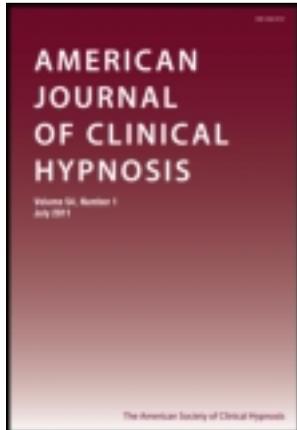


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I-95 Phobia Treated With Hypnotic Systematic Desensitization: A Case Report

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Systematic desensitization and hypnosis mediated therapy share empirical evidence of efficacy in the treatment of specific phobias. However, a review of the literature indicated there is limited documentation in the employment of these modalities for treating driving related phobias (DRP). This article reports on the use of hypnosis aided systematic desensitization (HASD) in the successful treatment of a case of non-accident related driving phobia, specifically manifested on Interstate 95 (I-95). The treatment consisted of 6 office sessions of HASD along with 14 in-vivo sessions where the patient performed multiple exposures/rehearsals of the behaviors that had been successfully mastered at the office visits. The results indicated that this patient with case of (DRP) was able to resume travel on I-95 at conclusion of treatment. The patient was symptom free at follow up 6 months later.

Keywords: hypnosis aided systematic desensitization, non-accident related driving phobia, simple phobia

Specific Phobia

The Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5;* American Psychiatric Association, 2013) defines “Specific Phobia” along the following dimensions:

- The individual experiences excessive and persistent fear of a specific object or situation.
- The individual experiences feelings of anxiety, fear, or panic immediately upon encountering the feared object or situation.
- The person recognizes that the fear is excessive, unreasonable, or out of proportion to the actual risk in the situation.
- The individual tends to avoid the feared object or situation, or if he or she doesn't avoid it, endures encounters with the feared object or situation with intense anxiety or discomfort.
- The individual's fear, anxiety, or avoidance causes significant distress (i.e., it bothers the person that he or she has the fear) or significant interference in the person's

day-to-day life. For example, the fear may make it difficult for the person to perform important tasks at work, meet new friends, attend classes, or interact with others.

- Avoidance, anxiety, or fear typically lasts for 6 months or more.
- The person's fear, panic, and avoidance are not better explained by another disorder.

Types of Specific Phobia

The *DSM-5* defines five types of specific phobias:

- (1) Animal Type: These include fears of animals such as dogs, cats, spiders, bugs, mice, rats, birds, fish, and snakes.
- (2) Natural Environment Type: These include fears of heights, storms, and being near water.
- (3) Blood-Injection-Injury Type: These include fears of seeing blood, receiving a blood test or injection, watching medical procedures on television, and for some individuals, even just talking about medical procedures.
- (4) Situational Type: These include fears of situations such as driving, flying, elevators, and enclosed places.
- (5) Other Type: These include other specific fears, including fears of choking or vomiting after eating certain foods, fears of balloons breaking or other loud sounds, or fears of clowns.

Driving Related Phobias

Accident Related Reactions

Accident related research has contributed to the understanding of the psychological consequences of motor vehicle-accidents. The contributions from this body of investigation (Kutch, Evans Watson, Bubela, & Cox, 1991; Mayiou, Bryant, & Duthie, 1993; Taylor & Dean, 2000; Vingilis, Larkin, Stoduto, Parkinson-Heyes, & McLellan, 1996) have shed light on characteristics that constitute the psychology of driving related phobia (DRP). More specifically, these characteristics include: (a) the functional definitions of DRP (Kutch, Cox, Evans, & Shulman, 1994); (b) the acquisition and severity of driving fears (Taylor & Deane, 1999); (c) the role of stress history and accident severity (Clapp et al., 2011); and (d) the unique characteristics of accident versus non-accident related driving phobias (Taylor & Deane, 2000).

Kutch and colleagues (1994) and Blanchard and colleagues (1997) define accident related driving phobia as either the complete elimination of all driving or severe restriction of all driving. Kutch et al. (1994) characterized accident phobia by three features: (a) the condition must meet the diagnostic criteria of Specific Phobia (*DSM-5*, 2013), (b) onset and content of the phobia are related to an auto accident, and (c) anxiety

symptoms and features of avoidance behavior center around excessive fears of repetition of the accident. Avoidance of accident related stimuli may manifest as driving with excessive caution (e.g., driving excessively slow on freeways), avoidance of optional driving (e.g., avoidance of pleasure trips), or avoidance of driving under certain conditions (e.g., avoidance of driving at night). Symptoms associated with driving include a fear-related reduction of driving of miles normally travelled; driving restricted to certain roads, weather conditions, drivers, and seats in the car; and excessive cautioning of the driver by the patient.

Non-Accident Related Reactions

The non-accident related driving phobia literature is considerably less prolific than the literature of reactions related to accidents. Despite such disparity, there is available clinical and research data that sheds light on this population. Taylor and Dean (2000) investigated elements of the nature of fear in cases of non-accident related driving phobia (participants who had not experienced an accident in their lifetime). The obtained findings were subsequently compared to data from a sample of accident related cases of driving phobia (participants who had experienced at least an accident in their lifetime) in terms of levels of fear severity, interference of fear in daily functioning, and help-seeking behaviors. The investigators concluded that there were no differences between the two participant groups on self-report measures of the physiological and cognitive components of fear. Patterns of concerns while driving were very much similar for the accident related driving phobia group to the non-accident related group. Moreover, there were no differences in terms of how their fear interfered with daily functioning. The findings suggested that there are no differences in the severity of driving related symptoms in those with a history of an accident to those without a history of an accident in terms of symptomatic presentation and functional impairments.

In a study that corroborated the above mentioned similarities Clapp and colleagues (2011) focused on measures of accident severity, accident-related distress, and life stress history. These three dimensions were investigated among individuals reporting accident involvement. Interactive effects of accident distress and self-reported stress history were noted across domains of anxious driving behavior. Examination of these effects indicated unique associations between accident distress and anxious behavior only in those reporting more severe life stress. Consistent with contemporary models of anxiety, these data suggest a stress history may serve as a general vulnerability factor for development of anxious driving behavior following accident involvement. The presence or absence and/or severity of the reported accidents was not the decisive factor toward catalyzing phobic reactions. Stated differently, the findings suggested that a prior history of accidents is not solely responsible for this fear reaction.

At this time, the available research findings and information from the category of non-accident related driving phobia is devoid of formulations that elucidate the onset, the precipitating events, and the perpetuating dimensions of non-accident related driving

phobias. This article represents the first case study, that we are aware of, that attempts to address the above mentioned areas. More specifically, the present case report constitutes the most current application of hypnosis aided systematic desensitization in the care of a non-accident related case of driving phobia.

Combined Applications of Systematic Desensitization and Hypnosis

Systematic desensitization is a behavioral method which enjoys a robust empirical legacy of efficacy in the treatment of anxiety states, specifically phobias. Conceptually, the procedure is based on reciprocal inhibition, which can be defined as anxiety being inhibited by a feeling or response that is not compatible with the feeling of anxiety (Wolpe, 1958; 1969; Wolpe & Lazarus, 1996). The operating components include relaxation training and construction of a hierarchy of anxiety evoking events associated with the phobic condition being treated. The placement of these events is carried out from least evoking to most evoking. The patient is exposed to imagery from the hierarchy, one image at a time, under relaxation, until all images have been presented and the patient has tolerated each without reporting anxiety.

There are several empirically based reports in the literature which support the combination of hypnosis with systematic desensitization to treat phobic conditions (Glick, 1970). The benefit accrued from combining these modalities is an abbreviation of the duration of therapy (Meyer & Crisp, 1970). Moreover, combined systematic desensitization with hypnosis was deemed superior to systematic desensitization by itself as a result of the superior depth of relaxation and vividness of visualization that is obtainable with hypnosis but not with ordinary relaxation techniques (Glick, 1970). Hypnosis can also help the patient to restructure negative thinking toward more positive expectations from treatment. These are all meant to build up the patient's psychic coping resources. Combined applications of these modalities have been employed in treatment of odontophobia (Moore, 1990), agoraphobia (Surman, 1979), phobia of a laundry product (Deiker & Pollock, 1975), and recurrent distressing dreams in a patient under treatment of obesity (Surman, 1979).

Case Report

The case presented was chosen because the clinical history was devoid of accidents. This individual fit the criteria for non-accident related driving phobia. The phobic reaction was circumscribed to Interstate 95 (I-95). This patient could travel without symptoms on city roads. The patient was a 59-year-old divorced, Caucasian male who was self-employed as a jeweler. He specialized in home sales to private customers. He had appointments all over the county and depended on I-95 to travel the distance of Palm Beach County¹. He developed discomfort when traveling on I-95 after hearing the news

on the radio of a family that died in a collision on this highway. Over the subsequent period of a month, the discomfort increased in frequency and intensity and turned into panic; he was forced to limit the distances he could drive on I-95. He was also forced to limit his speed on this highway. He quickly became unable to drive at all on this interstate highway. His alternative was to rely on city roads, however this became prohibitively time consuming.

Mental Status Examination

Mental status examination indicated an individual devoid of a family and personal histories of psychiatric illnesses. There was no history of alcoholism or drug abuse. Mood and affect were stable and he had no gross psychopathology other than the phobia in question. He was precisely oriented, was of above average intelligence, and his thinking was organized and goal directed. He was indeed impaired by the phobia and was losing customers and sales.

Formulation

Due to this patient's unremarkable family as well as personal psychiatric histories a decision was reached to treat him symptomatically and if necessary, proceed to uncovering methods. The etiology of this case consisted of features of panic disorder which created an optimal environment for phobic conditions to develop. The patient then created the avoidance from I-95 as a defense. The patient described the panic as terrifying. The episodes were accompanied by frightening sensations including shortness of breath and palpitations. These mid-stage panic attacks preceded and acted as precipitant to this patient's phobic reaction. Panic features have been documented to serve as precipitant in a host of anxiety disorders including PTSD, social phobia, as well as simple phobia—the diagnosis of the patient in this case report. Hypnosis has a well-documented literature in the care and management of anxiety disorders (Kirsch, Capafons, Cardena & Amigo, 1999; Smith, 1990). It has also been reported in the efficacious management of panic disorder (Iglesias & Iglesias, 2005). Moreover, hypnosis has been associated with the successful management of depersonalization disorder (Hollander, 2009). This condition has been differentiated from posttraumatic stress disorders and has recently been conceptualized as a subtype of panic disorder (Baker et al., 2003; David, 2004; Phillips & Sierra, 2003; Seguí et al., 2000).

Treatment

He was asked to construct a hierarchy of images associated with the phobia starting with the least upsetting and increasing to the most upsetting. The following list was constructed:

- (1) Starting the car to drive to a customer's home,
- (2) Driving to entrance of I-95,
- (3) Going up the ramp,
- (4) Increasing speed but not able to go above the minimum speed,
- (5) Difficulties merging into traffic,
- (6) Seeing that the next exit is far away,
- (7) Deciding that I have to get off as panic sets in,
- (8) Cannot continue, feeling too anxious and short of breath,
- (9) Cannot consider pulling to the side of the road—too scared.

In the first phase of therapy, after hypnosis was induced using an eye roll technique (Spiegel & Spiegel, 2004) the following protocol was presented:

You are to select a place in your mind that affords you a sense of safety. You are to see all that you need to see to make the experience authentic, to hear all the idiosyncratic sounds of this place in order to actually be there, to smell fragrances and odors that are unique to this place and to be able to touch items that belong in this place giving you the benefit of being there. I will then ask you to change channels and see yourself performing certain tasks. As I present the following scenarios, you will experience the situations without any distress. You will be able to visualize yourself performing the tasks successfully. If at any point in your treatment, you feel the slightest level of anxiety raise your distress finger.

Let's start. It is now time to start the business day. You are ready to visit a customer and are sitting in your car. You start your car. You are stable and relaxed. You are driving to the entrance of I-95. You turn into the I-95 entrance. You are breathing normally and feel relaxed. You are going up the ramp. As you go up the ramp you can see the traffic speeding on your left side. Thoughts of merging into traffic dictate that you increase the speed of your car. You feel relaxed as you make the decision to proceed. You are able to moderately and gradually increase your speed. You are comfortable and enjoy the control that you are able to exercise over your vehicle. You increase the speed and climb the entrance ramp quickly. You choose to increase the speed above the minimum. The speedometer shows the speed climbing to 50 mph and proceed to 60 mph. You are comfortable and are breathing normally. At this speed, you are able to merge in easily. You stay on the right lane and you proceed to drive # exits that were planned for today's session. Along the way, your thoughts are on your customers and the items that you have to show them. You also have the thought that the distance you are driving is manageable and realize that it is within your capability. You focus on the classical music from the radio. You see the exit ahead. You exit I-95 and then enter at the opposite direction entrance ramp to return. Repeat.

In vivo schedule: Travel 2 exits plus return at 55 mph 5 times (once/day for 5 days)

- (a) travel 4 exits plus return at 60 mph 5 times (once/day for 5 days)
- (b) travel 6 exits plus return at 65 mph 2 times (once/day for 2 days)
- (c) travel 8 exits plus return at 65 mph 2 times (once/day for 2 days)

Results

The gradual exposure to incremental mileage in hypnotic aided systematic desensitization was an effective approach which allowed for the second phase of treatment: in vivo rehearsal. In addition to six office visits comprising an assessment visit, four hypnosis sessions, and a final visit to summarize, the patient completed 130 miles in 14 days of in vivo rehearsal or mileage traveled as adjunct to therapy.

Discussion

Hypnosis aided systematic desensitization (HASD) allowed for a smooth flow of the presentation of the phobia related imagery. Visualization under hypnosis allowed the images to be observed and examined in a fraction of the time involved in comparison to traditional body relaxation techniques. In traditional systematic desensitization methods the images are presented one at a time in the spirit of an archaic slide projector. With hypnosis the images can be joined in a concatenation and presented in the manner of a movie. Moreover, the depth of trance under hypnosis provided an agent against anxiety and permitted the presentation of images without customary interruptions to address distress signals indicating the presence of anxiety.

The success of this patient's treatment begs the basic question of what caused the behavioral change. The absence of control and the multiple techniques employed in the treatment render generalizations impossible. A more important line of inquiry that lamentably cannot be answered by this case report is how much of the success can be attributed to hypnosis, to systematic desensitization, to in vivo rehearsal, or to combinations of these elements. The authors acknowledge these methodological deficiencies and offer the caveat that the objective of his report was to introduce a most unusual condition and offer a treatment approach that was worthy of empirical investigation. In terms of gains reported in this case report, these have to be understood within limitations reported in the literature (Choy, Fyer, & Lipsitz, 2007) which suggest that relapse is a common phenomenon in the treatment of specific phobia. The literature also reports that little is known about long-term outpatient treatment gains. With regards to this point, Choy et al. (2007) added that the understanding was that gains are generally maintained for one year, but longer follow-up studies are needed to better understand and prevent relapse.

Note

1. I-95 in Palm Beach County is approximately 43 miles long and has 32 exits. These exits are on intervals between one and six miles apart. The speed limit is 70 mph and the minimum speed limit is 40 mph.

References

- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.; *DSM-5*). Washington, DC: Author.
- Baker, D., Hunter, E., Lawrence, E., Medford, N., Patel, M., & Senior, C. (2003). Depersonalization disorder: Features of 204 cases. *British Journal of Psychiatry*, *182*, 428–433.
- Blanchard, E., Hickling, E., Forneris, C., Taylor, A., Buckley, T., Loos, W., & Jaccard, J. (1997). Prediction of remission of acute posttraumatic stress disorder in motor vehicle accident victims. *Journal of Traumatic Stress*, *10*, 215–234.
- Choy, Y., Fyer, A., & Lipsitz, J. (2007). Treatment of specific phobia in adults. *Clinical Psychology Review*, *27*, 266–286.
- Clapp, J., Olsen, S., Danoff-Burg, S., Hagedwood, J., Hickling, E., Hwang, V., & Beck, J. (2011). Factors contributing to anxious driving behavior: The role of stress history and accident severity. *Journal of Anxiety Disorders*, *25*, 592–598.
- David, A. (2004). The neurophysiological basis for depersonalization disorder. *Symposia Presentation 109B*. New York, NY: American Psychiatric Association.
- Deiker, T., & Pollock, D. (1975). Integration of hypnotic and systematic desensitization techniques in the treatment of phobias: A case report. *American Journal of Clinical Hypnosis*, *17*, 170–174.
- Glick, B. (1970). Conditioning therapy with phobic patients: Success and failure. *American Journal of Psychotherapy*, *24*, 92–101.
- Hollander, H. (2009). ECEM (Eye Closure, Eye Movements): Application to depersonalization disorder. *American Journal of Clinical Hypnosis*, *52*, 95–109.
- Iglesias, A., & Iglesias, A. (2005). Awake-alert hypnosis in the treatment of panic disorder: A case report. *American Journal of Clinical Hypnosis*, *47*, 249–257.
- Kirsch, I., Capafons, A., Cardena, E., & Amigo, S. (Eds.) (1999). *Clinical and self-regulation therapy*. Washington, DC: American Psychological Association.
- Kuch, K., Cox, B., Evans, R., & Shulman, I. (1994). Phobias, panic and pain in 55 survivors of road vehicle accidents. *Journal of Anxiety Disorders*, *8*, 81–87.
- Kutch, K., Evans, R., Watson, P., Bubela, C., & Cox, B. (1991). Road vehicle accidents in 60 patients with fibromyalgia. *Journal of Anxiety Disorders*, *5*, 273–280.
- Mayou, R., Bryant, B., & Duthie, R. (1993). Psychiatric consequences of road traffic accidents. *British Medical Journal*, *307*, 647–651.
- Meyer, V. & Crisp, A. (1970). *Phobias*. In C. G. Costello (Ed). *Symptoms of psychopathology: A handbook*. New York, NY: John Wiley and Sons.
- Moore, R. (1990). Dental fear: Relevant clinical methods of treatment. *Tandlaegebladet*, *94*, 58–60.
- Phillips, M., & Sierra, M. (2003). Depersonalization disorder: A functional neuroanatomical perspective. *Stress*, *6*, 157–165.
- Plaud, J. (2003). Pavlov and the foundation of behavior therapy. *Spanish Journal of Psychology*, *2*, 147–154.
- Seguí, J., Márquez, M., García, L., Canet, J., Salvador-Carulla, L., & Ortiz, M. (2000). Depersonalization in panic disorder: a clinical study. *Comprehensive Psychiatry*, *1*, 172–178.
- Smith, W. (1990). Hypnosis in the treatment of anxiety. *Bulletin of the Menninger Clinic*, *54*, 209–216.
- Spiegel, H., & Spiegel, D. (2004). *Trance and Treatment: Clinical Uses of Hypnosis*. Washington, DC: American Psychiatric Publishing.
- Surman, O. (1979). Postnoxious desensitization: Some clinical notes on the combined use of hypnosis and systematic desensitization. *American Journal of Clinical Hypnosis*, *22*, 54–60.
- Taylor, J., & Deane, F. (1999). Acquisition and severity of driving-related fears. *Behavior Research and Therapy*, *37*, 435–449.

- Taylor J., & Deane, F. P. (2000). Comparison and characteristics of motor vehicle accident (MVA) and non-MVA driving fears. *Journal of Anxiety Disorders, 14*, 281–298.
- Vingilis, E., Larkin, E., Stoduto, G., Parkinson-Heyes, A., & McLellan, B. (1996). Psychological sequelae of motor vehicle collisions: A follow-up study. *Accident Analysis and Prevention, 28*, 637–645.
- Wolpe, J. (1958) *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.
- Wolpe, J. (1969.) *The practice of behavioral therapy*. New York, NY: Pergamon Press Ltd.
- Wolpe, J. & Lazarus, A. (1996). *Behavior therapy techniques*. Oxford, UK: Pergamon Press Ltd.