



ONE VERSUS FIVE SESSIONS OF EXPOSURE IN THE TREATMENT OF FLYING PHOBIA

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Summary—Twenty-eight patients with flying phobia, fulfilling the DSM-IV criteria for specific phobia, were assessed with behavioral, and self-report measures. They were randomly assigned to two treatment conditions: (1) 1-session, or (2) 5-sessions of exposure and cognitive restructuring. The first condition consisted of a single 3 hr session of massed treatment, and the second condition of 6 hr of gradual treatment. Treatment was done individually by very experienced therapists. The results showed that the two treatment conditions did equally well and there were no differences between them. At post-treatment 93% of the 1-session group and 79% of the 5-session group managed to take an unaccompanied return flight. At the 1-yr follow-up assessment the effects were maintained on all measures except the behavioral test; in both groups 64% of the patients took the flight. The most plausible reason for this deterioration is that during the follow-up year the subjects who relapsed didn't have the opportunity to fly as a job requirement with the employer paying the expenses. The implications of these results are discussed. © 1997 Elsevier Science Ltd

INTRODUCTION

Flying phobia is classified as a specific phobia of the situational subtype by DSM-IV (American Psychiatric Association: APA, 1994). Various surveys of the general population in Europe (e.g., Ekeberg, Seeberg & Ellertsen, 1989; Nordlund, 1983) and the U.S.A. (Agras, Sylvester & Oliveau, 1969) have yielded fairly similar prevalence figures; around 10% never fly due to their phobia of air travel. In addition about 25% experience high anxiety while flying, often making it necessary for them to take tranquilizers or alcohol in order to accomplish the trip. These people very rarely, if ever, fly unless it is required as part of carrying out their work. On vacations they use other means of transportation.

In most western countries there has been a development in which private caregivers have started practices specialized in the treatment of flying phobia. Sometimes these caregivers work in co-operation with a local airline, which probably gives more trustworthiness to their services. The professional background, as well as the training in cognitive-behavioral therapy, of the people providing the treatment vary to a large extent. Another characteristic of these practices is the lack of evaluation of the effects the treatment has on the S's phobias.

A small number of randomized studies on flying phobia has been published. Solyom, Shugar, Bryntwick and Solyom (1973) compared systematic desensitization (SD), habituation (exposure), and aversion relief for 8 sessions over 4 weeks, with group psychotherapy for 12 sessions over 6 weeks. They found that the three behavioral treatments did equally well and significantly better than group psychotherapy. On the post-treatment behavioral test 70, 70, and 80%, respectively, took the flight. Of those patients who could not fly at pre-treatment 78% passed the test flight, but the authors they did not state what proportion of the total sample of 40 these avoiders made up. The follow-up assessment 8-24 months after the treatment did not include a behavioral test.

Denholtz and Mann (1975) compared various forms of SD in four groups of flying phobics; one group got the standard SD but with filmed scenes instead of imagined, one got relaxation but with no systematic presentation of scenes, one got no relaxation but presentation of scenes, and the last group got relaxation and a placebo film. The treatment time varied from 3-12 hr.

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The last three groups had high dropout rates (35, 45, and 29%, respectively) and all were significantly worse than the SD group. On the post-treatment behavioral test 65, 15, 27, and 17%, respectively, took the flight. Of the 51 patients who completed the treatment program 40 (78%) were able to fly after the treatment. The 3.5 yr follow-up (Denholtz, Hall & Mann, 1978) did not include a behavioral test.

Howard, Murphy and Clarke (1983) compared SD, implosion, flooding, and relaxation with a waiting-list control group for flying phobics who got 8 hr of treatment during an 8-week period. There were no significant differences between the conditions, and only on one measure—Attitudes to Flying questionnaire—did the active treatments yield better effects than the wait list group. No pre-treatment behavioral test was used, but on the post-treatment test 82% in SD, 82% in implosion, 64% in flooding, 92% in relaxation, and 70% in the No-treatment group flew. There was a follow-up after 3 months but no behavioral test was performed.

Haug *et al.* (1987) compared, in a small sample of flying phobics, the effects of consonant vs non-consonant treatment for 6 sessions over 4 weeks. The two treatment methods used were applied relaxation and self-instructional training, and a treatment was considered consonant if it focused on the anxiety component most prominent in the individual patient's anxiety reaction. Thus, for a patient with strong physiological reactions but weak cognitive reactions applied relaxation was the consonant method, while for a patient with the reverse pattern self-instructional training was consonant. The prediction was that a consonant treatment would yield better effects. On most measures there was a trend in that direction, but it was only significant on the self-rating of physiological arousal. This is probably due to low power, since there were only 11 Ss in the study. On the behavioral test 10 of the 11 patients got the maximum score at pre-treatment, i.e., sat in the plane for 10 min, while at the post-treatment test all 11 got the maximum score, i.e., took a short flight in the nearby surroundings. The 3-month follow-up did not include a behavioral test.

Finally, Beckham, Vrana, May, Gustafson and Smith (1990) compared a manualized form of stress-inoculation training with a no-treatment control group. This treatment was very cost-effective since the patients only got a 50-min introduction from the therapist and then carried out the treatment on his/her own over a 4-week period. The dropout rate was 21% in this group and 64% in the no-treatment group. On most measures the manual treatment was significantly better than the no-treatment condition. On the post-treatment behavioral test 82% in the treatment group and 36% in the no-treatment group took the flight. There was a 2-month follow-up, but without any behavioral test.

The major flaw in reviewed studies on flying phobia is the lack of a real life behavioral test administered pre, post, and at follow-up. By not excluding Ss who can manage to fly pre-treatment there will be an overestimation of the proportion of patients who can fly after the treatment, since this percentage will include those who could take a flight, albeit with anxiety, already before the treatment started. Furthermore, only using the flight that is included as the last step of the treatment (often called 'graduation flight') as a behavioral measure is a weak test. At this flight usually the patient is accompanied by fellow patients in the same treatment and/or the therapist. This increases the patient's feeling of security and adds a group pressure, but it is not a valid measure of how the patient can manage to take ordinary, commercial flights on his/her own in natural situations. The tentative conclusion that can be drawn from the reviewed studies is that some type of coping technique and systematic desensitization seem to be effective in flying phobia.

Recent research has shown that short intensive treatments during a single session maximized to 3 hr produces just as good results as more spaced programs do for specific phobias. Öst, Hellström and Kåver (1992) found that one session of exposure was equal to five sessions in injection phobia, and Hellström, Fellenius and Öst (1996) showed that one session of applied tension or tension-only was equal to five sessions of applied tension for blood-injury phobia. In spider phobia Öst, Salkovskis and Hellström (1991) found that the therapist-directed 1-session exposure and modelling treatment was superior to patient-directed manualized treatment. This was replicated by Hellström and Öst (1995) who also found no difference between a specific spider phobia manual and a general anxiety manual, or whether the treatment was carried out in the patients' homes or at the clinic. In the first 1-session group treatment of spider phobia Öst

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