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Phagophobia in a Young Woman with Autism Spectrum Disorders Using Speech Language Therapy: A Case Report

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Abstract

Purpose: Choking phobia or phagophobia is a rare disorder and relevant literature is extremely limited. Specifically, it is said that phagophobia is a phobic disorder and it is a form of psychogenic dysphagia. People with phagophobia face no pathological physical examination findings, even though they fear and avoid swallowing food, fluids and/or pills. Autism Spectrum Disorders (ASD) is a developmental disability. ASD individuals face difficulties with communication, social interaction with restricted and/or repetitive patterns of behaviour. There is no relevant research – that has come to my attention- in accordance with phagophobia and Autism Spectrum Disorders (ASD).

Method: In this article, I present an autistic 32-year-old female who visited me on her own and was facing difficulty, fear and avoidance of swallowing and was treated with speech and language therapy. As soon as she realized that she had that difficulty, 1 and a half year ago, she visited two different otolaryngologists who were unable to diagnose her as her laboratory results were normal. Nonetheless, she had difficulty swallowing different foods and eating in front of a crowd. The management of the patient included both behaviour and speech and language therapy (dysphagia techniques program). There were a 1-month weekly sessions, then a 2-month consolidation period and a follow up session.

Results: The case showed significant improvement. A speech and language therapy program in the form of a dysphagia program can successfully be used in the treatment.

Conclusions: The said research tried to enlighten phagophobia in an ASD individual. Therapeutic strategies are stated from the scope of speech and language pathology. As a case study, generalizations cannot be made and further research is highly recommended.

Keywords: Phagophobia • ASD • Fear of swallowing • Speech language therapy • Choking

Introduction

Phagophobia is a form of psychogenic dysphagia and is characterized by swallowing complaints even though physical examination shows no anatomical and/or physiological deficits Franko DL, et al. [1] it is a rare condition and the prevalence of phagophobia is unknown; literature is limited to defined case studies. In this situation, there is no aspiration hazard but individuals show fear and avoidance of swallowing a variety of food, liquids, and/or pills. It is recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) under the umbrella of Specific phobia disorder of Anxiety Disorders, as a specific phobia in "Other (300.29/F40.298)" category. This article presents an ASD female with characteristics of phagophobia, including clinical features and treatment techniques related to speech and language therapy that improved the patient's profile. This is the first known study related to phagophobia in an ASD individual in Greece. As there was no related piece of research in my home country and worldwide at the moment of this article, there is limited knowledge about the topic and thus, no general consensus over an appropriate therapy [2].

Case Presentation

The patient was a 32-year-old female with a diagnosis of ASD since she was 4 years-old. She developed fear of swallowing 1 and a half year before visiting the therapy setting. She was employed at the time, working in a company. Exploration of history revealed that she was afraid of swallowing, but she was not facing avoidance of swallowing food, fluids or pills. Her symptoms included a sensation of the food stopping at her throat and a feeling that food would become stuck in her throat and a fear of the food passing into the airway. In addition, there were not mentioned problems in initiating the pharyngeal swallow and globus sensation and there were not any diet food preferences as well. Her weight was normal and she felt relieved when she was relaxed and calm, with an improvement in swallowing. She mentioned that she was feeling tired during eating time because she was spending a lot of time and effort chewing the food. She was facing difficulties to start swallowing phase, also chocked during mealtime and faced shortness of breath. What is more, she mentioned severity of swallowing anxiety at work and/or outside places while at home she felt better.

There were not mentioned any family history issues. The feeling of discomfort was present every time she was eating at every single swallow. Generally, she mentioned that she had been feeling stressed many times for many reasons related both to work and her personal life. She had visited an otolaryngologist and had also undertaken gastroscopy with no pathologies found. As it is a rare and not well-known condition, doctors were not well informed to identify and specify this condition at the time when the research was conducted in our home country. At pretreatment phase, it was not known whether the case met the formal diagnostic criteria for an anxiety disorder or not.

At treatment phase, biweekly sessions were proposed, however, due to time restrictions, she attended weekly sessions for 6 weeks. Overall, she mentioned that in a scale of 1-10 (low-high) her difficulty was at 7 and what she was expecting from therapy was techniques and strategies to reduce the swallowing discomfort. The therapy cycle included the following schema: homework review-didactic session- new homework. I think it is extremely significant that the patient participate cognitively in the therapeutic session in order to generalize with more comfort what he/she has been taught.

The therapeutic management included:

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Education on the normal phases and pathophysiology of swallowing, including food modification when needed (liquidity, quantity, temperature, taste and smell, sensory)

Modification of the eating procedure (feeding environment, change of eating hours, small bites)

Use of techniques related to feeding and head positioning

Modification of current swallowing mechanism

Set individualized therapeutic goals and therapy plan

Behavioral intervention (slow diaphragmatic breathing, muscle relaxation techniques)

Other routines for relaxation (e.g., peppermint oil before eating)

I asked her to bring food within our sessions. We agreed upon the inclusion of foods of various difficulty levels in our meal therapy, from easy to moderate and difficult, in an analogy of 3-2-1 (easy-moderate-difficult). The above meant that in every session she had to bring different foods from each difficulty level. At the beginning of the therapy, she was a really slow eater with an average of 22 chews per bite (until swallowing). Gradually, we changed eating situations (e.g., feeding rate, food quantity etc.) in and out of the therapy setting, in order for her to be exposed to different situations and thus, learn to handle them. She found the use of supraglottic swallow, in order to manage her food in a better way, rather helpful. In addition, it was easier for her to eat in a sitting position rather than standing. Sometimes, she opted for head bending at the swallowing phase when she was sitting, because she had the feeling that she protected her trachea in that way. Moreover, we used diaphragmatic breathing before eating to support her either in stress situations or during the use of supraglottic swallow. We also used cough and coughing exercises as a strategy.

She improved and gained self confidence in eating. As a result, her self-awareness increased. In particular, she understood why she was facing a particular symptom each time and which technique was the best for her. Cognitive therapy helped her modify as needed and give the most appropriate solutions. At stage II, after 6 weeks of weekly sessions, there was a 2-month consolidation period where the patient was exercising on her own and used the strategies given without visiting me at my office. We agreed on 25-minutes everyday sessions at home. She was sending me her weekly food diary every week, as we had agreed. Specifically, that diary included: time of eating, duration of the meal, food eaten, place, eating position, any difficulties faced, strategy/ies used when necessary, feeding rate, modifications and other. In addition, she had to fill an observation checklist in order for me to understand her swallowing and eating behaviors. For example, she mentioned that sometimes she kept half of her bite at her mouth when she swallowed the other half and thus, she had to swallow two consecutive times in order to fully empty her mouth.

That had an impact on her eating rate and also meant that while she was doing that, it was the anxiety and/or the fear of her food being stuck at her throat that led to the behavior mentioned above.

After the consolidation period was completed, the patient visited me again for an after treatment follow up session. I found that she had improved steadily with the aforesaid methods. She mentioned that she was able to swallow sometimes small and others bigger food boluses from different kind of foods in different eating environments. At that moment, I suggested that her relatives be educated in order for them to be aware of the strategies used and as a result, to be able to manage any situation. In addition, I suggested psychotherapy in order for her to face and deal with her anxiety and other feelings. I asked to see her again in two weeks- four weeks-three months-six months. After six months, I found her in excellent condition with no symptoms referred. She was attending psychotherapy sessions and stated that her anxiety had been dramatically decreased and she could -in most situations- successfully manage it.

Discussion and Conclusion

That was a case of psychogenic dysphagia as the patient of the said research exhibited no organic cause(s). The patient visited me because she was facing problems with food and specifically, she had great difficulty when swallowing and a sense of her food getting stuck. She did not have issues with her weight as she was not avoiding eating even though it was a great issue for her. In this research, behavioral approaches and food therapy (from the view of speech and language therapy) were used in order to help the patient improve the situation stated. She made an improvement after 6 therapeutic sessions and the management of the patient included supervision during a consolidation period of two months and at a follow up stage. She remained well after six months and she also attended psychotherapy sessions. It is extremely important to enlighten the scientific community about choking phobia and specifically otolaryngologists and psychiatrists about the nature of this disorder. Consequently, they will be able to assess in detail and propose the most appropriate therapy.

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