Psychology and Behavioral Science
International Journal
ISSN 2474-7688

Juniper Publishers
key to the Researchers

Mini Review
Volume 19 Issue 1 - June 2022
DOI: 10.19080/PBSIJ.2022.19.556003

Psychol Behav Sci Int J

Cognitive Behavioral Therapy and Its Intervection in A Clinical Case of Specific Phobia Fear of Driving

Fabiana Darc Miranda*

Cognitive Behavioral Clinical Psychologist, Brazil

Submission: June 21, 2022; **Published:** June 29, 2022

***Corresponding author:** Fabiana Darc Miranda, Cognitive Behavioral Clinical Psychologist, Brazil

Summary

This article aims to present the process of psychotherapeutic care, focused on the cognitive-behavioral approach, carried out in a private institution, describing the care process in Cognitive Behavioral Therapy, in a case of specific phobia. Today in the society in which we live, driving has become a fundamental knowledge, since it facilitates people's access to work, leisure as well as the needs of daily life. It brings with it the notion of independence and raises the number of women who now did not have in the middle of traffic. However, despite the growing demand for this independence grows with it too, a large number of people who can not, after getting the long-dreamed qualification, a process that lacks time for dedication. In this perspective, we aim to analyze a case of specific phobia, associated with the fear of directing the light of the contributions of Cognitive Behavioral Therapy - CBT.

Keywords: Driving; Study; Fear; Therapy

Introduction

Currently we live in a moment of crisis in the situation of Brazilians, which makes people more concerned with reducing spending and acquiring knowledge. They seek to improve knowledge and become more independent beings every day, and within this process we find the daily struggle of an extensive part of the population, the class of working women and fighters, who go after their rights and seek autonomy in relation to the male gender.

The search for this class goes from a better job, to help in income, actions that promote self-esteem, as well as so many other basic needs that gender needs. Among these needs we have that in our society there has been a significant increase in women in the field of traffic. And it led to this demand, a careful look at this portion of the population.

In every small group these women meet, there are some who finish the process and when they reach the final stage – exercise the methods learned and then drive without the help of their instructors – driving becomes frightening. We have in this sense typical cases of phobias, related to the fear of driving, which cause many of these women to leave aside their so sacrificed jobs towards autonomy and independence.

Henceforth, our goal is to report a clinical case of phobia and from it establish the contributions that Cognitive Behavioral Therapy – CBT can offer within this our study, to alleviate the symptoms of phobia and why not eliminate it. Using for both methods and techniques of CBT that have already been used in several studies for the same type of phobias among others.

Finally, we will finish the work presented the results obtained from the clinical work performed. However, more studies will be needed to assess the fear of driving, since the intention is not to exhaust the topic.

Description of the Clinical Case

M.D.S.B., age 47; a civil servant, married, mother of two children, living in the southwestern region of Goiás. He sought therapy approximately 5 months ago, complaining of intense fear of driving, aquicardia, sweating and severe headaches when the subject was mentioned. When she started the initial procedures

to obtain the national driver's license, she felt safe, she did the necessary procedures and completed her process in less than a year. He got himself on the third attempt.

He says the family didn't want M. to drive. Husband of strong personality, with difficulty in accepting that the wife becomes independent. Fact that has been influencing your fears. Always upon returning from school she was under heavy pressure from her husband to give up. On the other hand, her instructor always supported and encouraged her, so that she was insecure and confident at least for long, presenting strong mood instability, visible in her two failed attempts to obtain the CNH.

Despite family resistance, M. got approval, but fear began to be present after the long-aforedreamed letter. M. can't stop thinking about her husband's statements, saying that M. is a terrible driver, what a woman's place in the kitchen, among other negative statements that negatively influence M's behavioral responses.

In this sense, after almost a year of obtaining a letter, M. then decided to seek help, to get rid of the trauma.

The process occurred over a period of four months and during this study, we will highlight the most important points that were worked on in the therapy.

The working method was based on Cognitive Behavioral Therapy, which has been presenting good results for this theme.

Case Discussion

According to the IAN (2000) - Institute of Behavior Analysis and Modification - the term psychotherapy covers all psychological treatment methods and, in turn, should also seek to remove, modify or delay existing symptoms; correct patterns of mis adapted behaviors and promote the development and positive growth of the client's personality. Cognitive-Behavioral Psychotherapy is a re educational technique. According to Rangé [1], the therapeutic process generally involves eight basic processes: conceptualization of the problem(s) faced by the patient; development of a relationship of cooperation/active participation between patient and therapist; motivation for treatment; formulation of the problem; joint establishment of targets; patient education on the cognitive-behavioral model; cognitive behavioral interventions; and prevention of relapses. However, a therapeutic relationship is effective when there is an interaction between the personal qualities of the patient and the therapist.

This model of therapy was initially introduced in the field of psychology by Judith Beck, and her studies are based on her cognitive model, which comprises beliefs (central and intermediate), automatic thoughts, cognitive distortions, among other concepts, all with a point of connection in the situations experienced by people in their day-to-day - including their thoughts, emotions and behaviors. From this model, the author places that if there is a change in these concepts, possibly changes will occur in the individual's life and in his thoughts, behaviors and emotions, through a cognitive resignification of these concepts.

Cognitive-Behavioral Psychotherapy is a form of objective therapy, based on scientific research, which seeks to treat symptoms directly and effectively, with emphasis on the present [1]. But it does not mean that the past experiences of the individual are not treated, but rather that, at the beginning of the therapeutic process, the focus of therapy is what most afflicts the patient, and to a large part these problems are thoughts, feelings and behaviors that are occurring in the person's day-to-day life [1].

The cognitive-behavioral therapist works together with the client, actively applying and teaching a series of techniques and procedures so that the person can feel better, while acquiring self-knowledge, through resignification, because the task of Psychology is to resignify the client's way of thinking, being and acting.

According to Beck [2], cognitive therapy is based on the theoretical assumption that an individual's affections and behaviors are largely determined by how to structure the world. This means that a person's vision of the world influences the way he thinks, feels and acts.

Psychotherapeutic techniques help identify, evaluate, control and modify

the beliefs that command a person's worldview and that can be dysfunctional. Beliefs are "certainties" that the individual builds through experience and some may condition his life by disturbing him [2]. Psychotherapy is a resource to help the patient better understand himself, the people around him and his problems, and can help him find ways to face difficulties and improve his situation. In this process, the client and the therapist examine emotional and social areas that are affecting them on a day-to-day basis or in specific situations, in order to better modify them.

People seek psychotherapy because they are concerned about their relationships, whether family, social or personal. These people want to better understand their relationships, what's going wrong with them and think about how to improve them [3]. This is the case of the patient attended at the School Clinic. She wants to improve her relationships and learn to be more active in the face of dependence on her children. She wants to learn how to deal with her husband and still wants to do the activities she likes, including hanging out and chatting with friends, but she is always burdened with daily tasks and responsibilities that are of others.

According to psychologist Pizol [3], Cognitive Behavioral Psychotherapy is concerned with the interpretations that each one gives to himself and to events to thus try to understand and modify his emotions, his thoughts and his way of acting. The main focus of therapy, still according to Pizol [3], is on how problems (current or not) interfere in the daily life of the patient. Psychotherapy will help you understand these problems and develop ways to deal

How to cite: Fabiana D M . Cognitive Behavioral Therapy and Its Intervection in A Clinical Case of Specific Phobia Fear of Driving. Psychol Behav Sci Int J. 2022; 19(1): 556003. DOI: 10.19080/PBSIJ.2022.19.556003

with them. This procedure was performed with the patient of the School Clinic.

Psychotherapeutic care was performed in the office, in an individual way. Psychological care allowed the organization and resignification of feelings and anguish brought by the patient in psychotherapy. The relationship established between patient and therapist was defined in the communication between the therapist and the client. Both share a task in an egalitarian relationship, even though their roles are different. The functioning of this relationship will depend on various conditions of the patient and also on the attitudes of the therapist and on his/her ability to offer specific contributions to the bond [1].

Rangé [1] states that the interventions aim at an understanding of the psychodynamics of the patient, which is instrumentalized in interpretations, in the planning of his daily life, in family orientation or work.

The therapeutic relationship is present in the construction of the therapeutic alliance permeated by the bond built between patient and therapist. The initial interview is conducted with the patient, in which the therapist welcomes him, collects information about the initial complaint and the reason for the consultation, observes the patient-therapist interaction. In addition, it provides feedback from the interview and establishes a contract [1].

The sessions were weekly lasting sixty minutes each. The initial complaint guided all psychotherapy. The sessions were based on welcoming the patient well, being empathic and congruent to his feelings. In fact, it was possible to establish a good therapeutic relationship and the work proved to be successful. The patient was resignifying her psychodynamic aspects in her usual relationships. The work was as direct and focal as possible, based on the methods of Cognitive-Behavioral Psychotherapy; and thus the process happened satisfactorily, both for the patient and for the therapist.

Cognitive Therapy is a form of new therapy, its studies have been disseminated in various corners of the world. However, despite being a very recent form of therapy, his studies and methods have proven increasingly effective in the field of psychology, both for the treatment of chronic diseases, caused by mild and severe mental disorders, as well as for simple problems, such as relational, social, marital conflicts, and is still used as a way to produce in the subject a form of self-knowledge. The central point for treatment within this approach is the objective reality, in which professionals return their work to help the subject observe the influence that their thoughts, or according to Beck [2], their cognitive processes, have on their way of being, acting and thinking.

Cognitive Therapy puts it that it is not the events themselves that are good or bad, but the interpretation that people make of each of them. Following this line, this model of therapy aims to propose works in which the subject may be able to evaluate his thoughts in a clear and realistic way, realizing the changes that are important and necessary in their lives. Thus, the subject is then instructed to analyze his competencies, failures and successes according to his way of life.

Cognitive Therapy focuses on the ability of individuals to provoke changes in the schemes of their thoughts, so that they are recognized, manned, evaluated and modified, in order to improve them in the future, in order to obtain changes in their behavior and in their life. What gets in the way of the individual is the distorted view he has about the world and things. And so, what therapy proposes, as said, is a resignification of this model of being apprehended by the subject. Such distorted thoughts are called by Beck [2] cognitive distortions.

Generally, the distortions are rigid and recurrent, requiring a lot of work of the therapist to know his central belief, because often the behaviors presented by the subjects are also, in one way or another, reinforced by their social environment. What we perceive, therefore, within therapy is that events are responsible for activating the central belief, or beliefs, that each individual possesses. Thus, such beliefs are the mechanism of activation of how situations are perceived and interpreted by each one, as well as those responsible for the emotional reactions of individuals [4-6].

The cognitive model proposes that dysfunctional thinking, which influences the patient's mood and behavior, is common to all psychological disorders. This model raises the hypothesis that people's emotions and behaviors are influenced by their perceptions of events, because it is not a situation in itself that determines what people feel, but how they interpret a situation. When the individual is in situations in which emotional uncontrol latde is revealed, it becomes necessary to thoroughly examination of the sets of beliefs that serves the purposes of disadaptation, causing in the person an immense suffering. As cognitive therapy is based on the cognitive model, the cognitive therapist seeks to produce cognitive change, that is, changes in the patient's thinking and belief system, correcting the erroneous interpretations constructed by the individual and decreasing some emotional sensations, aiming to promote lasting emotional and behavioral change. It is worth mentioning that a very important goal of cognitive therapy is to teach the client to be their own therapist, because the therapist who is responsible for helping the client in his problem risks generating or reinforcing a dependency, which can deprive the client of the opportunity to test and strengthen their own skills.

For the therapist to demonstrate competence, he needs to be seen in three stages. In the first, he needs to structure the session and use basic techniques, having basic skills to conceptualize a case in cognitive terms, based on an initial evaluation and obtaining information in the session. In the second stage, therapists begin to integrate their conceptualization with their knowledge of the techniques, strengthening their ability to understand the flow of

How to cite: Fabiana D M . Cognitive Behavioral Therapy and Its Intervection in A Clinical Case of Specific Phobia Fear of Driving. Psychol Behav Sci Int J. 2022; 19(1): 556003. DOI: 10.19080/PBSIJ.2022.19.556003

therapy. And in the last stage, therapists automatically integrate new data into the conceptualization. They refine their ability to formulate hypotheses to confirm or not their view of the patient. These stages are very important, because when the therapist conceptualizes the patient the trajectory of therapy becomes efficient and effective of treatment. After these internships the next step is the service. The first session has several goals, such as: establishrapport, refine the conceptualization, socialize the patient in the process and structure of cognitive therapy, educate the patient to the cognitive model and about his/her disorder and provide hope and some relief of symptoms. So, developing a solid therapeutic alliance and encouraging the patient to ally with the therapist to achieve therapeutic goals the latter is of paramount importance in this session.

Thereafter the basic elements for the other cognitive therapy sessions include a brief update and mood check, a bridge with the previous session, agenda/script establishment, a review of the homework, discussion of agenda/script topics, indication of new homework, final session summary, and feedback.

During the sessions, the therapist with his client will identify, evaluate and respond adaptively to automatic, central and intermediate thoughts; this can be more effective with the help of various cognitive therapy techniques, as they aim to influence the client's thinking, behavior and mood.

If the client has experienced a reduction in symptoms and still learned basic tools from cognitive therapy, therapy is gradually reduced. Because the client is prepared, from the first service, to the end and a possible relapse. The problems in reducing sessions and the end of the process are covered like any other problems.

Judith S. Beck, in writing this book, provided an advanced study on cognitive therapy, he actually educates, teaches and trains, we, future therapists and new in cognitive therapy. It really sharpens our skills, to plan an effective treatment, to solve difficulties during therapy, providing a repertorio of therapeutic techniques; demonstrates what it's like to be a therapist committed to your client. Such a cognitive model was very important for advances in current studies of cognitive therapy, and for the increasing production of knowledge.

Given the above, we have a two-way street, some people think it is standard to face traffic, while others see an intense anguish in this process. And so, the number of people seeking help from specialized professionals for not being able to drive increases every day. In this sense, before even getting close to cars people have unpleasant feelings that increase as they approach a vehicle. An invasive form of negative (catastrophic) thoughts prevails in their minds, and people tend to believe them without even questioning or defiant them. These thoughts lead patients to the initial symptoms of: aquicardia, short breathing, sweating, inability to relax, nervousness and treming that we call anxiety, accompanied by avoidance behavior. The latter prevents people from finding out how catastrophic the imagined situations were, and they cannot realize that anything they imagined happened.

Fear of driving is usually related to ansiogenic aspects within the specific phobia. In most cases the fear of driving has associations with other specific situations, as we can observe in the description of the case in question. Everyone probably knows someone who presents this intense fear of direction; some even finish the process and take the long-afored wallet, but do not use it. People believe that if there is a small possibility of something bad happening then it is likely to actually happen, and they fixatise around that thought. However, we also have other reasons that keep them away from the vehicle: fear of being observed, evaluated, criticized, rejected and punished or having gone through a traumatic situation in the past, as occurred with the patient in this article.

Piccoloto et al. (2007) affirm that cognitive behavioral therapy is the most indicated treatment for anxiety disorder so far. This is an approach that has shown good results. Its effectiveness is scientifically proven and causes people to overcome their fears with relaxation techniques and exhibitions, in addition to the challenges of thoughts. Patients are encouraged to think about fear in terms of thoughts, feelings and behaviors. According to Aaron Beck's cognitive therapy (1960), it is not the situation that determines emotion, but rather the way we interpret it. According to him, the closer we come to reality we think, the better we will feel. Realistic thoughts neutralize emotions that facilitate and influence problem solving.

Examples of thoughts that populate these people's minds are: "what if I lose control of the car? What if I crash the car? What if I hurt someone? What if I suffer or cause a serious accident? What if I get sequels from an accident? What if I don't make it? What if the other drivers don't pay attention? The other drivers are going to get mad at me. The other drivers will think I can't drive. I'm going to get lost. I'm going into a jam. My car's going to break down. Road conditions are dangerous," and so it goes. Apprehensive thoughts accompanied by much anguish and suffering. Many people feel panic when thinking about driving, and do not even realize that their thoughts are catastrophic, distorted beyond dysfunctional. They also do not realize that while they live, in their routine, they assume several risks with even greater probabilities of occurring and do not present avoidant behavior. They do it all the time; they walk down the street and risk being run over, robbed or assaulted and they don't even stop leaving the house. In these cases they are realistic. We can use that same principle for the fear of driving.

During the sessions, I realized that the conflicts that the patient had were relational, that is, it has to do with the way she sees her relationships. And I also gained an understanding of the relationship that the patient has with her lover. This issue has become clearer, and it is therefore an escape from their problems, just when they are at their peak. However, the patient brought to the sessions contents of a family and personal order, in which she understood conflicts that were unresolved, or at least she

How to cite: Fabiana D M . Cognitive Behavioral Therapy and Its Intervection in A Clinical Case of Specific Phobia Fear of Driving. Psychol Behav Sci Int J. 2022; 19(1): 556003. DOI: 10.19080/PBSIJ.2022.19.556003

did not know how to solve them. From a resignifcation of your thoughts and feelings, it was possible together with the patient to find a solution to the case. It is noteworthy that the patient experienced moments of anguish. When a situation ran out of her control and she didn't know how to solve it, she felt powerless, because she thought she had to take care of everything, that only she would solve a certain situation. It was oriented that we don't have to account for everything, we are human beings, we have to recognize our limits.

Her impotence was also present when her husband was drunk, had no dominion over him, and most of the time she didn't know how to act or what to do. On the other hand, their relationship with the family was also dependent, since the patient had difficulties in saying no and sharing responsibilities that were not completely her own. The patient did not have a firm pulse because she did not feel comfortable saying no. He had no attitude in the face of some situations that required a certain audacity and decision. Pr has always strengthened the relationships of dependence of his children. They themselves say, "Mother was the lady who taught us to be like this." She claims without question. His way of thinking made him not perform his own wills, such as performing the activities he loves so much and that he lacked, such as driving. She was always full of situations that required addiction, that she could not solve and take on on her own. The patient was passive in the face of situations.

Some techniques and some procedures were decided to be worked on during the visits. Such as: Cognitive Restructuring through Socratic questioning was one of these techniques, whose main objective was the confrontation of dysfunctional thoughts in order to better adapt them. In addition to the socratic questioning, procedures were worked with the patient that promoted the knowledge about her thoughts and emotions. One of the resources to do so was the automatic thought recording. However, the patient was unable to perform this part of the task.

Subsequently, sessions were held that promoted responsibility, whose objective was to work with the patient she is capable of. And yet, it is discussed the issue that she is solely responsible for her memsa, that the responsibilities for her treatment are hers. Finally, the reflection sessions came, in which the patient was oriented on the issues related to herself, and it was also emphasized that she is solely responsible for changing her problems, through the change of some of her behaviors.

He had extremely dependent and very insecure characteristics

The pattern of dysfunctional behaviors such as : "I will not succeed", contributed to the excess of activities that the patient proposed to perform, her concern to do everything made her anxious. Due to the characteristics observed, it is verified that pr has difficulties in their social relations, cannot assert themselves, impose themselves at times they need, making their behavior to help everyone be highly reinforced by all family members.

After several therapeutic sessions, the patient can already better deal with the fear of driving, knowing how to identify negative thoughts and what are the periods and attitudes in which she can modify, issues that depend only on her to solve. The patient already feels safer to take the direction of a vehicle, finally she was much more self-confident and safe in her attitudes.

Even her relationship with her husband is improving. Pr is being more patient and no longer fights with her husband when he despises and criticizes her, that is, she is managing to create mechanisms to solve this situation, which previously made her distressed and nervous. Currently, the patient is able to be discharged and with good resolution of the problem presented. There was a healthy psychotherapeutic process and good treatment.

Conclusion

The care provided a significant learning about the process of psychotherapeutic care in Cognitive-Behavioral Therapy. In practice, theoretical questions are more comprehensive. The clinic provides us with a rewarding and necessary form of work and experience for our training as psychologists. Through cognitive-behavioral evaluation of the patient's behaviors, thoughts and feelings, it became possible to have access to the understanding of the case and perform the necessary interventions. The patient contributed a lot to the process, and thus it was possible to perceive that the therapeutic relationship was well established.

During the visits there was enough empathy to be able to understand the patient and not judge her by her attitudes and forms of thoughts. It was also possible to demonstrate neutrality in the face of the problem exposed by the patient. I realized that each person will understand a situation in a certain way, will face it in a different way, because, we think, we feel and even act differently in certain situations. What cannot happen is to let situations become conflicting to the point where we cannot resolve them, and if they reach so much, that we know the time to appeal, and recognize that we need help.

Treatment with Cognitive Behavioral Therapy is very effective and depends on both the therapist and the client. It is necessary to overcome prejudice, be fully aware of the problem and know the time to seek help.

From the above it can be concluded that it is necessary that people who are afraid to drive learn new skills to deal with the problem situation, along with the support of a therapist in order to be able to restructure cognitively.

How to cite: Fabiana D M . Cognitive Behavioral Therapy and Its Intervection in A Clinical Case of Specific Phobia Fear of Driving. Psychol Behav Sci Int J. 2022; 19(1): 556003. DOI: 10.19080/PBSIJ.2022.19.556003

References

1. Rangoon Bernard (2001) Cognitive-behavioral psychotherapies: a dialogue with psychiatry. Porto Alegre: Artmed, Brazil.
2. Beck Judith S (1997) Cognitive therapy: theory and practice. Porto Alegre: Artmed, Brazil.
3. Kelen B Pizol (1994) Cognitive Behavioral Psychotherapy for adults, couples and adolescents.
4. Braz Werneck Clinical Psychology, contribution of reflective processes to cognitive therapy.
5. http://cleopsico.blogspot.com.br/2012/02/medo-de-dirigir.html
6. http://www.iansi.org/cl_tratamento.asp

DOI: 10.19080/PBSIJ.2022.19.556003

How to cite: Fabiana D M . Cognitive Behavioral Therapy and Its Intervection in A Clinical Case of Specific Phobia Fear of Driving. Psychol Behav Sci Int J. 2022; 19(1): 556003. DOI: 10.19080/PBSIJ.2022.19.556003