ROMANIAN JOURNAL OF PSYCHOLOGICAL STUDIES

HYPERION UNIVERSITY
www.hyperion.ro

PSYCHOTHERAPEUTIC APPROACH OF ANXIETY DISORDERS - A FALSE PHOBIA, PHAGOPHOBIA. CASE STUDY

CRISTINA-MIHAELA STOIAN, STELIANA RIZEANU [a]

[a] *Hyperion University, Faculty of Psychology and Educational Sciences*
Department of Psychology

Abstract

The case study presented in this paper has brought psychotherapists useful information about a rarely type of an anxiety disorder: ***phagophobia.***

Phagophobia belongs to the anxiety disorders category and represents the fear to swallow, of choking with food, pills or liquid, also known as psychogenic dysphagia. This type of phobia is more rarely encountered, but also more difficult to differentiate from other disorders due to similar symptomatology, specific phobia usually being accompanied by other pathologies. Thus, making a differential diagnosis, psychotherapeutic approach supported and highlighted triggers, maintenance and predisposing factors specific to patient, but also irrational and coping strategies used therein proved effective.

The conclusion is that a combination of eclectic psychotherapy techniques and tools, as well as making a differential diagnosis as realistic, can bring a positive influence upon the client towards resolving global problems and efficient functioning, the resource-orientation being a plus for this purpose.

Keywords: *phagophobia, anxiety, depression, borderline, psychotherapy.*

1. CASE HISTORY

The present work presents a case study concerning phagophobia, which highlighted the need for the eclectic approach in psychotherapy and anxiety disorders at the same time, making a differential diagnosis to assist in the psychotherapeutic process.

Ovidiu is a 26-year-old waiter, with secondary education, plus incomplete nurses post high-school studies. Religion is very important to him and he wishes to

Corresponding author: Cristina-Mihaela Stoian

E-mail address: psihotraining@gmail.com

mention that he is Catholic.

He has a younger sister and a brother who had died when he was 9 years old.

The patient came to the office, following certain discussions held on a medical website, where he participated under the protection of anonymity and where specialists provide information to interested parties. Once in the office, the patient described during this first meeting all the symptoms and provided a long list of problems, from which he chose to begin with phagophobia and the problems in his workplace. He diagnosed himself with phagophobia, reading the information on the internet and was startled to learn that the symptoms were getting worse instead of improving as expected, thus taking the decision to come to the office. Another motivator to request support was represented by his fear of not losing his girlfriend because of his permanent concerns and excessive interest for medical explanations.

3 years ago, while taking a walk one night with his friends, he needed to swallow and couldn't, he got scared and thought "*I'm afraid that I'll swallow my tongue and die, so how do I control it?!"* Ever since he's afraid to swallow, but at the same time, he developed a swallow compulsion that he can't restrain himself from doing.

The subject shows no significant pathologies in his history, but during the interview major depressive episodes come out, with less intensity than the current one, without being accompanied by a manic or hypomanic episode. Ovidiu is afraid to be by himself in his house, can't stand closed doors (during childhood and adolescence). At age of 20, when moving from his parents house, he had the first depressive episode, in which he consumed a large quantity of alcohol, maintaining the alcohol consumption after the depressive episode remission for about 2.5 years, followed by some untreated depressive episodes.

The patient's brother passed away following an oncological disease, and his father went to a few meetings with a psychiatrist (from the interview arises the information that his father suffered from depression). The patient's mother is very anxious (especially since his brother died) and suffered a surgery for herniated disc (she stopped having a job ever since).

The patient consumes alcohol in moderate amounts, 3-4 beers/weekend, or at every 2-3 evenings; no other substances were declared. The difficulties at work, the unfinished studies, living on rent conditions (in common with several people and his girlfriend), withdrawal from social environment resulting in the loss of his friends, represents the current major stressors.

2. DIAGNOSYS AND EVALUATION

The patient was diagnosed with phagophobia, using the criteria in DSM-V (APA, 2013). I used Leahy Scale (Leahy & Holland, 2012) to measure the level of

anxiety symptoms and comorbid disorders, and a very high score (45) was obtained, which indicates severe anxiety and confirms other diagnoses of anxiety disorders (phagophobia, social phobia, obsessive-compulsive disorder). For the same purpose I used the diagnostic criteria from DSM-IV (APA, 2000), but also the diagnostic Scheme for social phobia and for specific phobia (Leahy & Holland, 2012).

The major depressive episode has been confirmed by the criteria in the DSM-IV and depression inventory BDI-II (Beck, Steer & Brown, 1996) -52 score.

For Axis II, I used the diagnostic criteria from DSM-IV (APA, 2000) and Structured Clinical Interview for DSM-IV Personality Disorders - SCID-II (First, Spitzer, Gibbon, Williams, Benjamin, 1997) and the avoidant, obsessive-compulsive, borderline personality disorders can be confirmed, including accentuated signs of other personality disorders: paranoid, narcissistic.

We performed a differential diagnosis, considering the fact that, although phagophobia is similar in terms of avoiding social phobia, the reason of avoidance is different. Often, both disorders go together and are very hard to be differentiated; in phagophobia, as in social phobia, all sorts of irrational beliefs emerge regarding the way in which the person sees himself, excessively valuing the opinions of others and being very worried regarding the way he could be assessed or judged. Thus, anxiety is triggered every time the subject gets into social situations, such as eating in public, the subject having a low self-esteem (Mc Klintock, 2001).

The major difference between phagophobia and social phobia is represented by the subject's obsession toward behaviours and actions aimed at orality, while in social phobia, the fear of evaluation does not stop at it (such as the fear of speaking in public, aiming orality as well), but can be also extended towards areas concerning the body (I'm fat/skinny, short/tall), cleaning issues (e.g., fear of getting dirty and being humiliated by others), or the fear to show emotions being afraid to be considered as awkward.

Phagophobia should be also differentiated by another food disorder like anorexia, refusal of new foods, or expressing preferences for food by refusing other food, such as happens with children (Evans, Pechtel, 2011). One of the criteria for differentiation between phagophobia and food disorders such as bulimia and anorexia would be that the patient does not wish to drop weight, although this symptom appears in phagophobia. In phagophobia, a perception of distorted body image also appears, as in dysmorphia-phobias (Çiyiltepe & Türkbay 2006).

Phagophobia is a psychogenic dysphagia, and dysphagia represents a severe medical condition that is frequently encountered, and in physiological& pathologic terms, it is a syndrome (Shapiro, Franko, Gagne, 1997; Suraweera, Hanwella and de Silva 2014). The swallowing mechanism is composed of a complex set of reflexes, involving more than 25 muscles, as well as 6 phases of the

swallowing reflex. It is sufficient for one stage to be interrupted and the ineffective swallowing (dysphagia) and aspiration occurs (Evans, Pechtel, 2011).

3. CLINICAL CONCEPTUALIZATION

Following the interview and the assessment the following were recorded: predisposing factors (obsessive-compulsive and avoidant borderline disorders, together with his paranoid and narcissistic personality, but also with inherited anxiety feelings) combined with the stress of witnessing his brother death, led to the phagophobia and social phobia symptoms occurrence, which increased due to secondary benefits (parental attention) and irrational beliefs ("I need to be safe - I may die suffocated";"No one can understand me";" If anyone sees me swallowing, I will be laughed at and be perceived as a freak no one wants to be near with";" I guess I'll never get rid of this problem!").
The locus of control is external (Rotter, 1990) and contributes to the maintenance of the patient's problems.

4. PSYCHOLOGICAL INTERVENTION

We chose an eclectic approach involving the use of strategies common to several schools of psychotherapy — Ericksonian hypnosis, modern forms of psychotherapy such as cognitive-behavioural or experiential psychotherapy — to make a contingency plan according to the client's needs, diagnosed with phagophobia. The psychotherapy has been carried out over a period of twenty-four sessions and pursued objectives such as: assessment schemes, automatic thoughts and negative beliefs (Beck, 1995; Rizeanu, 2013), identification of the client's resources and using them for cognitive restructuring, decreasing symptomatology, development of adaptive coping strategies, developing communication and correlation skills, resolutive capacity, improving the quality of life.

During those 24 meetings, we considered as useful combining several psychotherapeutic techniques and tools, such as role playing, the technique of vertical arrow, prescribing the symptom, cost-benefit analysis, searching for evidence, pros-cons, suggestive and relaxing techniques, techniques for EGO – confirmation, experimental techniques, values, etc (Rizeanu, 2014; Stoian, 2015).

Examples of techniques and circumstances in which they were used: knowing that the patient has developed swallowing compulsion, we asked him to consciously perform that act for about 5 minutes and to observe himself in a behavioural, cognitive and emotional way. We discussed a similar situation in

which he could notice himself swallowing and in which he had some thoughts, emotions and behaviours, comparing them with those taken at the simulation from the office. The reflex act brought into conscious plan was used to prescribe the symptom, especially due to the cognitive restructuring. The cost-benefit analysis of the cognitive biases (Beck, 1995) used very frequently by the patient, but also exposure in vitro and in vivo, have brought very good results and increased his motivation. The client had improved his communication and correlation ability after drafting a letter to his parents, in which he mentioned what bothered him about their relationship, thus noting that such a catastrophic and anticipatory thinking is not an effective strategy for problem-solving and no one leaves him if he shows his needs.

The psychotherapeutic strategies were primarily used with the purpose of mitigating the symptoms, particularly the suicidal ideas, using the patient's religious beliefs, beliefs that don't approve suicide acts (values = resources, in this case) and secondly, to maintain the anxiety to a tolerable level, with the aim to firstly complete the cognitive restructuring (firstly in the suicidal ideas area).

In this case, phagophobia has represented only a *symptom* (even if clinically speaking, it is a disorder) for the client's attempt of adaptation.

The client's strong motivation for change was the main pawn which has led to rapid results. He managed to make and implement plans for changing his job and his housing; he improved his communication and bonding with others, also increasing his self-esteem.

5. CONCLUSIONS

The self-diagnosis may increase symptomatology and based on inadaptation coping strategies, the client may aggravate his condition, the pathology increases and recovery becomes more difficult achievable.

Blocking the therapist in "the reason for the consultation", as representing the basic diagnosis without performing a differential, may lead the therapeutic act in a wrong direction, especially if he doesn't have the needed training and expertise understanding of the pathology or issues faced by the patient. For this reason, for a good therapeutic approach, we can say that the collaboration of specialists in the field of mental health: psychiatrists, clinical psychologists, neurologists, psychotherapists, other specialists is very important and where a multidisciplinary team cannot be formed, the developing knowledge of the therapist in his field of activity will be a plus for his work, for the clients' benefit.

The use of multiple types of psychotherapeutic approaches (especially if the client refuses psychiatric therapy) may prove beneficial in the long term (Stoian, 2015).

A positively oriented psychotherapist, who seeks out resources and not deficits, can contribute to the achievement of a good therapeutic approach, focused on the client's needs.

Received at: 15.09.2017, Accepted for publication on: 25.09.2017

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).* Washington DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author

Beck, J.S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press.

Beck, A.T., Steer, R.A., & Brown, G.K. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.

Çiyiltepe, M. & Türkbay T. (2006). Phagophobia: a case report. *Turk J. Pediatr*, 48:80-84.

Evans, I. M., Pechtel, P. (2011*).* Phagophobia: Behavioral Treatment of a complex Case Involving Fear of Fear. *Clinical Case Studies*, XX(X) 1-16. Sage DOI: 10.1177/1534650110391085

First, M.B., Gibbon, M., Spitzer, R.L., Williams, J.B.W., Benjamin, L.S. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders,* (SCID-II). Washington, D.C.:

Leahy, R.L., Holland, S.J. (2012). *Planuri de tratament și intervenții pentru depresie și anxietate.* Cluj-Napoca: ASCR.

Mc Klintock, E. (2001). The underlying psychopathology of eating disorders and social phobia. A structural equation analysis. *Eating Behaviors* 2, 247–261.

Rizeanu, S. coord. (2014). *Psihoterapie şi consiliere; Studii de caz*. Bucureşti: Universitară.

Rizeanu, S. (2013). *Introducere în psihoterapie*. Bucureşti: Universitară.

Rotter, J. B. (1990). Internal versus external control of reinforcement: A case history of a variable. *American Psychologist*, Vol. 45(4), 489-493.

Shapiro, J., Franko, D.L., Gagne, A. (1997). Phagophobia: a form of psychogenic dysphagia. A new entity. *Ann Otol Rhinol Laryngol*, 106:286-290.

Stoian, C. (2015). Cazul Robin sau copilul „Angry birds" In Rizeanu, S. coord. (2015). *Evaluare clinică şi psihoterapie. Studii de caz*. Bucureşti: Universitară.

Suraweera, C., Hanwella, R. and de Silva, V. (2014). Phagophobia: a case report. *BMC Research Notes*, 7:574.