$)

Table 2.

Item	First Exploratory Factor Analysis						Communality
	1	2	3	4	5	6	
1. Phobia treatment should focus on enhancing the ability of the phobic person to regulate, control, cope with, and process her or his emotions.	.865						.848
2. Phobia treatment should focus on positively transforming and changing the emotions related to phobia.	.673						.622
3. Phobia treatment should focus on increasing awareness of the emotions related to the phobia.	.627						.560
4. A method whereby an individual is gradually introduced to his/her feared object or situation, first in his/her imagination and then in reality, would be an effective treatment for a phobia.		.873					.823
5. A phobic person needs to familiarize him/herself with, or gradually get used to, his/her feared object or situation in order to be cured.		.760					.684
6. Merely understanding why you are phobic will not necessarily cure you without doing something about it.		.402					.326
7. Phobias are incurable.	—	—	—	—	—	—	.194
8. People with phobias could be helped by courses in acupuncture.			.925				.883
9. Homeopathic medicine can offer a cure to phobic people.			.750				.675
10. Phobics can be helped to cope with their fears by hypnotherapy.			.505				.313
11. The best treatment for a phobic individual is a stance of unconditional empathy and respect.				.740			.744
12. The best treatment for a phobic individual is to be held in a state of unconditional positive regard, accepted exactly as and for who she or he is as a person.				.655			.480
13. The best treatment for a phobic individual is a non-directive, empathic approach in which the therapist does not tell the client what to do but rather guides the individual in their own learning and thinking, through a journey of self-discovery.				.406			.409
14. Phobias can be treated by using drugs which stop anxiety.	—	—	—	—	—	—	.107

15. If a phobic individual sees someone else coping well in his feared situation and practices imitating this behavior, then he/she will soon learn to do the same.								.727	.575
16. Group therapy, where people practice treatment methods and talk through their fears together, is particularly helpful for people who suffer from a fear of unfamiliar situations and open spaces.								.552	.445
17. The only way to cure a phobic individual is to confront him/her directly with his/her fear. As an example, a claustrophobic should be shut in a cupboard until eventually his/her fear subsides.	–	–	–	–	–	–			.134
18. An individual with a phobia needs to be helped to come to terms with the real underlying, unconscious source.								.519	.379
Eigenvalues Total: 11.90									
% Variance Explained: Total: 66.12	24.31	14.69	8.42	7.27	5.87	5.56			

Table 3.

Second Exploratory Factor Analysis				
Item	Factor Loadings > .4			
	1	2	3	Communality
1. A method whereby an individual is gradually introduced to his/her feared object or situation, first in his/her imagination and then in reality, would be an effective treatment for a phobia.	.837			.702
2. A phobic person needs to familiarize him/herself with, or gradually get used to, his/her feared object or situation in order to be cured.	.747			.572
3. Merely understanding why you are phobic will not necessarily cure you without doing something about it.	.534			.322
4. Phobia treatment should focus on increasing awareness of the emotions related to the phobia.		.658		.554
5. The best treatment for a phobic individual is a stance of unconditional empathy and respect.		.652		.471
6. The best treatment for a phobic individual is a non-directive, empathic approach in which the therapist does not tell the client what to do but rather guides the individual in their own learning and thinking, through a journey of self-discovery.		.556		.357
7. Phobia treatment should focus on positively transforming and changing the emotions related to phobia.	.434	.555		.534
8. Phobia treatment should focus on enhancing the ability of the phobic person to regulate, control, cope with, and process her or his emotions.	.552	.552		.609
9. The best treatment for a phobic individual is to be held in a state of unconditional positive regard, accepted exactly as and for who she or he is as a person.		.489		.285
10. People with phobias could be helped by courses in acupuncture.			.927	.898
11. Homeopathic medicine can offer a cure to phobic people.			.755	.618
12. Phobics can be helped to cope with their fears by hypnotherapy.			.493	.301
Eigenvalues Total: 7.55				
% Variance Explained: Total: 62.89				
	32.15	20.67	10.07	

Discussion

For the first analysis, 6 cogent factors emerged. They were themed around emotion-focused therapy concepts (Factor 1); desensitization, which is a feature of cognitive and behavioral therapies (Factor 2); alternative medicine (Factor 3); person-centered therapy principles (Factor 4); social learning and group therapy (Factor 5); and a single item for psychoanalytic therapy (Factor 6). Items concerning the supposedly-incurable nature of phobias, the pharmacological treatment of phobias, and the treatment of phobias by intensive flooding methods (an exposure technique characteristic of behavioral therapies), did not load.

For the second analysis with the aforementioned non-loading items removed, there were 3 factors comprising a mixture of the emotion-focused and cognitive-behavioral themes (Factor 1), person-centered approaches (Factor 2), and alternative medicine (Factor 3). It was interesting to observe, considering EFT's theoretical roots in Rogerian therapy, that the emotion-focused and person-centered items cross-loaded. Participants not only associated the included EFT principles with the more directive cognitive and behavioral sensitization techniques, implying altogether a sense that these methods of therapy involve a certain *doing-to*, but thus suggested that these principles of EFT in particular might *also* be associated with non-directive, client-derived processes of change as one sees in person-centered therapy. That is, in person-centered therapy, it is not the therapist who directs the client's changes, but the client themselves who finds, from within, the capacity and ability for change and then moves in that constructive direction with the therapist as a companion on the client's journey (Bohart, 2021). The cross-loading of these items suggests that although we did not write them as such, participants understood the emotion-focused techniques basically portrayed here to be client-, rather than therapist-, directed and thus for the associated change to be originated within the client.

The factor 1 loading of the more traditional cognitive and behavioral items with the EFT items—and the non-loading of Furnham’s flooding item—suggests that participants, at least in this study, prefer a gentler, more positive approach to the changing of behaviors and cognitions. Emotion-focused therapy is implicitly embedded within a Rogerian paradigm whereby the therapist provides empathy, unconditional positive regard and acceptance of the person as unique, and congruence, and although it is directive in part it is also associated at a fundamental level with non-directivity and client choice. Thus, we can infer that although participants indicated desire for directivity through the factor 1 loadings, this directivity is also associated with the more implicit and explicit aspects of Rogerian therapy shown in factor 2. These results suggest that perceptions of at least this formulation of EFT and PCA principles are as intertwined as the relationship between weather conditions and the natural environment in which they occur (Bolton & Lazzaro, 2021).

In contrast to the developmental portion of our study, replicating 4 of Furnham’s 5 possible themes, here we only replicated Furnham’s alternative medicine factor. We did not measure political orientation but this *may* be related to more conservative perspectives on medicine and science being held by this sample, which was recruited primarily within the researchers’ network in the heavily-conservative Southeastern U.S. (e.g., Carl et al., 2016; Dworkin, 2001; Hornsey, 2021; Washburn & Skitka, 2018). Further, juxtaposed with their psychoanalytic beliefs on the unconscious origins of phobias and lay-beliefs about psychoanalysis and the unconscious more generally (Bolton et al., 2021; Shedler, 2006), participants in our study did not believe phobias can be effectively treated through psychoanalysis. However, this may be due to the fact that, to avoid attrition, we did not add

additional psychoanalytic items as we had relating to the development of phobias (Bolton et al., 2021). Psychoanalysis remains popular, albeit misunderstood (Shedler, 2006).

Implications of this Study for the Literature and Future Research

While this study was narrowly focused on phobias—and broadly at that, not detailing any of the subtypes of phobia but rather the general concept—our findings on the whole contradict recent work endorsing pure therapist directivity (Cooper & Norcross, 2016; Cooper et al., 2019; Cooper et al., 2021). Our findings underscore the sentiment that people desire a gentler, less-intrusive and domineering form of therapy in the treatment of phobias, and add support to the evidence-base around preferences for overarching person-centered approaches to therapy. They suggest that, rather than a strictly directive approach, clients desire a more pluralistic and even non-directive framework for psychotherapeutic practice (Cooper & McLeod, 2010). This is especially true within the context of deliberate attempts and interventions by the therapist to engineer cognitive and behavioral change within clients.

Methodological Limitations

As with all self-report studies, this one has several limitations. There are, first, the typical concerns of participant honesty, attention, and accurate item understanding (Kreitchmann et al., 2019). Second, as we noted with the developmental origin portion of this project (Bolton et al., 2021), an important consideration is that some of the items could have multiple interpretations based on their specific phrasing. Certain factors might be differentially interpreted as a result. Indeed, we may have observed robust findings with respect to psychoanalytic treatment if we had added new items. Further, while most participants were indeed American, person-centered approaches have been criticized in non-Western contexts due to their individualistic rather than collective focus (MacDougall, 2002; Swan & Ceballos, 2020). Thus, as with the developmental

items, further refinement of the treatment perception and preference items and wider recruitment of those with differing cultural backgrounds might yield useful information and allow for a better understanding of treatment preferences in non-Western cultures. Future research could, and should, address this from a variety of theoretical perspectives and sub-perspectives (such as differing person-centered views). Moreover, as was previously discussed, most of the sample was White and educated, at least generally if not in psychology. A larger and more diverse sample should therefore be recruited for future research in this area.

Conclusions

The results of our study indicate support and preference in 2020, as opposed to 1995, for a gentler, more relational approach to psychotherapy. While people do indicate a desire for therapeutic techniques provided by the therapist, there is also an indication in our data that they wish for these to be positive and blended with less directive methods, as seen in person-centered approaches to therapy. Our data suggest that a blending of cognitive-behavioral and emotion-focused techniques overlain on Rogerian, person-centered principles is one preferred way of therapy, alongside preferences for alternative medicine. Thus, future research should not undervalue the contributions which can be made by person-centered therapy approaches.

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