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Case Report / Olgu Sunumu

Treatment of Flight Phobia (Aviophobia) Through The Eye Movement Desensitization and Reprocessing (EMDR) Method: A Case Report

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ABSTRACT

Treatment of flight phobia (aviophobia) through the eye movement desensitization and reprocessing (EMDR) method: a case report

All phobic individuals, when faced with the phobic situation, feel obvious, severe, persistent and irrational fear. The presence of traumatic experiences are not necessary in the etiology of phobias. Even though there are many patients with no traumatic experiences in the history, if there is a detectable traumatic event in the history, EMDR therapy seems to be a good option for the treatment.. Also, although there is not a traumatic event at the beginning, after the formation of phobic fear, every encounter to phobic object, even the idea, can be seen as traumatic event.

This support that EMDR may be an option for the treatment of phobias. In this article, EMDR treatment of a case who experienced a jolt of the aircraft during a flight because of a turbulence and who then developed flight anxiety and could not get on a plane is presented. Within the framework of the protocol defined by Shapiro, three EMDR sessions, each session lasting about an hour, were applied as treatment. And it was observed that phobic fear and avoidance of the patient were disappeared. As a result, EMDR may be considered as a treatment option in several clinical conditions thought to occur after the experiences of the past conditioning.

Key words: EMDR, flight phobia, specific phobia

ÖZET

Uçuş fobisinin (aviofobi) göz hareketleri ile duyarsızlaştırma ve yeniden işleme (EMDR) yöntemi ile tedavisi: Bir olgu sunumu

Tüm fobilerde bireyler, fobik durumla karşılaştıklarında, belirgin, şiddetli, ısrarlı ve mantıksız korku yaşarlar. Fobilerin etiyolojisine bakıldığında travmatik yaşantı varlığı şart olmamakla hatta birçok hastada öyküde travmatik yaşantı bulunmamakla birlikte eğer saptanabilen bir travmatik yaşantı varsa tedavide EMDR de iyi bir seçenek gibi görünmektedir. Ayrıca başlangıcı bir travmatik yaşantı olmasa bile fobik korku oluştuktan sonra, korku nesnesiyle her karşılaşma hatta karşılaşma düşüncesi bir travmatik olay olarak ele alınabilir. Bu da fobi tedavisinde EMDR'nin bir tedavi seçeneği olabileceğini desteklemektedir. Bu yazıda da, bir uçuşu sırasında uçağın türbülansa girmesi nedeniyle uçuşta sarsıntı yaşayan, sonrasında uçuş korkusu gelişen ve uçağa binemeyen bir hastanın EMDR ile tedavisi anlatılmaktadır. Tedavide, Shapiro tarafından tanımlanmış olan fobi protokolü çerçevesinde her biri yaklaşık bir saat süren üç EMDR seansı uygulanmış ve hastanın fobik korku ve kaçınmasının ortadan kalktığı gözlemlenmiştir. Sonuç olarak, EMDR'nin geçmişte koşullanma deneyimleri sonrası oluştuğu düşünülen birçok klinik tabloda tedavi seçeneği olarak düşünülebileceği söylenebilir.

Anahtar kelimeler: EMDR, uçak fobisi, özgül fobi

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INTRODUCTION

All phobic individuals, when faced with the phobic situation, feel obvious, severe, persistent and irrational fear. When faced with phobic stimulus, the anxiety starts and its severity varies according to the degree of proximity and the easiness of avoiding from this stimulus (1). Today, commercial flights are one of the most reliable activities to be made. Statistically, two and half events occur in each one million flight hours in average. Of this two and half events, only less than two of ten end in death (2,3). However, in spite of these

facts related with safety, the aviophobia is quite common. Even if the diagnostic criteria have changed, for example, the lifetime prevalence of 2.5% was detected in a study performed with randomized 7076 German adults by using DSM-III criteria (2,4).

Severe anxiety and sense of shame is experienced related with flight process in patients with aviophobia. A natural result of this fear is the avoidance behavior and this avoidance may lead to some disagreements in interpersonal relations (2). Also, in addition to individual challenges, this phobia may be harmful for the business career of the individuals, especially when they have to fly long distances for business (5,6).

In the treatment of specific phobias; pharmacotherapy, behavioral therapies and cognitive therapies are used (7). Traumatic experiences may be also effective in the development of phobias and if there is any traumatic experience which may be determined, EMDR seems to be a good option in the treatment. On the other hand, even if there has not been a traumatic experience at the beginning, after the formation of phobic fear, every encounter to phobic object and even its idea may be discussed as a traumatic case (8). It means that EMDR may be a therapeutic choice in the treatment of phobias. In this article, EMDR treatment of a patient diagnosed with aviophobia is discussed.

CASE

Twenty-six years old, married female patient was defined herself as generally patient, silent, calm person and reported that she was trying to avoid stressful situations.

There was no story of illness or drug utilization in the medical history. According to her definition, she grew up with a younger brother in a sensitive and tolerant family. There was no sexual or emotional abuse story.

The patient specified that she had been facing with flight fear and could not fly for almost one year when she applied for the treatment. She said that she was always travelling by plane previously when it was possible. She stated that the plane came across turbulence one year ago in her last flight and she felt like the plane would crash; and she experienced a great fear then. Afterwards, she tried to get on a plane; and, even if there was not any misadventure in that flight, she said that she tightened during all flight, she could not put her feet on the ground and she put her hand baggage there and put her feet only over the hand baggage, she held the armrest very tightly, experienced palpitations and difficulty in breathing, she felt fear during all flight even if the passenger next to her slept during the flight and then she never got on plane after that. She looked for a job in private sector; however she felt anxiety since this condition might pose an obstacle. Therefore, she was in search of treatment by stating that this condition created difficulties and conflicts in her life since her husband did not travel by any means other than plane.

Diagnostic interviews of SCID-I and SCID-II were applied in the psychiatric evaluation of patient. No personality pathology was detected in Axis II. Her condition in Axis I was in accordance with specific phobia, situational subtype. It was decided to start treatment of patient with the diagnosis of aviophobia.

TREATMENT

The treatment was implemented by an experienced therapist who completed second level EMDR training. The phobia protocol defined by Shapiro (9) and the stages of which specified below was implemented: 1. Teaching the self-control procedures to cope with the fear experienced; 2. Targeting the followings and reprocess them: a) the processor events causing the phobia, b) the first time when the fear was experienced, c) the most disturbing experiences, d) the last time when the fear was experienced, e) any other stimulus related with this fear, f) physical sensations or other indications related with the fear; 3. Placing a positive template; 4. Making an agreement to go into act; 5. Having the patient watch a mental video of all this and reprocessing the problem; 6. Completing the reprocessing of targets determined between the sessions.

The patient was informed about EMDR and her approval was taken. In the implementation of EMDR; it is required to teach the patient the self-control techniques in order to cope with her disturbing sensation

and/or thoughts which may arise since the process will continue between the sessions. A reliable location was determined with the patient in this context.

The first, worst and last experiences of the patient were determined. The first and worst experiences were the same. It was decided to start the treatment with this memory. She stated that she got on a plane afterwards; this was taken as the last experience. The patient was requested to define the best picture representing memory of flight travel that she experienced the aviophobia. The picture she selected was the moment when the plane came across the turbulence and she felt like the plane would crash and they would die. She was asked what was the best expression to define her when she thought this traumatic moment and looked at herself in this picture (NC, negative cognition; "I am desperate"). Also, she was asked about her positive cognition which may replace negative cognition. She was asked to rank her positive cognition VoC from 1 to 7 [(Validity of cognition) where 1 was "completely wrong" and 7 was "completely correct"]. The believability of positive cognition for the patient was 2 between 1 and 7.

During the first two sessions of the treatment, the patient was asked to think about traumatic event-with NC, relevant somatosenses and the place of somatosenses. When the patient was asked to rank the degree of distress from 0 to 10 (where 0 means "I feel no distress" and 10 means "It is the severest distress I have ever had"), she said that she felt the distress at level 9. The patient was instructed to follow the moving finger of therapist with her eyes without moving her head by releasing all thought, image, sensation and feeling she felt in her brain and body. Some short breaks were taken in order for patient to define what she realized after each set. Between the bi-directional stimulations; the patient realized some events, images and sensations related to the flight that she first experienced phobia and her next flight. As recommended in EMDR treatment, no comment was made related with them. Bi-directional stimulation was started to be given through eye movements since the preference of patient was on that way (bi-directional stimulation may be visual, aural and tactual and each of them is called as channel in EMDR terminology). Where the channel was blocked, the thought-feeling-bodily sensation channels were scanned; where the blockage was continued, it was passed to tactual stimulus from eye movements or the speed of bi-directional stimulation was changed.

During the third session, the patient said that she realized a positive effect after the previous session and wanted to continue EMDR sessions. When the patient was asked to rate the degree of distress she felt when she thought the image determined related with her memory, she said that she felt no distress (SUD-subjective unit of disturbance=0). Such a decrease in SUD degree forms a basis to pass the next stage of protocol. At the beginning, the believability degree of positive cognition (PC-I can cope with), VoC, was rated as 4. The remaining of session was planned for increasing the belief for PC. Bi-directional stimulation was continued for this purpose until the believability degree of positive cognition was increased (until it reached to 6 in VoC scale). While six is an enough degree for believability degree of positive cognition, the patient should be asked why not seven. The answer of patient specified in this article was "she would see this when she tried". Since this was an acceptable answer, it was passed to the next phase in the treatment. In this phase, a scenario was created and read to patient as video record including all triggers stimulating the anxiety of patient such as: buying the flight ticket, preparing the luggage, setting the alarm for waking up early to catch the flight and sleeping, getting ready to leave for flight in the morning, getting in the car, turning from airport sign, parking the car in the airport, making the check-in, moving up the ladder of plane, saluting the cabin crew, walking on corridor of plane, sitting in the chair, moving of plane, acceleration of plane for flying, taking off of plane, swinging during the flight and starting to descend. The patient was instructed to stop therapist at any point disturbing her. Each disturbing point of this process was processed as a separate object. EMDR treatment was continued until all "mental video record" "could be watched" without any problem.

After completing this memory, the SUD degree of the last memory was taken. Since SUD degree was

descended to zero, there was no need to handle this memory through EMDR session.

The patient was required to make a flight in the route where she experienced the first flight fear in the next day. The patient was instructed to inform the therapist. In the e-mail coming from the patient, she stated that "My flight was quite good, I felt very comfortable than I expected, I do not think that I will have difficulties in my next flights, thank you very much". The patient was interviewed one month and six months later for control purposes. In the control interviews; it was learned that she made some flights in this period and she did not have any experience which could be defined as traumatic, she did not have any concern and avoidance related with flying.

DISCUSSION

Specific phobias are the phobias limited with specific objects or conditions. Animal phobias, acrophobia, achluophobia, ceraunophobia, elevator phobia, claustrophobia, dentophobia, homophobia, panthophobia and injection fear etc. are included in this group (10). They are mainly seen in women and may begin at any age. No explanation has been made on how specific phobias have emerged; our genetic traits ascribed to us, the experiences we have had and the environmental effects are also important. Although it is considered that negative traumatic events play a part in the development of specific phobias, this is not necessary and there may be many patients diagnosed with phobia without having this kind of experiences. Aviophobia is situational subtype of specific phobia. It is very common (50-80%) that patients with specific phobia may have more than one phobia which may be classified in the same subtype (11).

The patient specified in this study is a woman with aviophobia and this phobia started when she was 25 years old. She had traumatic flight experience almost one year ago. Also, she had elevator phobia which comes along with aviophobia for one year and exists before the aviophobia.

In the treatment of specific phobias; pharmacotherapy, behavioral therapies and cognitive therapies may be used (7). In terms of pharmacotherapy; there are some studies performed with diazepam, imipramine and beta-blockers and enough efficiency has not been specified yet (12,13). It is difficult to say that pharmacotherapy is efficient in the treatment of specific phobias. In behavioral therapies, the patient is encountered with location, condition and object forming the phobic anxiety until the anxiety has been decreased. It may be said that behavioral therapies based on adaption principle are effective.

There is no enough information in the relevant literature concerning the usage of EMDR in treatment of phobia. The patient in this study was implemented three EMDR sessions each of which lasts about one hour. When thought that the phobia and anxiety have disappeared, it can be said that it has a very strong effect.

It is not clear what is responsible for the effect of this treatment made through EMDR. EMDR is based on the theory that the experiences, which has incommoded sensationally, are stored in the brain and not processed and cause malignant psychological effects by being "node" (9). EMDR process; while the brain scans the negative experience, ensures that "the thought is re-processed without experiencing the negativity accompanying with it previously" by using the distractors such as light, sound and movement (9). It is not exactly clear whether the distraction caused by repeating stimulus given by the therapist is at the back of treatment efficiency or whether other factors such as exposure play a main role in the treatment efficiency. It has been said that the exposure may be at the back of treatment efficiency (14). In fact, fearful memories and imaginary exposure are the main components of EMDR and the efficiency may depend on getting used to this anxiety. However, total exposure time implemented in the sessions of this patient for the treatment of aviophobia was less than 10 minutes. It can be said that so short exposure time to traumatic events may not be enough for the adaption in this kind (15).

Some positive results have been reported in some publications related with the place of EMDR in the treatment of specific phobia (16). In a study comparing EMDR and in vivo exposure in the treatment of

arachnophobia; it is stated that EMDR is not effective compared to in vivo exposure (17). Then, we can say that EMDR may be particularly effective in the treatment of specific phobias in which traumatic factors have played a role in the formation. Related with the aviophobia of our patient, we can say that the traumatic experience and crash fear she had during the flight one year ago has been revived when flying is a matter. It can be said that such a mechanism applies to certain subtypes of specific phobia such as fever phobia, swallowing phobia, dentophobia; but does not apply to conditions such as arachnophobia (18).

When the data related with the efficiency of EMDR in patients diagnosed with posttraumatic stress disorder is taken into consideration (19), it can be said that EMDR may be a treatment option in many clinic pictures considered to be arisen as a result of the conditioning experiences in the past.

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