

Treating Self-Injection Phobia in Patients Prescribed Injectable Medications: A Case Example Illustrating a Six-Session Treatment Model

Darcy Cox, David C. Mohr, and Lucy Epstein, *University of California, San Francisco*

This article provides a case description of a patient with multiple sclerosis prescribed interferon beta-1a (IFN β -1a), a weekly intramuscular injection, who met DSM-IV criteria for specific phobia, blood/injection type. This patient successfully completed a 6-week manualized cognitive-behavioral treatment for self-injection anxiety. Issues presented include dealing with vasovagal responses and examples of typical dysfunctional thoughts related to self-injecting. The patient was able to successfully self-inject following treatment, and gains were maintained for 18-month follow-up.

SPECIFIC PHOBIA, blood/injection type, is a common problem, with an estimated prevalence of 7% to 22% in the general population (Agras, Sylvester, & Oliveau, 1969; American Psychiatric Association, 1994; Bienvenu & Eaton, 1998; Cartwright et al., 1993; Costello, 1982). In the past, injection phobia was noted mainly as an occasional barrier to care in pediatric, primary care, and dental clinics, which have traditionally been the sites where most injections take place. However, there has been an explosion in the number and variety of medications developed, designed, and marketed for home injection over the last several years. Drugs designed for frequent home injection are now used to treat a variety of chronic medical conditions, including multiple sclerosis. Multiple sclerosis (MS), which affects about 350,000 Americans, is an autoimmune disorder characterized by demyelination in the central nervous system (CNS), producing a wide variety of possible physical, cognitive, and psychological symptoms. The most common symptoms, which may be permanent or transient, include fatigue; weakness; limb paralysis; neuropathic numbness; tingling and pain; difficulties with vision, bladder, bowel, and sexual functioning; and mild cognitive impairment (Mohr & Cox, 2001). There are four treatments that slow the progression of disease in patients with relapsing-remitting MS, the most common form of the disease, all of which require self-injection either subcutaneously (SC) or intramuscularly (IM). Interferon beta 1b (Betaseron), and glatiramer acetate (Copaxone) are administered SC, while interferon beta-1a (IFN β 1a) has been approved with two separate administration methods, subcutaneously (Rebif) and intramuscularly (Avonex) (Durelli et al., 2002; Jacobs et al., 1996;

Johnson et al., 1995; The IFNB Multiple Sclerosis Study Group, 1993).

SC injections use a small, thin needle and are self-injected into the abdomen, hips, thighs, or upper arms. SC injections can be performed with an auto-injector, a device that does not require the patient to see the needle or to directly depress the plunger. IM injections require a longer, thicker needle and are self-injected into the thighs or hips. Patients cannot use auto-injectors for IM injections.

Self-injection, rather than reliance on a caregiver, allows the patient maximal independence and reduces the risk of missed injections or drug discontinuation due to unreliable assistance. In MS, psychological factors, including injection anxiety and low injection self-efficacy, have been shown to contribute to inability to self-inject, which in turn can lead to discontinuation of injectable medications (Mohr et al., 2001). Up to half of all patients prescribed IFN β 1a, an intramuscularly injected drug, experienced injection anxiety sufficient to prevent self-injection (Mohr et al., 2001).

In an effort to develop a successful, manualized intervention to teach self-injection to injection-phobic patients, we conducted a literature review and developed a treatment that we hypothesized would be of benefit to MS patients with self-injection phobia. To ensure that the treatment would be easily exportable to health-care settings, we maintained an easily reimbursable 50-minute session structure and limited the treatment to an easily reimbursable number of sessions. We also hoped to develop a treatment that would be both simple and brief enough to allow its use by other health care providers, such as registered nurses. Nurses are the front-line providers for MS patients, and we wanted our treatment, if effective, to be accessible to the target population.

A number of case studies (Ellinwood & Hamilton, 1991; Ferguson, Taylor, & Wermuth, 1978; Jacobsen, 1991; Thompson, 1999; Trijsburg et al., 1996) and small studies

(Öst, Hellström, & Kaver, 1992) demonstrate that individuals phobic about self-injecting or receiving injections respond to behavioral interventions. While purely behavioral exposure therapies have been shown to be highly effective in the treatment of injection phobias in medically healthy patients requiring occasional injections or in medical patients with intrusive symptoms relieved by the injections, the injections required for MS are frequent and do not produce an immediate, visible benefit for patients. While these medications work to slow the progression of disease, patients do not see an improvement day by day and may experience flu-like side effects when initiating therapy.

We find that most MS patients have disease-specific dysfunctional thoughts that need to be addressed before exposure will be of benefit. In our experience, almost all patients report feeling that performing the injection constitutes “allowing the disease into my life,” “accepting I have MS,” and/or “increasing the burden of MS.” Current MS treatment recommendations encourage physicians to initiate treatment immediately following definitive diagnosis with a relapsing-remitting course, so many patients starting treatment experience few or no MS symptoms. For many patients, the anxiety, intrusive thoughts, and other phobic symptoms related to the injection are a more significant day-by-day burden than MS symptoms. While MS patients certainly experience anxiety, sadness, and fear related to their diagnosis, it is often necessary to help patients separate anxiety about the injection from anxiety about MS before exposure therapy will be successful.

Our treatment manual was initially tested on eight patients with MS who were prescribed INF β 1a but were unable to self-inject due to anxiety and phobia. A complete description of these findings is presented elsewhere (Mohr, Cox, Epstein, & Boudewyn, 2002). We have continued to use this model clinically and are conducting follow-up studies with RNs as treatment providers. A summary of the treatment plan for each session is provided in Table 1. The purpose of this article is to present a case example that illustrates treatment of self-injection phobia in this population.

Case Study

This case was selected because it illustrates some common presenting problems in patients with self-injection, including low self-efficacy about injection, vasovagal responses, and a history of avoidance. Vasovagal responses, reported in up to 75% of individuals with injection phobia (American Psychiatric Association, 1994), involve a sudden slowing of heart rate and drop in blood pressure which leads to a feeling of faintness, dizziness, and/or disorientation. Patients with vasovagal responses may feel faint or dizzy or lapse into a brief period of unconscious-

Table 1
A 6-Session Cognitive-Behavioral Treatment Model
for Self-Injection Anxiety and Phobia

Session 1: Introduction to the model, introduction to use of SUDS scale, relaxation training, training in hierarchy development, application of relaxation to injection in session. Homework: practice relaxation, create hierarchy.
Session 2: Review of homework. Refine hierarchy. Application of desensitization procedures to hierarchy items in session. Introduction of thought monitoring, elicitation of thoughts about injection. Homework: continue relaxation, practice injecting inanimate objects, read about thought records.
Session 3: Review of homework. Complete thought records and review thoughts associated with self-injecting. Set date for self-injection attempt (session 4 or 5). Homework: relaxation, practice injecting inanimate objects, complete thought records.
Session 4: Review homework. Attempt self-injection, if appropriate. If not, continued review of thought records and cognitive reframing. Homework: created by patient and therapist to address continuing areas of difficulty.
Session 5: Review homework. Attempt self-injection/perform second self-injection. Continued cognitive reframing. Homework: read about relapse prevention, generate relapse prevention plan.
Session 6: Review homework. Second/third self-injection. Refine relapse prevention plan, review treatment.

ness (syncope; American Psychiatric Association, 1994). Vasovagal responses can be prevented by maintaining adequate blood pressure. This is usually achieved through muscle tension exercises, although beta-blockers or caffeine at the time of injection may also be useful. The treating therapist was the first author (DC), a Caucasian female psychologist.

A.B. is a 40-year-old Latina professor living with her life partner. A.B. was diagnosed with RRMS (relapsing-remitting MS) roughly 8 months prior to seeking treatment and met *DSM-IV* criteria for specific phobia, blood/injection type. This diagnosis is characterized by excessive and unreasonable fear and anxiety triggered by situations where the patient expects to be or is exposed to blood or an injection, and a pattern of avoidance of situations where this exposure is anticipated, causing marked distress and/or interference with the patient's lifestyle. A.B. reported a lifelong history of extreme and excessive fear of injections and blood, including a history of vasovagal response during injections and at the sight of blood. While she recognized her fear as unreasonable, she reported that she was unable to control her symptoms of anxiety and panic despite her best attempts. She reported a great deal of avoidance behavior associated with injecting, and that she was only able to tolerate injections from

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات