**Pediatric Phagophobia: Treatment Strategies for the SLP**
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**Definition**
- Fear of swallowing that is characterized by significant complaints of dysphagia
- "Phagophobia" vs. "Choking phobia" (Shapiro, Franko, Gagne, 1997)
- Recognized in DSM-IV

**Causes of Dysphagia in Children**
- Organic (anatomical, neuromuscular)
- Developmental (dysfunctional, discoordinated)
- Functional (conversion, conditioned)
  (Culbert, Kajander, Kohen, Reaney, 1996)

**Etiology**
- Most patients acquire after episode of choking on food (McNally, 1994)
- May develop into a preoccupation with choking (Chatoor, Conley, Dickson, 1988)
- Can be triggered by a traumatic event

**Incidence and Prevalence**
- More often in females than males
- Onset childhood to old age
- Prevalence is unknown (McNally, 1994)

**Is Phagophobia an eating disorder?**
- Psychogenic dysphagia rather than eating disorder (Barofsky, Fontaine, 1998)
- “Developmental vulnerability”-co-existing developmental conflicts exacerbated by choking event (Chatoor, Conley, Dickson, 1988)
- No intentional weight loss; displeased with loss
- No distorted body image (Shapiro, Franko, Gagne, 1997)
- Troubled by problems and gratified by successful treatment (Greenberg, Stern, Weilburg, 1986)

**Symptoms of Phagophobia**
- Fear and avoidance of swallowing food, fluid, or pills
- Sensation of foreign body in throat
- Throat pressure
- Constriction of throat
- Difficulty initiating the swallow
- Weight loss secondary to decreased oral intake
- Avoidance of eating in public
- Malnutrition
  (Chorpita, Vitali, Barlow, 1997)
Contributing Behavioral Factors
1. Specific choking event (witnessed or experienced)
2. Child temperament style (anxious)
3. Heightened oral sensitivities
4. Negative perceptual frame and self-talk about eating
5. Developmental stage
6. Distorted body image
   (Culbert, Kajander, Kohen, Reaney, 1996)

Contributing Psychosocial Factors
• Force-feeding
• Sexual or physical abuse
• Classically conditioned negative eating associations
• Family eating habits and meal time culture
• Modeling and imitation
• Parental anxiety about child’s food intake
• Dysfunctional family dynamics
• Secondary gain/social reinforcement
   (Culbert, Kajander, Kohen, Reaney, 1996)

Components of an SLP Evaluation
• History
• Clinical Swallow Evaluation
• Instrumental Assessment
  - VFSS vs. FEES

History
• Symptom: duration and description
• Relevant antecedent event or stressors
• Family history of dysphagia
• Weight loss or dietary modification
• Food aversions
• Parental Concerns:
  – Food dropped from diet
  – Weight loss
  – Refusal to eat

Clinical Swallow Examination
• Localization of where bolus feels stuck
• Maneuvers required to move bolus
• Inconsistent symptoms
• Sensation of aspiration
• Related symptoms:
  – odynophagia, globus, nasal regurgitation, ptosis, diplopia, dysarthria, dysphonia, diffuse
    muscle weakness, heartburn (Shapiro, Franko, Gagne, 1997)

Medical Causes for Globus
• Irritation left by foreign body
• Enlarged lingual tonsil
• Postnasal drip
• Vallecular cyst
• Acute tonsillitis
• Pharyngeal atrophy
• Chronic laryngitis
• Contact ulcers
• Elongated uvula
• Tumor
• Pachydermia laryngis
• Epiglottis leaning to one side
• Diverticulum

• Webs
• Esophageal stenosis
• Hiatus hernia
• Cervical osteophyte
• Hypothyroidism
• Anemia
  (Greenberg, Stern, Weilburg, 1988)

Instrumental Assessment
• When is it indicated?
• When is it not indicated?
• Which one to do?
  – VFSS vs. FEES

Diagnosis: Phagophobia
• Normal VFSS or FEES
• Inconsistent CSE findings
• History
  – Relative antecedent event
  – Normal feeding prior to incident

Treatment Goals
• To get the child to eat—Speech
• To address the underlying disorder—Psych (Chatooor, Conley, Dickson, 1988)

Psychology Evaluation
• Psychiatric history
• Current symptoms
• Onset of disorder
• Precipitating and maintaining factors
• Patient’s perception of cause of disorder
• Consequences to the patient’s physical and psychological well-being
• Feelings related to lack of medical findings
  (Shapiro, Franko, Gagne, 1997)

Treatment Strategies in the Literature
• Cognitive-behavioral treatment
• Systemic desensitization
• Education intervention
  – Anatomy and physiology
  – Nutritional counseling
  – Thoughts linked to physiological responses (Culbert, Kajander, Kohen, Reaney, 1996)
• Hypnotherapy
  – Graduated exposure in vivo (Chorpita, Vitali, Barlow, 1997)
  – Relaxation techniques (Kopel & Quinn, 1996)
• Antipanic medications (McNally, 1994)

Treatment Efficacy
• Literature limited to uncontrolled, descriptive case studies

**Examining 5 Case Studies:**
- Contributing Antecedent Event
- Diet Level Onset of Therapy
- Previous Feeding Problems?
- Reported Symptoms of Dysphagia
- Speech Language Evaluation
- VFSS Findings
- Referrals Preceding SLP Treatment
- Speech Language Treatment (from the literature)
- Speech Language Treatment (not from the literature)
  1. Oral motor/swallowing awareness —OM exercises and swallowing/breath hold awareness
  2. Visual biofeedback —visual awareness of feeding skills and bolus control
  3. Food chaining —linking preferred foods to modify flavor, texture to bring non-preferred foods into diet
  4. Food mapping —listing preferred and non-preferred foods
  5. Positive reinforcement

**Case 5 Session Breakdown**
- **Session 1:**
  - History
  - Clinical swallow evaluation
  - Food mapping
  - OM/swallowing awareness/desensitization with preferred food
  - Education and visual biofeedback

  **Homework:** OM awareness exercises with preferred foods, food chaining, visual biofeedback during meals

- **Session 2:**
  - Child arrives with “yellow light” food
  - OM/swallowing awareness/desensitization
  - Visual biofeedback with education
  - Food chaining
  - Positive reinforcement

  **Homework:** OM awareness with preferred foods, food chaining, visual biofeedback during meals, child to try “yellow light” and “red light” foods and provide feedback next session

- **Session 3:**
  - Child to arrive with “red light” foods
  - OM/swallowing awareness
  - Positive reinforcement
  - Food mapping

  **Homework:** Child is discharged with continued visual biofeedback to be used at meals (eventually faded)

**Summary**
- Multiple possible causes of phagophobia
• Multiple symptoms of phagophobia
• Team approach: get the child to eat/address the underlying disorder
• Improvement in the variety of foods eaten and reduction of anxiety related to eating was achieved in all case
• Gains achieved appears to be due to a variety of treatment techniques
• Treatment should be brief (3-4 sessions)

References