Phobias and related fears

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Translation of Chapter XIII “Fobieën en verwante angsten” in “*De zielenmarkt, over psychotherapie in alle ernst*”, Boom, Meppel 1982. Translation by Kevin Cook.

[[Drafts of this chapter that were written by my father have been supplemented with additional text. In the year before he died, Johan and I often discussed the contents. Passages which are based on those discussions are in single square brackets **[ ]**; passages which are in keeping with the rest, and which I believe Johan would have agreed with, are in double square brackets **[[ ]]**. Henk Barendregt **]]**

[[Summary

The thesis is advanced that phobias are caused by the phenomenon known as ‘depersonalization’. When people cease to perceive their personality (which is terrifying in itself), they interpret the *situation* in which this occurs as terrifying, dangerous and something to be avoided. This is because a terrifying situation provides some form of *bearings* and hence is preferable to depersonalization, which provides none.

This is an extension of the definition which sees a phobia as a misinterpretation of an unpleasant experience – for example, shortness of breath while in a full bus may be interpreted as fear. **]]**

1. Aspects of fear

Phobias are unreasonable fears, i.e. fears that everyone – including those who suffer from them – considers incomprehensible, absurd or even childish. Each year more than a hundred people of all ages, from teenagers to pensioners, seek help from our Phobia Project. Each of

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them is given a preliminary interview. Their symptoms they mention form the basis for this chapter.
The symptoms are of many kinds, and are often physical. People may be afraid:

> in the street, in squares, on bridges; in shops, in public transport vehicles, in busy places; in lifts, tunnels, queues of traffic; of crowds, of silence; of thunderstorms, gales or clear weather; of animals, especially insects; of anything that might have to do with death or disease; of strangers, visitors, the phone, the doorbell; of pouring coffee; of flickering candles or rustling leaves; of how boats wait on the river while waiting for a bridge to open; of signing their names; of people who utter an 'o' sound;

or they may be afraid:

> of blushing, of fainting, of hyperventilating; of having palpitations or even a heart attack; of having cancer; of panicking, of going mad.

The fears are usually perceived with great intensity. However, the main difference between 'normal' people who are sometimes afraid out of doors (e.g. afraid of cars) and agoraphobics is that the latter feel afraid *whenever* they leave the house.

Occasionally, people report that they are afraid of practically everything, everywhere and all the time. Others report being afraid in just one situation. More often, people report something in between. Moreover, those who mention only one specific situation often turn out, on being interviewed, to suffer from other fears. Conversely, those with extensive generalized fears are usually able to mention situations in which they feel somewhat calmer. Nonetheless, there are great differences between patients, depending on how general or specific their fears are.

Not only can people be afraid in many situations, but they also be afraid in many different ways. Some describe their fears in a variety of ways, but others use the same word each time. It seems that fears may be more general or specific in this respect too.

It is not only people with phobic symptoms that seek help from the Phobia Project – at least, not according to commonly used psychological classifications such as the DSM-III, the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association,

1978), which defines phobias as ‘persistent avoidance behaviour secondary to irrational fears of a specific object, activity or situation’ and subdivides them into agoraphobias, social phobias and more specific phobias.

Our patients’ symptoms cover a broader category of the DSM-III, the ‘anxiety disorders’. Besides phobias, these include panic attacks, obsessive-compulsive neuroses, general anxiety neuroses and atypical anxiety neuroses.

The DSM-III classifies fears according to the *situation* in which they arise – the ‘phobogenic situation’. Examples include agoraphobia, social phobia and arachnophobia (fear of spiders). Yet the phobogenic situation is just one aspect of a phobia. Others are given names such as ‘cardiophobia’ or ‘erythrophobia’, but these are not different phobias, just different aspects of the first set of phobias. People who do not dare to go outdoors (agoraphobia) may give the fear of having a heart attack as a reason (cardiophobia); people who cannot bear attention being focused on them in company (social phobia) may blush in such situations and feel ashamed of this (erythrophobia). **[** This classification by type of fear rather than the phobogenic situation will be of use when discussing models of phobias in Section 4. **]**

2. ‘It’

Occasionally someone will begin the interview as follows: ‘It’s as if something’s going to happen – I don’t know what, just a nameless feeling.’ In practice, it is never completely nameless: ‘It’s ominous; it’s as if something dreadful’s going to happen.’ But in most cases it has already happened, in fact more than once, and it continues to happen again and again. People cannot explain exactly what has happened. ‘It’s something you can’t put into words.’ That is why it is sometimes simply called ‘it’. Some people try to make things clearer by saying what it is not. ‘I’m not afraid of anything, but this fear....’, or ‘I’m afraid of dogs, because once as a child I was bitten so badly by a dog that I ended up in hospital – but with spiders it’s *different*, do you see?’, or ‘It isn’t fear – I feel afraid when ‘it’ has already happened. When it happens, I feel afraid, and afterwards I call it fear.’

Even though ‘it’ cannot be put into words, luckily most patients manage to say something about it. Here is just a small selection from the interviews:

> you can't breathe and you feel your heart racing; it's as if thousands of pins are pricking you; you're shaking like a leaf and crying like a baby; it's as if you're fainting; you think you're dying; it's as if houses are cardboard scenery; everything's swaying; everything feels so strange; it's as if you're dreaming; it's as if nothing's real any more; there's no certainty any more; your hand doesn't belong to you; you're being pulled to one side; you no longer have any say in what you're doing; it's as if you're a doll, a puppet; you've got a head, but no face; it's as if your soul's been laid bare; you've completely lost your bearings; the void; it's as if there's no-one else left; it's as if you're a different creature; you're no longer a person; you can't think any more; it's as if you're a computer that's gone crazy; utter panic; you're out of control; it's as if you're going mad; you no longer have a self; you're alive, but you don't exist.

These are our patients' different ways of trying to put into words what are referred to in psychopathology as acute de-realization and depersonalization experiences. The individual differences are evidently considerable: *it may be that no experience is as personal as the experience of depersonalization*. We will return to this later.

Many patients think that 'it' only happens to them. Some are ashamed of it. 'If people notice, they'll think that I'm crazy, that I've gone mad.' Others complain how hard it is to communicate the experience. 'My husband's so sweet – if I'm ill or in pain, he's really caring. But he hasn't the slightest idea what this is like.' Or they feel totally despondent because no-one can help them when 'it' happens. 'You're completely on your own, even if there's someone else there with you.' Even if it is a lonely experience which everyone perceives and describes in his or her own way, it is by no means exceptional. Depersonalization and de-realization experiences are part of most psychiatric syndromes. In fact, apart from those who think they know exactly how life works, everyone knows 'it' from personal experience. If they have enough *courage de luxe* (see 8), they give their depersonalization and de-realization experiences a philosophical, literary name rather than a psychological one – existential angst, alienation and so on – but they're basically the same thing. And, like patients and psychiatrists, philosophers and writers have had trouble finding suitable terminology. Writers use a variety of words such as 'nothingness', 'emptiness', 'the void', 'the abyss of the soul', 'the Big Thing' (Rilke). And one patient with a philosophical bent described the experience of 'it' as 'loss of belief in the illusion of the self'.

3. Depersonalization

Do the experiences mentioned in the previous section differ like headache and stomach ache, or like toothache and heartache? Or are they different ways of describing the same 'it'?

The descriptions of 'it' are full of vague hints, graphic imagery, 'as-ifs'. If someone says 'It's fear of dying' and is then asked 'You thought you were dying?', the answer is something like 'Well, no, not really, but fear of dying can't be any worse'. If someone says 'You think you're fainting' and is then asked 'Did you lose consciousness?', the answer is something like 'No, not quite – I could still hear my husband speaking, but you lose your grip on your body and everything, so it feels as if you're fainting'.

What 'it' means is described vague and indirectly, because the very essence of 'it' is bewilderment. 'It' is the experience that one's existing repertoire of categories of perception, thought and feeling – the systems and behavioural patterns that make it possible to organize one's perceptions and respond meaningfully – no longer suffice, and that one is no longer able to assign meanings[2], see connections or act functionally; 'it' is the experience of disorganization or – to put it in perhaps too extreme terms – irrationality.

Each of these descriptions contains a contradiction. One person described 'it' by saying 'it's as if you're a computer that's gone crazy'. But then the computer must still be able to produce the word 'broken' – in which case it isn't completely broken. Rather than irrationality itself, what the above selection describes is the experience, the categorization, the awareness of it – and that is no longer irrationality.

Perhaps this is only to be expected, for the quotes come from interviews which in most cases proceed calmly, not from people at the point when they are experiencing 'it'. Our patients' detachment may be partly due to the fact that 'it' lasts a relatively short time, from a few seconds to rarely more than an hour (the feeling 'that something dreadful's going to happen' – not so much 'it' as the threat of it, the fear of fear – is much more long-lasting). Yet even if we witness their disorganization either during an interview or at other times, it is not total disorganization. It is not the utter chaos that is verged upon in some acute psychoses.

[2] **[[** I was taught the following game by a girl at my primary school. You say a word – for instance 'yellow' – and repeat it over and over again. Eventually you will only hear the sound, and the word will have lost its meaning. Later I heard that this phenomenon is known as '*jamais vu*' or 'semantic fatigue'. In *jamais vu*, a meaning is lost; during 'it', more than one meaning is lost, and in an uncontrollable manner. **]]**

Although our patients are likewise unable to restore order while ‘it’ is going on, there is a major difference. Their attention is not scattered over disconnected perceptions – on the contrary, it is focused on the lack of connections. During ‘it’, our patients do not *consist* of disorder – rather, they are mesmerized by it. In psychiatric terms this is not depersonalization, but the *perception* of it. This distressing state of mind has far-reaching effects. Just as with stress in general, it is not the harmful influences themselves but the perception of them that puts the organism on high alert (for example, see [3]).

What the descriptions of the perception of depersonalization have in common is the evidently distressing experience that the categories which have previously enabled patients to organize their perceptions so that they are able to act no longer suffice. Where they differ is in the categories themselves.

Section 2 discussed the personal aspects of the perception of depersonalization. This contradiction is only apparent. The word ‘personal’ – and the same is basically true of words such as ‘individual’ and ‘identity’ – has at least two meanings. First, it refers to the features that distinguish one person from another. During the perception of depersonalization, these are not lost. People’s hair and eyes do not change colour; people who are taciturn by nature, remain taciturn, and talkative if they are talkative, stupid if they are stupid, even intelligent if they are intelligent. Second, the word ‘personal(ity)’ refers to the coherence in people’s behaviour, the organization of what they are and what ‘makes them tick’. It is in this sense – disorganization – that people lose their personality. The fact that people are largely organized through their personal features, and that their organization is what mainly distinguishes them from others, does not make the difference between the two meanings any simpler, but does not eliminate it either. To paraphrase Musil (see [4]), when people depersonalize, they do not lose their distinguishing features, but their distinguishing features lose *them*.

This inevitably brings us to the awkward question of what the ‘essence’ or ‘core’ of the personality is. The following comparison may be of help here. Snow and hail both have the chemical properties of H_2O, but have different crystals and hence different physical properties. When they melt (‘depersonalize’), they do not lose the first kind of properties, but they do lose the second kind and so cease to be snow and hail. It is in this sense that people can live and at the same time not exist. Just as a hailstone cannot be found in an H_2O molecule, the ‘core’ of the personality does not lie in any one of its features. Cf. Ryle’s

anecdote describing how he gave a guest a guided tour of Oxford University. They saw libraries, laboratories, lecture halls and so on. At the end of the tour, the guest asked, ‘But where is the *university*?’ Ryle says he then had to explain that the university was not a separate building, but the way in which everything the guest had seen was organized. This is not to say that the core of the personality is the famous ‘nothingness’. The person is the structure, the organization of the individual features.

When a hailstone melts, it loses its hardness. When a snowflake melts, it loses its softness and lightness. For the same reason, people depersonalize in a personal manner. ‘Have someone depersonalize, and I’ll tell you who he is.’

Although the descriptions of the perception of depersonalization are only hints and metaphors, it clearly always involves the absence or failure of various categories, systems or organizing principles. The descriptions can, for example, be classified according to the perception of:

de-realization: inability to apply the constancy principle (it’s as if houses are cardboard scenery; everything sways; it’s as if nothing is real).

disorientation: loss of order in time and/or space (it’s as if yesterday and today have got mixed up; it’s as if the map of the city is suddenly all wrong).

de-somatization: systems for locating and/or attributing internal stimuli during strong physiological, usually autonomous reactions are no longer adequate (it’s as if I’m on fire; it’s as if my body’s boiling over).

de-somaesthization: tactile and/or kinaesthetic sensations no longer fit into the familiar somatic system (it’s as if your head is very big, or very small; it’s as if your hand doesn’t belong to you; it’s as if your car’s playing up; it's as if you've got rubber legs).

de-emotionalization: systems and patterns for categorizing, attributing and expressing emotions are no longer adequate (then you get that odd feeling; it’s like a cacophony of feelings; it’s as if you could do the craziest things, but you don’t know what).

de-motivationalization: goals are no longer available as guidelines for action (everything's so pointless; everything disgusts you; the very height of boredom).

4. Phobias as repersonalization

4.1 *Phobia model*. **[** This section provides a model for understanding the mechanism behind the 'phobia' phenomenon. Although I cannot prove that the model provides the best description, and cannot formulate it so that it is falsifiable, I would like to advance the following thesis.

A phobia develops in the following way. In certain situations, people no longer have a sufficient repertoire to organize their way of observing things and the processing thereof. This creates chaos in their consciousness, which in turns leads to depersonalization as described in Sections 2 and 3. This 'it' situation is so unreal, so absurd, that they desperately try to recover their bearings and find them in fear, which is preferable to the void of 'it'. Since their fear is itself a very negative experience, coping mechanisms are developed to channel and rationalize it.

This phobia model can be summarized as follows:

(1) situation → chaos → 'it' → fear → coping
d r

d: depersonalization
r: repersonalization

Some comments are needed here. Chaotic observation should not be interpreted as something like the observation of an untidy room, but rather as the observation of a room in which, besides chairs and tables, the person suddenly also sees the molecules and atoms that compose them – or rather, besides observing a chair, the person is suddenly aware of all the patches of colour that make up the observation of the chair, and may briefly lose the notion of a 'chair'.

When repersonalizing from 'it' to fear, the person does not actually see that the level and structures of observation have got mixed up, but misinterprets this and says there is 'something wrong'. There may be something wrong with the person's body:

> I have palpitations; I feel pressure on my chest; my vision is blurred; I blush; I'm ugly; I'm suffocating.

or something wrong with the person or his relationship to others:

> I have anxiety attacks; I'm the kind of person who.....; other people will think I'm crazy; I'm all alone.

or something wrong with the outside world:

> it's as if I'm dreaming; it's as if the houses are made of cardboard.

The degree of reality in such reinterpretations may vary. People may say that it's *as if* the houses are made of cardboard, or say that they *are* made of cardboard. The latter is a delusion. There is a continuum of possibilities between 'as-ifs' and delusions.

Those who repersonalize in a delusion about the outside world will be described as psychotic rather than phobic. However, if the delusion is about the person's own body ('there's something wrong with my heart'), it is less likely to be described as a psychosis.

The descriptions of the 'it' experience in Section 2 are in fact already repersonalizations. People are attempting to put their disordered observations into organized words. Everyone does this in his or her own way. This is another reason why there are so many different descriptions and perceptions of 'it'. In Section 3 we saw that people perceive 'it' according to which part of their (observation/personality) structure they lose. Since they can repersonalize in different ways, the number of possibilities becomes even greater.

Coping: Once people have repersonalized from 'it' to fear, they must still learn to live with this. They do so with the help of coping mechanisms. People suffering from fear may take refuge in various quarters, including (1) substances, such as alcohol or tranquillizers; (2) other people, such as partners or doctors; (3) obsessive-compulsive acts or ideas, such as avoiding the phobogenic situation or feeling doomed. It is above all these coping mechanisms that make phobics such a problem for themselves and for others. The mechanisms may even become completely autonomous, after the original fear has faded into

the background. For example, a patient cannot leave the house unless she is accompanied by her husband or one of her children. The tension that this causes is reduced by taking medication. The anxiety or fear has almost gone, but the situation is still untenable. **]**

4.2 **[** *Other models*. We will now look at several other models of how phobias develop. **]**

A. There have been frequent attempts to induce phobias artificially by means of a simple conditioning process (for example, see [11]). A healthy test subject is shown some harmless object (the 'conditional stimulus', or CS) and is then immediately given an unpleasant stimulus (the 'unconditional stimulus', or UCS – usually a small electric shock or a loud noise). After this has happened several times, the test subject may start to find the harmless object unpleasant, even when shown it separately. He may even attempt to escape from it or avoid it altogether. A phobia has then supposedly been induced. The reasoning behind this is that a natural phobia also develops from an unpleasant experience in, and avoidance of, an essentially harmless situation. **[** This conditioning or learning-theory model can be summarized as follows:

(2) situation → fear (→ coping)
c

c: conditioning

The model in diagram 1 is also a conditioning process, but one involving 'it' rather than a harmless stimulus. **]** There are indeed people who cannot put an electric plug into a socket because they once received a shock, who are afraid of dogs because they were once bitten by one, or cannot get into a car because they once had an accident. But such things are not often mentioned in interviews. If anything, they are the exceptions that confirm the rule: what is mentioned is the fear of an unexpected electric shock, rather than the pain. I have never heard anyone say he was afraid to close doors after getting his finger caught in one. One of the people quoted earlier said she was afraid of dogs after having been bitten, but that with spiders it was 'different'. People in whom dogs cause a similar 'different' feeling turn out never to have been bitten. Almost none of those who cannot get into a car has ever been in a car crash. What happens as a rule is that old fears which were thought to have been overcome recur after an accident, worse than ever. The few who do not dare drive again after a car crash do not mention the pain, but the panic they feel – not what they went

through afterwards, but the constant uncertainty of having to live with ‘a hole in time’, their amnesia about what happened.

[[For these reasons, I do not consider that conditioning model 2 is adequate to describe phobias. **]]**

B. Seligman has surmised that situations in which people often display phobic reactions may no longer be dangerous, but certainly used to be (see [7]). It was very useful for prehistoric humans to be afraid of spiders (which could be poisonous), not to venture out onto open plains (where enemies could see them), not to enter enclosed spaces (which would be difficult to escape from) and so on. Such fears increased rather than decreased their chances of survival, and have therefore not been evolved out. Even now, people are genetically ‘prepared’ (as Seligman puts it) to develop fears that were once useful and are now termed irrational. This is a plausible argument, and it is possible, even probable, that Seligman is right at least as far as some phobias are concerned. But in human prehistory, as with the human unconscious, it is hard to distinguish between what is really there and what has been put there. Working independently, two Master’s students, Kroese and Mallens (see [2]), attempted to ‘translate’ a large number of phobic symptoms to prehistoric times, using a key described in an article co-authored by Seligman (see [7]). There was disappointingly little similarity between Kroese’s and Mallens’s translations. Seligman leaves the possibility open in the case of other phobias, but says ‘they should be less frequent, since they are less prepared.’

Where Kroese and Mallens did agree was in concluding that only a minority of phobic symptoms were fears that may once have been useful. Nor, on the basis of Seligman’s assumptions, would one expect to find that spider phobia is common but that phobia of flies and mosquitoes is rare, since flies and mosquitoes can transmit diseases and hence were – and are – far more dangerous than spiders.

[[C. Psychiatric literature has already pointed to the link between phobias and depersonalization phenomena; examples include Oberndorf (see [6]), Roth (see [9]) and Noyes *et al.* (see [5]). Noyes *et al.* claim that depersonalization is a defence against fear. This produces the following model of a phobia:

(3) situation → fear → ‘it’ (→ coping)

d

d: defence

Oberndorf makes a further distinction between primary and secondary fear. This can be summarized as follows:

(4) situation → primary fear → 'it' → secondary fear (→ coping)

Oberndorf also sees depersonalization as a defence against (banishment/masking of) fear.

The difference between model 4 and my own model 1 is that model 1 provides an explanation for the shift from 'it' to phobic fear (phobic fear has a repersonalizing effect, it restores people's bearings), whereas model 4 does not. Moreover, model 4 provides a different explanation of the shift from the situation to 'it', i.e. via fear as defence. In model 1, the explanation was:

situation → no repertoire → chaos → 'it'

Model 3 is part of model 4. In model 3, depersonalization is merely a secondary phenomenon. This model does not explain why phobias are so persistent. **]]**

4.3 **[** *Other forms of repersonalization*. Depersonalization may lead to phobias, but there are other ways to cope with 'it'.

(a) Being in love. **]** Outsiders who see phobic reactions as childish nonsense are often less harsh in their judgements when their attention is drawn to a counterpart of phobia: being in love. Instead of avoiding the object, the person seeks proximity to it; apart from that, there are numerous similarities. **[** People cannot put their love into words. The world becomes unreal, as if in a dream (only this time it is a pleasant dream). The wish to be close to the object is obsessive-compulsive. And is it not a cliché that being in love causes the self to dissolve – to fuse with the other's self? If the love object rejects such proximity, repersonalization does not operate. In that case, the person in love reverts to 'it'. And here again we find the usual coping mechanisms. Since this whole process of being in love has very often been the subject of poetry and song (at all levels – from Homer to the Top 10), the behaviour of unrequited lovers is more socially accepted than that of phobics. **]**

[(b) Psychoses. In Sections 2 and 3 we saw that perceptions of depersonalization are often described using the words ‘as if’ (‘it’s *as if* the houses are made of cardboard’). As we have mentioned, some people really do think the houses are made of cardboard, and behave accordingly **[[** (‘I won’t go out of doors, because the houses are made of cardboard and the wind might blow them down on top of me’). **]]** We are then dealing with a psychotic delusion. Such patients are sometimes less unhappy than phobics **[[** (‘It’s not me that’s crazy, it’s the people who think the houses are made of bricks’). **]]**

Various types of psychosis can be described thus, as repersonalizations from ‘it’, only this time using constructs which common sense tells us are impossible. The constructs that phobics use for their repersonalizations may be unrealistic (‘I avoid all contact with people, for I might start blushing’) but are in keeping with customary patterns of thinking.

There is a continuum from phobias to psychoses as described above. **]**

[[(c) Hypnosis. The compulsion felt while under hypnosis may also be seen as a repersonalization phenomenon. The trances people go into when hypnotized are a form of depersonalization. People do not panic because they have reached an ‘it’ state under the hypnotist’s supervision. The post-hypnotic suggestion restores their bearings. However, if the suggestion is not correctly followed, they revert to ‘it’. This explains the compulsiveness with which post-hypnotic suggestions are followed after successful hypnosis. Anything is better than ‘it’. **]]**

[(d) *Courage de luxe*. This term, which comes from Rilke, has already been mentioned in Section 2. Rilke also describes ‘it’, which he calls ‘the Big Thing’ (*'das Große'*). He says, ‘Only one step, and my deep misery would be beatitude.’ But he lacked the *courage de luxe* to face up to ‘it’, to ‘live without existing.’ **] [[** Psychiatric literature contains descriptions of patients who enjoy depersonalization, for it is then that they have *courage de luxe*. Buddhism often refers to emptiness or ‘voidness’, in ways that make it clear this is considered a favourable quality. A key concept in Buddhism is *anatta* (‘no self’). The purpose of meditation is to realize that *anatta* is one of the characteristic features of existence – and to continue living with that knowledge. This, too, is *courage de luxe*. **]]**

4.4 **[** *Gap in the phobia model*. A weak point in the explanation of phobias shown in diagram (1) is the lack of an analysis of situations that lead to 'it'. **]**

Whether it be an object, a creature, a situation or an action, there is sure to be someone somewhere who has a phobia about it. This is not to say that all phobias are equally likely. More people are phobic about spiders than about flies or mosquitoes (another argument against the importance of pain experiences in phobias); more are phobic in buses, trams or trains than in cars; more are phobic in tunnels or lifts than in squares or streets, and more in squares or streets than in parks; there are more people who cannot stand the sight of blood than people who cannot bear words containing an 'o' sound; there are quite a lot of people who can't drink coffee in company, but very few who can't sign their names in front of other people (they use block letters instead). If phobias are common in one situation and rare in another, there must be some essential difference between the two – but what? Pain, physical injury and material damage hardly play a part in our patients' phobias, so the situations concerned can hardly be considered dangerous. In that sense, phobias are indeed irrational fears.

Just as in love and art, everyone has his or her own preferences, and yet some do better than others on the love and art markets. Just as phobias do not arise because of the pain experienced in a situation, people do not fall in love because the other person is so lovable. The love object simply has 'it'. **[** Polly in Brecht's *Threepenny Opera* says this clearly. One day a man came her way, a fellow who lacked money, good manners and a clean shirt. But 'he went and hung his hat on a nail in my little attic, and what happened I can't quite recall.' **]**

What is it about these people, works of art and situations that leads to 'it'? A good question, but one that is hard to answer; some suggestions can be found in Barendregt and Frijda (see [1]). **[** Besides the situation, the person's physical and mental condition plays a part. Depending on the influence of stress or hormones, drugs, tranquillizers and so on, people will be quicker or slower to reach an 'it' state in particular situations.

Yet there is something that can be said about situations in which 'it' arises. If you are in a lift, you may feel briefly disoriented. The movement of a snake or a spider is so different and subtle as to fall outside our usual repertoire of observation. To a biologist, however, the curious locomotion of snakes and spiders is something to be studied, and hence something that can be observed safely. **]**

Mainly on the basis of studies of animal psychology, Schneirla (see [10]) says that situations with high-intensity stimuli or great irregularity lead to withdrawal. **[** However, it is still not clear just what situations lead to 'it'. If we knew that, we would know not only how phobias arise, but also what being in love is, and what art is. Psychology would have taken a great step forward. **]**

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