

## Driving Phobia : a case report

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### ABSTRACT

*This is a case study of a forty year old man who had a severe driving phobia with a huge bearing on his occupation. He had been involved in a road traffic accident on the motorway and developed phobic symptoms after that episode. The treatment consisted of a systematic desensitisation of driving scenarios in imagination and after twelve treatment sessions, the patient made a complete recovery and was able to drive on all public roads. He was also prescribed Paroxetine and Clonazepam. Following each session, the patient was encouraged to drive as he was a skilled driver. Thus a combination of systematic desensitization in vitro and medication helped in the management of driving phobia.*

**Key words:** *driving phobia, driving, systematic desensitization, paroxetine, clonazepam.*

### INTRODUCTION

Driving phobia is classified as a specific phobia, situational type in DSM-5 [1] in which the patient often experiences high levels of anxiety which increase when (s)he anticipates, or is exposed to, stressful driving situations [2]. This phobia leads to avoidance behaviour in which the patient voids driving and the phobic disturbance which then becomes entrenched. The literature on driving phobia has concentrated on patients who have become phobic subsequent to vehicle accidents but this may not always be a precipitant as noted by authors [3]. Patients that have been through a motor vehicle or road traffic accident are affected greater by their driving phobia and have more severe

cognitive and affective symptoms than those whose phobia is not a result of an accident [4]. The use of in vivo desensitisation has a number of drawbacks when applied to the treatment of driving phobia. The main objection is that these patients experience high levels of anxiety and due to the unpredictability of the roads, are at a greater risk of causing, or being involved in, an accident. This procedure also involves investment of a lot of time and energy on part of the therapist. Drop outs are also very high with this form of therapy [5]. The advantage of in vitro desensitization is that, as soon as anxiety levels rise appreciably, the imagined scene can be withdrawn and the patient can relax [6]. The patient participates with the therapist in a graded series of driving scenarios in a similar way to the construction of a hierarchy for systematic desensitization [7].

## **CASE REPORT**

A 40 year old male presented alone to our outpatient department with the chief complaint of that having frequent episodes of anxiety and palpitations throughout the day. On enquiring it was ascertained that he was a heavy vehicle driver and 5 years prior to presentation he had met with a road traffic accident while driving home from work, while he was alone and luckily he was not hurt in the accident. He then felt anxious, had palpitations, sweating and insomnia throughout that night and for the next 3-4 days remained absent from work. When he joined back to work, he felt restlessness, palpitations, giddiness, breathlessness, sweating, cold hands and feet and a feeling of impending doom that something was going to happen and had recurrent thoughts that he was going to meet with an accident while driving. Whenever he would drive this feeling remained for 8-10 minutes, but later on he managed to drive after the episode. He noticed that he was not able to accelerate his car, and whenever some car overtook his car, he would experience the same symptoms again. Gradually he started remaining absent from work and he left his job. He joined other jobs, where he was supposed to drive within the city as he felt that it will be suitable for him as he would not have to drive long distance.

But, whenever he would start driving he would develop similar symptoms which lasted for 10-15 minutes per episode. He started feeling ashamed of himself, about the fact that he was failing as a driver that he would feel anxious about driving. He noticed that whenever he accelerated his vehicle, he would feel anxious again and had to slow down his speed. He was often not able to complete small driving task that were given to him and started leaving jobs. Ultimately, he was terminated from the job. In the span of 5 years, he went for job interviews to several places and due to his anxiety related to driving he had to quit the job in a few days or was asked to leave. Presently, he claimed that even the thought of driving, being in a car caused so much discomfort that he was avoiding travel in vehicles, buses and preferred to walk down the distance or avoided going out completely. He would get irritable if anyone asked him to drive or accompany them on travels. He would try to drive but would have to stop due to anxiety symptoms.

He had a history of regularly consuming tobacco in form of chewing it to ease his anxiety, which had increased in last 4 years. He occasionally consumed alcohol but denied drinking regularly or abusing the same. He denied any major medical or surgical illness and his family history was insignificant.

He was educated upto the 12<sup>th</sup> standard and had left his education due to financial problems and his first job was that of driving a heavy vehicle, which he continued for 12 years. He was married, had 2 children and was the only earning member in his family. He had shown socio-occupational deterioration over the last 3 years. He went for an interview 10 days prior to presentation, where he had been offered a job of driving, that he was suppose to join in 15 days. He was feeling anxious of thinking of driving again. On mental status examination, he was average built, well dressed, well groomed and sitting well throughout the assessment. He was sweating profusely. He was very communicative and understood the nature of questions asked. He conveyed his mood to be anxious and his affect was anxious as well. His thoughts were preoccupied with the fear of driving again. His Mini Mental Status Examination (MMSE) was normal (29/30) and his insight grade 5 out of 5. He was able to appreciate that he had a psychological illness that was due to his fear of driving. On the basis of the history and clinical assessment, according to DSM 5, we diagnosed him as a case of Specific Phobia (motor vehicle and driving type). He was psychoeducated regarding the nature and course of his illness. All routine blood investigations, ECG and Chest X Ray were within normal limits. We started him on Paroxetine 12.5 mg at night and Etizolam 0.25mg on an as an when required basis. He was educated about the role of pharmacotherapy combined behavior therapy-psychotherapy in phobias. After explaining to him the various behavior therapy options available and based on his agreement we started systematic desensitization (in vitro) with him.

On his next visit, a detailed history of the driving related fears and phobia was elicited and he was explained the procedure of systematic desensitization. He was taught Jacobson's Progressive Muscle Relaxation [8] and advised to practice the same whenever he felt anxious. He was assisted in making a hierarchy of his fears and in grading them on the scale of 0-100 as subjective units of discomfort (SUDS) from the least anxiety provoking to the most anxiety provoking situation. In each sessions, he was made to imagine the situations one by one and at peak of his anxiety he was asked to relax using muscle relaxation. Gradually, with 12 such sessions over a period of 4-5 weeks, he joined work as a driver again and we continued medication throughout the procedure. On his last follow up he reported feeling less anxious and being able to work well. He also mentioned that he practiced muscle relaxation regularly as that help him alleviate his anxiety. We decided to continue medications for a period of six months and then start tapering gradually.

## **DISCUSSION**

The basis of all behavioural approaches in driving phobia involves fear reduction through systematic desensitisation (in reality or imagination) [9]. The patient described in this paper experienced high levels of anxiety related to driving and even entering a car. Systematic desensitization is a useful method in the management of phobias and fears but is time consuming and involves a lot of time investment on both the part of the therapist and patient. Another disadvantage of the imaginary desensitization is that it needs the patient to imagine the situation well. This procedure is often affected by the fact that patients have different imagination capacities and therapists have to put in extra effort to recreate a situation using verbal cues so that the patient is able to imagine the same [10]. It is often seen in such procedures that at the height of anxiety instead of imagining and relaxing, the patient may just stop imagining and may continue to say that he is doing so while he is not. The patient's imagination is in his mind and can never be totally controlled by the therapist [11]. The case report

here validates the need to practice behaviour therapy techniques in clinical practice in unison with medical treatments.

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