

•Case report•

Choking phobia : an uncommon phobic disorder, treated with behavior therapy : A case report and review of the literature

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Summary: Choking phobia is a relatively uncommon phobic disorder which is often encountered by otorhinolaryngologists and referred to psychiatrists as a cause of psychogenic dysphagia. If not diagnosed early and treated appropriately, it can have severe detrimental effects on the physical and psychological health of an individual. We present a case of a 20 year old female who presented with choking phobia and was treated with behavior therapy. Additionally, we discuss the differential diagnosis and treatment strategies of this rare anxiety disorder.

Keywords: Choking, Phobia, Psychogenic dysphagia, Behavior therapy, India

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1. Introduction

Choking phobia is a rare condition characterized by intense fear of choking accompanied by avoidance of swallowing solid food, liquids and taking pills/tablets in the absence of anatomical or physiological abnormalities.^[1,2] Patients usually present with a history of intense fear to swallow food or drinks after a traumatic event of being choked but it may also be seen without such an event.^[3] Existing diagnostic systems have classified it under “Other (300.29/F40.298)” category in Specific phobia disorder of Anxiety disorders in DSM IV and the same has been retained in DSM 5.^[4,5]

Existing literature on this rare phobic disorder is limited to a handful of case reports/series and review articles.^[6-8] Indian data on choking phobia is almost not available, though it is not uncommonly encountered in routine clinical practice by otorhinolaryngologists and psychiatrists. Several treatment strategies have been used, but there is no common consensus over an appropriate approach. Most of the case reports/series support use of behavior therapy. We report a case of choking phobia in a 20 year old female who underwent successful treatment with behavior therapy.

2. Case history

Miss X, a 20 year old girl, 2nd in birth order, an engineering student living in a hostel, and hailing from a urban background was referred to our Psychiatry Outpatient department from the Otorhinolaryngology department for detailed assessment and management. Exploration of history revealed that she had developed a constant fear of swallowing solid/semi- solid foods and pills for the past 5 months after a choking incident which occurred while she was having her dinner consisting of “chappatis (bread) with black gram curry” which are some of the more commonly prepared food items in our country. Prior to the incident, she was stressed due to exams and some family issues. She reported during the choking incident, she suddenly felt as if some food particles had stuck to her throat. She started to feel an abnormal sensation which did not go away by drinking water. Following which she started to have negative automatic thoughts like she would be choked to death and no one would help her. She had a panic attack characterized by severe anxiety with palpitations, sweating, difficulty in breathing, and restlessness along with a sense of impending doom.

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Her fellow classmates rushed her to the emergency department of a nearby private hospital within 15-20 minutes. However, by the time she arrived her anxiety had decreased significantly and after a non-eventful detailed examination of her throat by the otorhinolaryngology resident she was discharged. However, after reaching the hostel again she had the same feeling of something being stuck in her throat and started having the same degree of anxiety. Being unable to sleep and having the same choking feeling again, she was readmitted to the same hospital but no physiological or organic cause was detected. Despite being counseled again and again by the treating doctors regarding her unreasonable fear she continued to harbor anxiety. Within a week, she started to have fear whenever she would be given food to eat and would have thoughts that she would be choked by the food item, thereby leading to severe anxiety and refusal to eat. Her parents visited several otorhinolaryngologists but no organic cause could be found. Gradually her condition further worsened. She started to refuse solid/semisolid food items and completely shifted her diet to liquid based food items like fruit juices and soups. Later on, she even began to have doubts that fruit juices may contain some fine residues (e.g. seeds etc.) which may choke her and started to avoid them as well. She would scrutinize each food item before eating, at times would even use a sieve to check for any fine residue or grind up the food items. Due to such behavior, there were repeated altercations at home leading to significant family disruption. She refused to go back to her college or to continue her studies and would be preoccupied with the fear of having an anxiety attack if she stayed alone at the hostel and of being choked. She lost around 7-8 kg of weight within a span of two months. She was completely preoccupied with her fear related to swallowing and she did not bother about her exams and family issues during this period. By this time, she also started to have depressive symptoms such as persistent pervasive sadness, anhedonia, feeling helpless, ideas of worthlessness, low self-esteem and decreased sleep. For these reasons, they initially visited to the Otorhinolaryngology department of our centre and after ruling out all organicity (both clinical examination and barium swallow did not reveal any obstructive pathology) she was referred to us. There was no history of any suicidal ideations, delusions or hallucinations or any history of fear of any other specific object or situation. No history of constant preoccupation with body image or weight related issues or any previous mood episode could be elicited. Family history revealed a dysfunctional family in which her father used to be an alcoholic since the patient's childhood who would physically abuse her mother under intoxication. Her mother appeared to have chronic depressive illness along with a generalized anxiety disorder but she never received counseling for this. However, no history of any physical/sexual abuse to the patient was reported.

On the mental status examination, the patient was alert and oriented, with constant preoccupation with excessive fear of being choked if she ate food. Insight was preserved i.e. she assumed that her fear was irrational, illogical and mostly psychological and agreed for treatment. A diagnosis of specific phobia "choking phobia" along with comorbid moderate depressive episode was considered. She was started on Escitalopram 10 mg and benzodiazepines (Clonazepam 0.25 mg BD). Personality assessment using International Personality Disorder Examination (IPDE) revealed cluster B traits of emotionally unstable borderline type. After 2 weeks, her symptoms suggestive of depression improved by nearly 60% but her phobia regarding eating or swallowing food remained the same as she would even grind all tablets and then take them with water. She was then taken up for behavior therapy with her consent. Hierarchy of food items which cause anxiety were charted down with subjective unit of distress (SUD). Along with progressive muscular relaxation exercises and proper psycho-education regarding behavior therapy, biweekly sessions were started with the food item with the least SUD. She would be asked to eat the food item in presence of the therapist and to face her anxiety. After initial resistance due to excess anxiety, she started to carry out sessions as described. After 10 sessions, she developed confidence and started to carry out daily similar sessions at home. Clonazepam was stopped within one week of starting of behavior therapy. A total of 25 sessions were taken and by the end of 3 months, she reported very minimal or no anxiety while eating. In the subsequent sessions, family issues were discussed. Her father was brought into the treatment network and family therapy was planned. In spite of continuing family issues at home, there had been no recurrence of symptoms of choking phobia at 12 months follow up and subsequently Escitalopram had been stopped.

3. Discussion

Phagophobia and swallowing phobia are other commonly used synonyms of choking phobia.^[8] It is of the utmost importance to differentiate it from organic dysphagia before labeling it to be of psychogenic origin. Very commonly it has been misdiagnosed with eating disorders and conversion disorder. However, it should be kept in mind that phenomenologically it is completely distinct from eating disorders, it is characterized by the phobic stimulus of swallowing that results in the avoidance of food or drinks, and ultimately to weight loss, social withdrawal, anxiety and depression states whereas in eating disorders the main psychopathology is the constant preoccupation with losing weight or fear of becoming fat.^[2] Similarly, it can be differentiated from conversion disorder (Globus Pharyngeus) as in Globus pharyngeus, patients often have the 'perception' of an abnormal sensation and a feeling of globus which

is usually unrelated to actual swallowing. Conversion disorder was ruled out as our patient had the sensation of being choked and the fear that food would become lodged in the throat was experienced only during meal time.^[9] Two types of choking phobia (i.e. post-traumatic type and malingering type) have been described. In the 'post traumatic' type, the psychic trauma is caused after an experience of gagging or choking whereas in the 'malingering' type, the malingering maintains the symptoms and conversion symptoms allow the patient to avoid conflicts.^[10] The index case belonged to the former type of choking phobia and organicity was ruled out by clinical examination and detail investigations by several otorhinolaryngologists.

It has been proposed that choking phobia occurs most commonly secondary to a conditioning experience of being choked by food.^[7] In the index case, swallowing food became conditioned with the fear of being choked after a choking incident leading to an avoidance or restriction of foods, panic attacks and weight loss. Panic attacks in the index case acted as a fear conditioning factor and maintained the vicious cycle of anxiety leading to avoidance. Existing literature reflects that choking phobia has been most commonly seen in females but in a very wide range of age groups (i.e. as low as 5 years to as high as 78 years).^[7] Comorbidity with other psychiatric disorders like social anxiety, panic disorder, personality disorders, depression etc. has been reported.^[8] The index case was also in line with these facts.

In the index case, medication was continued during the course of behavior therapy for management of depressive symptoms and for the anxiety related to the choking phobia. Currently, no controlled trials or guidelines are available for the treatment of choking phobia. However, existing case studies describe a variety of treatment approaches ranging from hypnotherapy^[11], Eye Movement Desensitization and Reprocessing (EMDR)^[12] and cognitive behavior therapy.^[6] Although pharmacotherapy like low dose selective serotonin reuptake inhibitors had been used for treatment,^[13] behavioral approaches have been more commonly used.^[1,14] Treatment protocol consisting of psycho-

education, cognitive restructuring, aversion /distraction and in-vivo exposure had resulted in remission of symptoms in patients with choking phobia.^[15] Given the severity and level of dysfunction in the index case, both modalities of treatment (i.e. pharmacotherapy and behavior therapy) were combined. Though Clonazepam has a half life of ~16-24 hours, however in anxiety disorders a low dose Clonazepam (0.25-0.5 mg) BD or TDS dosing is recommended^[16] which was later tapered off following improvement with behaviour therapy. Treatment followed in the index case was holistic and complete (i.e. psycho-education, cognitive rechallenging and in-vivo exposure in front of therapist) which ultimately led to complete and sustained remission.

The index case highlights that otolaryngologists should be aware of this disorder along with the fact that psychogenic dysphagia needs to be evaluated in detail. Further, if appropriate treatment strategies are followed then such conditions can have a very good outcome.

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The authors declare that they have no conflict of interest related to this manuscript.

Informed consent

The patient signed an informed consent form and agreed to the publication of this case report.

Authors' contributions:

SS drafted the manuscript and NH critically reviewed the manuscript.

SS, NH and SKP jointly made the clinical diagnosis and the psychiatric evaluation.

SS carried out the behavior therapy sessions. All authors read and approved the final manuscript.

行为疗法治疗一例罕见的窒息恐惧症：病例报告及文献复习

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概述：窒息恐怖症是一种较少见的恐怖症，是心理性吞咽困难的病因之一。患者往往在耳鼻喉科就诊，之后被转诊到精神科。如果诊断不及时、治疗不恰当，那么它会严重影响患者的身心健康。我们报告一个 20 岁的女性患者，表现为窒息恐怖症，接受行为治疗。

此外，我们还讨论了这种罕见的焦虑障碍的鉴别诊断和治疗策略。

关键词：窒息、恐怖症、心理性吞咽困难、行为治疗、印度

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