THOUGHT SUPPRESSION IN PHOBIC AND NON-PHOBIC DENTAL PATIENTS

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The present study investigated the role of thought suppression in dental anxiety. Non-phobic (n = 49) and phobic (n = 35) patients were instructed either to suppress or to express (i.e., think about) negative dentistry-related thoughts while undergoing dental treatment. Results show that phobic patients exhibited higher levels of suppression and intrusive thinking than non-phobic controls. Only in the non-phobic group, suppression instructions produced a significant increase of intrusive thinking and anxiety. The counterproductive effects of thought suppression were less evident in the phobic group. Altogether, these results suggest that thought suppression exacerbates dental anxiety in normals, while it is part of the habitual style of coping in dental phobics.

Keywords: Thought suppression; Dental anxiety; Specific phobia

Systematic research on thought suppression started after Wegner et al. (1987) published their “white bear” experiment. The general outline of their experiment was as follows: undergraduate students were assigned to one of two groups. The first group was an initial suppression group that was instructed to suppress the thought of a white bear for a 5-minute period. Following this, subjects in this group were given expression instructions, i.e., they were invited to

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think about a white bear during a 5-minute period. For the second
group, termed the initial expression group, the order of the instruc-
tions was reversed. Thus, initial expression subjects first engaged in
expression and later in suppression. All subjects were asked to ring
a bell whenever the thought of a white bear occurred to them.
Wegner and associates (1987) found that subjects reported a height-
tened frequency of white bear thoughts when they had previously
engaged in suppression. Accordingly, Wegner and co-workers con-
cluded that suppression of unwanted thoughts leads to a rebound
effect.

Several authors have stressed the immediate counterproductive
effect of thought suppression rather than its delayed rebound effect.
This initial enhancement effect was observed in several laboratory
studies. For example, in an experiment by Lavy and Van den Hout
(1990), undergraduate students were assigned to one of two condi-
tions. Subjects in the suppression condition were instructed “not to
think of vehicles”, whereas subjects in the control condition were free
to think of anything. Results showed that the suppression condition
produced an immediate increase in thoughts about vehicles relative
to the control condition.

Wegner (1989; see also Salkovskis, 1989) has claimed that thought
suppression plays a role in the etiology and/or maintenance of
unwanted, negative thoughts that occur in obsessive-compulsive
disorder, depression, post-traumatic stress disorder, generalized
anxiety disorder, and specific phobias. The empirical support for this
claim is restricted since only a few studies have examined the effects
of thought suppression in clinical populations.

One exception is a study of Becker et al. (in press) in which
patients with generalized anxiety disorder (GAD), speech phobias,
and non-anxious controls were asked to verbalize their stream of
consciousness for two 5-minute periods. During the first period, all
participants had to suppress thoughts of a white bear. During the
second period, all participants were instructed to avoid thinking
about their main worry. GAD patients had more intrusions about
their main worry than of white bears, whereas the opposite was true
for speech phobics and non-anxious controls. This finding, at least,
suggests that thought suppression might be a relevant mechanism
in GAD.
Another study of Muris et al. (1997) attempted to examine the role of thought suppression in spider phobia. Spider phobic and non-phobic participants were asked to monitor their thoughts for three 5-minute periods. During the first period, all participants were instructed “to think about anything”. During the second period, half of the subjects received suppression instructions (i.e., they were explicitly asked “not to think of spiders”) whereas the other half once again received instructions “to think about anything”. During the third period, all participants were instructed “to think about anything”. Results indicated that, during all three periods, spider phobics reported higher levels of spider-related thoughts than non-phobic subjects. Furthermore, phobic patients tried harder to suppress spider-related thoughts than non-phobic controls. Finally, although some evidence was obtained for the counterproductive effects of thought suppression, its contribution to the frequency of spider-related thoughts was minimal. Apparently, thought suppression does not play a key role in this type of specific phobia.

Recently, a correlational study by De Jongh et al. (1996) found evidence to suggest that thought suppression adds to the severity of dental anxiety. In that study, participants were instructed to suppress negative, dentist-related thoughts during a one-minute period. After this suppression period, participants rated the extent to which they had succeeded in suppressing their dentist-related thoughts (i.e., thought control) and the extent to which they had spent on thinking about these thoughts (i.e., intrusiveness). Results showed that high dental anxiety was positively related to intrusiveness and negatively associated with successful thought suppression. Thus, the higher participants’ level of dental anxiety, the more time they spent thinking about the negative, dentist-related thoughts, and the less successful they were in suppressing such thoughts.

Using an experimental approach, the present study further investigated the role of thought suppression in dental anxiety. More specifically, non-phobic and phobic dental patients were instructed either to suppress or to express negative, dentist-related thoughts while undergoing a dental treatment. The effects of this manipulation on intrusive thinking and anxiety were then measured. With Wegner’s (1989) theory in mind, it was expected that suppression instructions would result in heightened levels of intrusive thinking and anxiety.
METHOD

Participants

All participants were patients who had to undergo invasive dental treatment which required local anesthesia (e.g., fillings, root canal treatments, placement of crowns, or tooth extractions). The group of dental phobics consisted of 35 patients (23 women) of a clinic specialized in the treatment of patients with dental fear. All dental phobics met the DSM-IV criteria for specific phobia (American Psychiatric Association, 1994), had a history of avoiding dental treatment and a score of at least 12 on the Dental Anxiety Scale (DAS; Corah, 1969). Mean age of this group was 33.66 years (SD=8.20, range 19-55 years). Forty-nine patients (22 women) of the Academic Centre for Dentistry Amsterdam served as non-phobic control group. These patients were regular dental patients and scored 11 or lower on the DAS. Mean age of the non-phobic group was 35.86 years (SD=11.90, range 21-60 years).

Initially, 110 patients (53 non-phobics and 57 phobics) were asked to participate in the experiment. Eighty-eight patients (50 non-phobics; 38 phobics) agreed to participate. Four patients were excluded from the experiment because their DAS score was not in the phobic (3 participants) or non-phobic range (1 participant).

Assessment and Materials

Trait Measures of Dental Anxiety

Dental trait anxiety was measured with the Dental Anxiety Scale (DAS; Corah, 1969; α = 0.95). The DAS is a reliable and valid four-item measure that has been widely used in studies on dental anxiety. Items (e.g., “When you are sitting in the dentist’s chair while the dentist is preparing his drill, how do you feel?”) are scored on a scale that ranges from 1 to 5. Scores are summed to give an overall anxiety score varying between 4 (not anxious at all) and 20 (extremely anxious).

Habitual ways of negative thinking about dental treatment were assessed with a shortened version of the Dental Cognition Questionnaire (DCQ; De Jongh et al., 1995; α = 0.93). The short-version DCQ lists
24 negative thoughts that patients may have during treatment (e.g., “While being treated, I think that everything will go wrong”). Participants are asked to tick “yes” or “no” for each item. “Yes” responses are summed to yield a total negative thought score (range 0–24).

State Measures

State anxiety was measured using 100 mm visual analogue scales (VASs), horizontal lines with not anxious at all and very anxious as anchors. Participants rated the VAS by placing a vertical mark. The ratings were measured in mm.

Intrusive thinking during dental treatment was assessed in two ways. First, participants retrospectively scored intrusions by means of a VAS, i.e., they indicated how frequently they had experienced negative thoughts during treatment (0 = not at all; 100 = all the time). Second, patients were given a checklist and asked to indicate which of the DCQ thoughts they actually had experienced during treatment. In addition, they were asked to rate how much discomfort these thoughts had elicited (0 = not at all; 100 = very much).

Suppression, i.e., the extent to which participants had tried to suppress negative thoughts during treatment was also measured with a VAS (0 = not at all; 100 = as much as possible).

Procedure

In the waiting room, patients were asked whether they were willing to participate in a study concerned with thought strategies during dental treatment. After patients had given their informed consent, they first rated their level of state anxiety on a 100 mm VAS (0 = not anxious at all; 100 = very anxious) and then completed the DAS and the DCQ. Next, patients were given written instructions about the cognitive strategy that they should use during the upcoming dental treatment. The experiment followed a 2 (groups: phobic versus non-phobic patients) × 2 (conditions: suppression versus expression) factorial design. Thus, there were two conditions: a suppression and an expression condition. In the suppression condition, the written instruction ran as follows: “Within a few minutes, you will undergo dental treatment. It is possible that during this treatment, negative thoughts will come to your mind. Please try to suppress such
thoughts as much as possible. Although you may have the tendency to think negatively about dental treatment, please try to interrupt negative thinking. Suppress all negative thoughts!” In the expression condition, the instruction was: “In a little while, you will undergo dental treatment. It is possible that, during this treatment, negative thoughts will come to your mind. Please think about such thoughts as much as you can! Although you may have the tendency to avoid negative thoughts about dental treatment, please try not to interrupt negative thinking. Think about all negative thoughts!”

After treatment, patients rated their level of state anxiety on a 100 mm VAS. Next, patients retrospectively scored intrusions, suppression, and state anxiety during treatment. Finally, patients were given the DCQ checklist to identify the negative thoughts that they actually had experienced during treatment and to assess the discomfort that was elicited by these thoughts.

RESULTS

Table 1 shows demographic variables and mean scores on various measures for phobic and non-phobic patients in the suppression and expression conditions. Data were first analyzed by means of separate 2 (groups: phobic/non-phobic) × 2 (condition: suppression/expression) analyses of variance (ANOVAs), with both factors being between-subjects factors. This revealed significant main effects of group on DAS \( F(1,80) = 315.59, p < 0.001 \), state anxiety before treatment \( F(1,80) = 134.27, p < 0.001 \), years of avoiding treatment \( F(1,80) = 47.94, p < 0.001 \), and DCQ \( F(1,80) = 43.09, p < 0.001 \): as expected, phobic patients had higher levels of dental trait anxiety, had avoided dental treatment for a longer period of time, and habitually experienced more negative thoughts during treatment than non-phobic patients. Note further that treatment duration (in minutes) in the phobic group was remarkably shorter than that in the non-phobic group \( F(1,80) = 302.98, p < 0.001 \). No significant group differences were found with respect to age \( F(1,80) < 1.00 \) or sex distribution \( \chi^2(3) = 5.80, p = 0.12 \).

Significant main effects of group were found on all dependent variables: phobics had more intrusions \( F(1,80) = 21.77, p < 0.001 \) and
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<th>Non-phobic</th>
<th>Phobic</th>
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<tr>
<td></td>
<td>Total group (n = 69)</td>
<td>Suppression (n = 19)</td>
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<tr>
<td>Men/women</td>
<td>27/22</td>
<td>13/6</td>
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<tr>
<td>Age</td>
<td>35.86 (11.90)</td>
<td>33.05 (10.59)</td>
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<tr>
<td>DAS</td>
<td>7.43 (1.83)</td>
<td>7.84 (1.71)</td>
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<tr>
<td>DCQ</td>
<td>1.74 (1.77)</td>
<td>2.26 (1.71)</td>
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<tr>
<td>Avoidance (years)</td>
<td>2.16 (3.02)</td>
<td>2.00 (3.04)</td>
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<tr>
<td>Duration of treatment</td>
<td>159.29 (35.92)</td>
<td>158.68 (30.70)</td>
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<tr>
<td>Suppression</td>
<td>32.33 (26.05)</td>
<td>47.95 (23.47)</td>
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<tr>
<td>Intrusions</td>
<td>25.20 (25.18)</td>
<td>33.05 (24.10)</td>
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<tr>
<td>Negative thoughts</td>
<td>2.25 (2.24)</td>
<td>5.05 (2.90)</td>
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<tr>
<td>Discomfort of thoughts</td>
<td>8.55 (9.46)</td>
<td>12.26 (10.53)</td>
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<tr>
<td>Anxiety before treatment</td>
<td>21.44 (20.71)</td>
<td>27.10 (21.46)</td>
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<tr>
<td>Anxiety during treatment</td>
<td>25.71 (23.95)</td>
<td>35.84 (24.93)</td>
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<tr>
<td>Anxiety after treatment</td>
<td>10.20 (18.99)</td>
<td>17.47 (26.71)</td>
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Note: Means in the same row that do not share the same subscripts differ at \( p < 0.05 \) (one-tailed in case the hypothesis tested was unidirectional); DAS = Dental anxiety scale; DCQ = Dental cognition questionnaire.
negative thoughts \( F(1, 80) = 33.03, p < 0.001 \), tried harder to suppress negative thinking \( F(1, 80) = 12.35, p < 0.005 \), experienced more discomfort with negative thoughts \( F(1, 80) = 59.70, p < 0.001 \), and were more anxious during \( F(1, 80) = 75.65, p < 0.001 \) and after treatment \( F(1, 80) = 10.71, p < 0.005 \). Furthermore, a significant main effect of condition was found on suppression \( F(1, 80) = 13.69, p < 0.001 \); suppression participants indicated that they tried harder to suppress negative thoughts during treatment than expression participants. Finally, interaction effects of group and condition emerged with respect to intrusions \( F(1, 80) = 5.73, p < 0.05 \) and negative thoughts \( F(1, 80) = 4.89, p < 0.05 \).

To get a more detailed picture of the source of main and interaction effects, a series of follow-up \( t \) tests was carried out comparing the mean scores of the four groups. The results of these analyses are shown in Table I. For the purpose of the present study, the comparisons between suppression and expression participants within each group are most interesting and will be discussed hereafter.

**Non-Phobic Patients**

Chi-square and \( t \) tests indicated that within the non-phobic group there were no significant differences between suppression and expression participants on demographic variables and pre-experiment levels of dental fear (DAS, DCQ). Furthermore, participants' perception of how hard they had tried to suppress negative thoughts during treatment differed significantly between both conditions, means being 47.95 (SD = 23.47) and 22.43 (SD = 22.81) for suppression and expression participants, respectively \( t(47) = 3.77, p < 0.001 \). This indicates that the experimental manipulation in the non-phobic group was successful. Most importantly, one-tailed \( t \) tests revealed that suppression participants were more plagued by intrusions \( t(47) = 1.78, p < 0.05 \) and negative thoughts \( t(47) = 2.08, p < 0.05 \) experienced more discomfort with these negative thoughts \( t(47) = 2.21, p < 0.05 \), and had higher levels of state anxiety during \( t(47) = 1.94, p < 0.05 \) and after treatment \( t(47) = 2.12, p < 0.05 \) than expression participants (see left panel of Table I).

Pearson product-moment correlations between the main means were computed for the non-phobic group. The expected pattern found (see upper panel of Table II).
THOUGHT SUPPRESSION IN DENTAL PHOBIA

That is, anxiety, intrusions, negative thoughts, and suppression were all positively and significantly interrelated.

Phobic Group

There were no differences between suppression and expression participants in the phobic group with respect to sex distribution, age, duration of avoidance, DAS, or DCQ. However, treatment sessions of expression participants lasted significantly longer than those of suppression participants, means being 50.29 (SD = 13.97) versus 39.72 (SD = 14.90) minutes [r(33) = −2.13, p < 0.05, two-tailed].

Remarkably, suppression efforts did not differ significantly between suppression and expression participants, means being 59.22 (SD = 18.19) versus 47.00 (SD = 26.12) [r(33) = 1.61, p > 0.05, one-tailed]. This suggests that the experimental manipulation failed in the phobic group. Irrespective of instruction, all phobic participants tried to some extent to suppress their negative thoughts during treatment. Not surprisingly, no significant differences between suppression and expression participants emerged on any of the dependent measures (see right panel of Table I).

In contrast to the correlational pattern in the non-phobic group, Pearson product-moment correlations between main measures in the phobic group revealed only five significant associations (see bottom panel of Table II). Most importantly, suppression was not substantially related to measures of intrusive thinking and anxiety (i.e., suppression was only significantly associated with state anxiety after treatment: r(35) = 0.37, p < 0.05, one-tailed). In other words, in the phobic group, no convincing evidence for the counterproductive effects of thought suppression emerged.

DISCUSSION

The main results of the current study can be catalogued as follows. To begin with, phobic patients reported higher levels of intrusive and negative thinking during dental treatment than non-phobic patients. Secondly, phobic patients tried harder to suppress their negative thoughts than non-phobic participants. Thirdly, in the non-phobic group, suppression instructions resulted in increased levels of anxiety.
TABLE II  Pearson product-moment correlations between main measures computed for non-phobic (n=49) and phobic (n=35) groups separately

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<td><strong>Non-phobic</strong></td>
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<td>1. DAS</td>
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<td>2. Suppression</td>
<td>0.37**</td>
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<td>3. Intrusions</td>
<td>0.45***</td>
<td>0.58***</td>
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<td>4. Negative thoughts</td>
<td>0.22</td>
<td>0.45***</td>
<td>0.36**</td>
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<td>5. Discomfort of thoughts</td>
<td>0.38**</td>
<td>0.43**</td>
<td>0.72***</td>
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<tr>
<td>6. Anxiety before treatment</td>
<td>0.60***</td>
<td>0.37**</td>
<td>0.15</td>
<td>0.38**</td>
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<tr>
<td>7. Anxiety during treatment</td>
<td>0.34***</td>
<td>0.42**</td>
<td>0.74***</td>
<td>0.41**</td>
<td>0.64***</td>
<td>0.54***</td>
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<td>8. Anxiety after treatment</td>
<td>0.24*</td>
<td>0.28*</td>
<td>0.62***</td>
<td>0.38**</td>
<td>0.47***</td>
<td>0.21</td>
<td>0.57***</td>
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<td><strong>Phobic</strong></td>
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<td>1. DAS</td>
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<td>2. Suppression</td>
<td>0.02</td>
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<td>3. Intrusions</td>
<td>0.07</td>
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<td>4. Negative thoughts</td>
<td>0.16</td>
<td>0.22</td>
<td>0.16</td>
<td>0.72***</td>
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<tr>
<td>5. Discomfort of thoughts</td>
<td>0.41**</td>
<td>0.13</td>
<td>0.01</td>
<td>0.07</td>
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<tr>
<td>6. Anxiety before treatment</td>
<td>0.08</td>
<td>0.27</td>
<td>0.36*</td>
<td>0.03</td>
<td>0.26</td>
<td>0.12</td>
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<tr>
<td>7. Anxiety during treatment</td>
<td>-0.05</td>
<td>0.37*</td>
<td>0.11</td>
<td>0.06</td>
<td>-0.07</td>
<td>0.19</td>
<td>0.31*</td>
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<td>8. Anxiety after treatment</td>
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*Note: *p < 0.05, **p < 0.01, ***p < 0.001 (one-tailed); DAS = Dental anxiety scale.*
and intrusive thinking. Fourthly, in the phobic group, suppression instructions had no additional detrimental effects.

De Jongh et al. (1996; p. 124) argued that "...in anticipation of an anxiety-provoking encounter such as dental treatment, thoughts become more frequent and intrusive. To avoid feelings of discomfort anxious patients may try to suppress such thoughts and become trapped in a cycle of negative thinking and thought suppression efforts, thereby maintaining or even intensifying their fear”. To some extent, the present data support the idea that thought suppression adds to the severity of dental fear. That is, in non-phobic patients, a suppression strategy resulted in an increased frequency of intrusions and negative thoughts and higher levels of state anxiety. Furthermore, in the non-phobic group, correlational analysis revealed a pattern that fits nicely with de Jongh et al.’s (1996) speculations. Of course, correlations are not sufficient to establish cause-and-effect relationships. But, at least, the correlational pattern underlines the plausibility of de Jongh et al.’s (1996) line of reasoning, which for the present data can be rephrased as follows: Dental trait anxiety results in state anxiety as soon as the patient enters the dentist’s office ($r = 0.54$, $p < 0.001$). State anxiety leads to a heightened frequency of intrusions ($r = 0.74$, $p < 0.001$) and negative thoughts ($r = 0.41$, $p < 0.01$), which in turn, elicit discomfort ($r = 0.43$, $p < 0.001$ and $r = 0.72$, $p < 0.001$, respectively). To reduce these feelings of distress, people engage in thought suppression ($r = 0.34$, $p < 0.01$). However, this manoeuvre is counterproductive and further enhances the frequency of intrusions ($r = 0.58$, $p < 0.001$) and negative thoughts ($r = 0.45$, $p < 0.001$). Eventually, the patient will find him- or herself trapped in a positive feedback loop of anxiety, intrusions, and thought suppression.

In phobics patients, a somewhat different picture emerged. To begin with, compared to controls, phobic patients reported higher levels of intrusive thinking and tried harder to suppress these negative thoughts. This is consistent with the notion that thought suppression plays a role in psychopathological conditions such as the anxiety disorders (e.g., Wegner, 1989). Even phobic patients who had been instructed to think about their negative thoughts (i.e., expression instructions), engaged in thought suppression. Obviously, then, phobic anxiety is difficult to reconcile with non-suppression (see,
Muris et al., 1997, for a similar conclusion). In other words, it may be extremely difficult for phobic patients to comply with explicit instructions. This may undermine comparisons between phobic and non-phobic patients. Second, correlational analyses revealed that the phobic subgroup, suppression was not associated with higher levels of intrusive thinking and anxiety. Thus, in the phobic group, no evidence for the paradoxical effects of thought suppression was found. These findings suggest that thought suppression is not a crucial maintenance factor in the psychopathology of this particular disorder. Clearly, the current findings and those of Muris et al. (1997) contradict the idea that suppression sustains psychopathology in specific phobias. However, it should be noted that specific phobias constitute a particular type of disorder and consequently the present result cannot be generalized to other anxiety complaints (e.g., obsessive-compulsive disorder).

In the past ten years or so, there have been more than 30 annual studies investigating the effects of thought suppression. Although there are some studies that failed to document the rebound at initial enhancement effect (e.g., Merckelbach et al., 1991), the majority found support for the idea that thought suppression is counterproductive and leads to an enhanced frequency of the suppressed material in the stream of consciousness (see, for a review, Muris et al., 1996). On the basis of this observation, some authors (Wegner, 1989; Salkovskis, 1989) have emphasized the theoretical relevance of this phenomenon. Anxiety disorders such as phobias, generalized anxiety disorder, post-traumatic stress disorder, and obsessive-compulsive disorder are usually accompanied by levels of intrusive and/or negative thinking which, in turn, may result in thought suppression efforts. Few studies have actually investigated the exact role of thought suppression in these disorders. The study examined thought suppression in relation to dental phobia. Results indicate that instructed thought suppression intensified intrusive thinking and anxiety during dental treatment in non-phobic dental patients. Phobic dental patients were found to exhibit levels of suppression and intrusions than non-phobic controls. The findings suggest that thought suppression may accompany the manifestations of dental anxiety. That is to say, thought suppression exacerbates dental anxiety in normals, while it is part of the...
coping style of dental phobics. Future research should examine whether these results can be generalized to other types of anxiety disorders and should concentrate on the precise cause-and-effect relations involved in thought suppression and pathological anxiety. Clearly, this requires longitudinal research projects.

References


