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## Panic Disorder with Choking Phobia: A Case Report

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### ABSTRACT

Panic disorder is a form of anxiety disorder characterized by repeated panic attacks and preoccupied with worrying that a panic attack will occur. Panic attacks are characterized by fears of a disaster or loss of self-control even though there is really nothing to worry about. Other symptoms experienced during a panic attack are heart palpitations (similar to a heart attack), shortness of breath, feelings of suffocation, and the body feels weak. If this disorder is not detected early, it will affect the daily life of the patient. This case report presents the case of a 34-year-old woman who experiences symptoms of panic disorder with choking phobia that is managed with antidepressants and cognitive behavior therapy. In addition, there is discussion of differential diagnosis and the role of cognitive behavior therapy in handling this case.

### 1. Introduction

Panic disorder is a form of anxiety disorder characterized by repeated panic attacks and anxiety about panic attacks. Panic attacks are characterized by fears of a disaster or loss of self-control even though there really isn't anything to worry about.<sup>1,2</sup> Other symptoms experienced during a panic attack are heart palpitations (patients complain of symptoms similar to a heart attack), tremors, shortness of breath, feelings of suffocation, and the body feels weak.

Meanwhile, choking phobia is a rare condition and is characterized by severe anxiety and is followed by fear of swallowing solid food, drinks, taking pills / tablets, without any anatomic abnormalities or abnormalities in organ function. Until now, no data related to panic disorder and specifically accompanied by choking phobia have not been obtained in Indonesia. Management of this disorder is very rare and is still in the form of a hypothesis. We report a case of panic disorder accompanied by choking phobia

that has been successfully treated with antidepressants and cognitive behavior therapy.

### 2. Case History

Mrs. X, a 34 year old woman, 4<sup>th</sup> in birth order, a postgraduate student living in a home with her husband and daughters and coming from a good socio-economic background, came to the Mental Health Cattleya Consultation Center, Indonesia with complaints of difficulty swallowing since 2 months ago. Patients came to get a detailed examination and comprehensive management related to this complaint. Exploration of history revealed that patients initially experience heart palpitations, especially after the lecturer gave a very difficult assignment. this situation is getting worse and starts with symptoms of fear of swallowing solid food or pills. The patient has difficulty swallowing and feels like a lump in his throat. She then consulted a cardiologist and an otolaryngologist,

but after a thorough examination no anatomical and physiological abnormalities were found in her. 1 month later during lunch time, the patient feels suffocated after eating Pempek (fish cake) and drinks. She felt a strange symptom in his throat that did not go away after drinking water. The patient then begins to think automatically that she is afraid that he will die after choking and no one will help him immediately. She began experiencing panic attacks marked by severe anxiety followed by palpitations, sweating, difficulty breathing and restlessness with the sensation of being trapped in impending doom.

Her friends took her to the emergency room of nearby hospital in about 5 minutes. By the time they arrived at the hospital, the patient's tension and anxiety were reduced, but the feeling of suffocation was still felt by the patient. Then she requested a detailed examination of her throat and heart. However, the results of laryngoscope examination and electrocardiography showed no abnormalities. Because the patient still feels anxiety, the patient asked to be admitted to the hospital and examined in more detail about her health. During treatment, patients are afraid to eat solid food for fear of being stuck in the throat and causing shortness of breath. Even the patient is only able to eat a little porridge, for fear that the solid portion of the pulp will get stuck in her throat. Because of this concern, the patient was unable to take care of his two children and had to take a temporary leave from college for fear of sudden panic attacks. She was afraid of being left alone at home for fear that she would suddenly choke and no one would help her. She lost about 10 kg in 2 months. She was completely preoccupied with her fear related to swallowing and she did not bother about her lectures 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, and low self-esteem. For these reasons, she initially visited the Otorhinolaryngology department again and after ruling out all organicity (both clinical examination and barium swallow did not reveal any abnormality), she

was referred to psychiatry department for mental assessment. There was no history of any suicidal ideas, 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 episodes could be elicited.

Family history shows a dysfunctional family in which her father used to physically abuse her mother with harsh words. She also said he had seen his father threaten her mother with a sharp knife and that was never told to her brothers. Her mother died 5 years ago and that didn't bother the patient too much. Because the patient feels closer to her brother than her mom or her dad. However, no history of any physical or sexual abuse reported to patients was reported.

On the mental status examination, the patient was alert and oriented, with preoccupation with the fear of panic attacks, and fear of swallowing solid food for fear of being suffocated. There are symptoms of moderate depression that accompany patient complaints. Insight was preserved in example she was sure that her fear was irrational, illogical and caused by psychological disorders and the patient agreed to be treated. A diagnosis of panic disorder with choking phobia was considered. She was started on fluoxetine 20 mg / day and clobazam 5 mg/day. Personality assessment using Millon Clinical Multiaxial Inventory IV (MCMI-IV) shows that the dominant patient's personality is narcissistic, histrionic and turbulent type, which is accompanied by clinical depression, anxiety, tension, insomnia, and fatigue that have no apparent cause. The graphic test with House Tree Person shows that the patient experienced extreme anxiety and had a past psychological trauma. The degree of patient anxiety measured by the Hamilton Anxiety Rating Scale (HARS) is 26 (severe anxiety).

After 2 weeks, the patient's anxiety begins to decrease (HARS Score is 23), but the patient is still worried about eating solid food and swallowing it, and is still afraid when traveling alone. So she still must be accompanied by her husband every time he left. She was then agreed to do cognitive behavior therapy with

her consent. Patients were asked to recognize in what situations patients usually start to feel worried and kept a daily journal. To overcome the phobia choking, Hierarchy of food items made which cause anxiety were charted down with subjective units of distress (SUD) were made. 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 the 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 8 sessions, she developed confidence and started to carry out daily similar sessions at home.

Clobazam was stopped within one week of starting psychotherapy. After a total of 12 therapy sessions, the patient feels minimal anxiety (HARS 14) and begins to dare to eat a variety of solid foods (i.e. rice, fish fillets, meat and bread). Her father was brought into the treatment network and family therapy was planned. In spite of continuing family issues at home, there has been no recurrence of symptoms of choking phobia at 6 months follow-up and subsequently fluoxetine has been stopped.

### **3. Discussion**

Panic attack accompanied by choking phobia or phagophobia is a rare clinical condition.<sup>1</sup> Phagophobia must be distinguished from organic dysphagia before diagnosing it as a psychogenic disorder. This disorder is often misdiagnosed with eating disorder or malingering disorder. However, this disorder can be distinguished from eating disorder, where phagophobia is characterized by the phobic stimulus of swallowing that results in avoidance of food or drinks, and extremely weight loss, social withdrawal, anxiety and depression states in eating disorders, the main psychopathology and there is recurrent preoccupation with losing weight or fear of becoming fat.<sup>2,3</sup> 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 because the sensation of being choked and the fear that food would become lodged in the throat was experienced only during meal time.<sup>4,5</sup>

It has been proposed that choking phobia occurs most commonly secondary to a conditioning experience of being choked by food.<sup>6,7</sup> In this case, swallowing food and drinks becomes conditioned with the fear of being choked after the choking incident which results in food avoidance, panic attacks, panic disorder and weight loss. Panic attacks become a fear conditioning factor and maintain 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 (ie as low as 5 years to as high as 78 years).<sup>7</sup> Comorbidity with other psychiatric disorders such as personality disorders, depression etc. has been reported.<sup>8,9</sup> The index case was also in line with these facts.

In this case, medication was continued throughout the cognitive behavior therapy process as a management of symptoms of depression and anxiety experienced by the patient. The recommended modality for psychotherapy in panic disorder accompanied by choking phobia varies from hypnotherapy, eye movement desensitization and reprocessing (EMDR) and cognitive behavioural therapy. Management protocols consisting of psychoeducation, supportive psychotherapy, cognitive restructuring, and in vivo exposure have resulted in remission of the symptoms of patients in choking phobias.<sup>10</sup> Based on the severity of symptoms and the level of dysfunction in this patient, a combination of psychotherapy (Cognitive Behavior Therapy) and pharmacotherapy is given. Clobazam is given in the recommended therapeutic dose (5-20 mg / day) and the dose is reduced along with the start of cognitive behavioural therapy. Treatment followed in this case was holistic and complete (i.e. psycho-education, cognitive rechallenging and in-vivo exposure in front of

therapists) which ultimately led to complete and sustained remission.<sup>9,10</sup>

#### 4. Conclusion

Panic attacks with choking phobias should be differentiated carefully by clinicians, especially after no organic causes have been found. Appropriate treatment of this disorder will facilitate the total remission of symptoms of patient anxiety.

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