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BEHAVIORAL TREATMENT OF CHOKING PHOBIA IN AN ADOLESCENT: AN EXPERIMENTAL ANALYSIS*

BRUCE F. CHORPITA,* AMY E. VITALI† and DAVID H. BARLOW†

*University of Hawaii, Hawaii, U.S.A.

†Center for Anxiety and Related Disorders at Boston University, U.S.A.

Summary — A multiple baseline approach across foods was used to evaluate an exposure-based treatment for choking phobia in a 13-year-old girl. Following 14 sessions, the patient demonstrated substantially reduced self-reported, observer-rated, and parent-reported anxiety, increased eating rate and bite size, and increased variety of food intake. Clinical diagnoses present at pretreatment were not present at posttreatment at a clinical level. These gains were maintained at a 9-month follow-up assessment. © 1997 Elsevier Science Ltd. All rights reserved

Choking phobia is characterized by the fear and avoidance of swallowing food, fluids, or pills. It is recognized in the DSM-IV as a specific phobia in the residual category (i.e., "other"), along with phobias of vomiting or contracting an illness. Effects of choking phobia can include weight loss, avoidance of eating in public, and malnutrition. McNally (1994) proposed that choking phobia is most often the result of a direct conditioning experience (e.g., choking on food or pills). The prevalence of choking phobia is as yet unknown (McNally, 1994).

No controlled trials have been conducted to evaluate treatments for choking phobia. However, a variety of case studies offers preliminary support for a diversity of treatment approaches (for a review, see McNally, 1994). Although pharmacotherapy has been used (e.g., Kaplan, 1987), evaluations of patients with choking phobia have more commonly involved psychosocial treatments. For example, Ball & Otto (1994) used a treatment protocol consisting of psychoeducation, cognitive restructuring, aversion/distraction (i.e., pinching one's hand while chewing food) and in vivo exposure. The authors reported positive gains in all three patients following 11 to 13 sessions, and reported positive follow-up observations (2 months and 3 months) for two of the three patients. Unfortunately, with the exception of weight gain, no quantitative or diagnostic data were presented to describe patient status at pretreatment, posttreatment, or follow-up.

The most common evaluations of treatment for choking phobia have consisted exclusively of in vivo exposure (e.g., Kaplan & Evans, 1978; Lukach & Bruce, 1988). For example, McNally (1986) used in vivo exposure to treat choking phobia in a 30-year-old male and reported good outcome following 6 sessions. In this case, scores on a number of self-report measures of fear

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Requests for reprints should be addressed to Bruce F. Chorpita, Department of Psychology, University of Hawaii, 2430 Campus Road, Honolulu, HI 96822, U.S.A. Tel.: (808) 956-3607; Fax: (808) 956-4700; E-mail: chorpita@hawaii.edu.

and anxiety evidenced a noticeable decline at posttreatment and 6-month follow-up. In general, the collective literature on the treatment of choking phobia is characterized by uncontrolled and qualitative case studies, and specifically, the evidence for the efficacy of such treatments in children and adolescents is relatively lacking. To address this issue, we evaluated an exposure-based treatment of choking phobia in an adolescent girl. The design represented an improvement over previous psychosocial treatment studies in that it involved a multiple baseline to allow for controlled tracking of treatment effects. Moreover, posttreatment and follow-up data incorporated self-report and parent-report questionnaires, independent diagnostic assessments, and behavior tests.

Method

Patient Description

The patient was a 13-year old girl with extreme difficulty eating solid foods for fear that she would choke and die. She stated that at the age of five, she choked on food and needed the assistance of her father to clear her throat to allow breathing. According to the parents, she had been a slow and cautious eater since that time, although her difficulties did not create substantial distress or impairment until adolescence. Over the six months prior to assessment, she had a pronounced increase in her fear of choking. At that time, she was unable to eat most solid foods or drink beverages with ice. Moreover, she reported that she was embarrassed about her dietary restrictions and was unable to enjoy common social activities involving food. In addition, she reported checking her mouth in the mirror frequently to look for food and chewing excessively while eating even the limited soft foods that remained in her diet (e.g., yogurt, ice cream). Associated symptoms included clamminess, tachycardia, constriction in the throat, chest pain, smothering sensations, paresthesias, and dizziness. In addition to these specific symptoms, the patient reported that she felt generally anxious and dysphoric much of the time because of her impaired ability to eat. She was tearful often during the day, and stated that the principal focus of her distress was her fear of choking. Despite these difficulties, she maintained her normal weight through a high intake of ice cream, yogurt and fruit drinks. In addition to the problems with food, the patient also reported frequent panic attacks during which she experienced such symptoms as palpitations, tachycardia, sweating, dyspnea, choking, paresthesias, and fear of dying. Although these panic attacks had initially been cued by eating and the associated fear of choking, these attacks eventually became uncued and unexpected, and occurred in the absence of thoughts or stimuli related to eating. At the time of intake and throughout treatment and follow-up, the patient was not on any medication.

Diagnostic assessment. At pretreatment, posttreatment, and follow-up, the patient was assessed by an independent evaluator using the Anxiety Disorders Interview Schedule for DSM-IV, Child and Parent Versions (ADIS-C/P; Silverman & Albano, 1994), a structured clinical interview for children and parents designed for diagnosis of childhood anxiety, mood, and other disorders. This interview is a revision of the ADIS-C/P for DSM-III-R (Silverman & Nelles, 1988), which has been shown to possess satisfactory reliability across a range of parameters and ages (Silverman & Eisen, 1992). Although reliability data are not yet available, the new version most likely represents an improvement in reliability, in that general revisions to the DSM diagnostic criteria were intended to provide more reliably identifiable features.

Clinicians also rated the severity of the disorders on a 9-point scale (Clinical Severity