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Case Report

Role of a Speech Therapist in the Assessment and Management of Psychogenic Dysphagia: A Case Report

B.S Premalatha[1], Sneha Mareen Varghese[2], Revathi Gundelli[2]

[1]Professor & Head of Dept., [2]Lecturer,
Department of Speech Language Studies,
Dr. S. R. Chandrasekhar Institute of Speech and Hearing, Bangalore, India.

Corresponding Author: Sneha Mareen Varghese

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ABSTRACT

Psychogenic dysphagia is a rare condition encountered by speech therapists in a clinical set up. The present case report focuses on the sequences of evaluation carried out to establish a label of 'psychogenic dysphagia' and thereby the management. A comprehensive assessment included case history taking, inspection of oral structure and function, physical observations during the swallow. Evaluation revealed no evidence of neurogenic or mechanical dysphagia and was suggestive of stress related swallowing difficulty. After three sessions of counselling and clinical reassurance, significant improvement was reported. Thus, we conclude that an individual of suspected psychogenic dysphagia should be handled with caution where the speech therapists should strictly follow a diagnosis by exclusion and focus on counselling

Keywords: Psychogenic dysphagia, Speech therapists, Diagnosis by exclusion, Counselling

INTRODUCTION

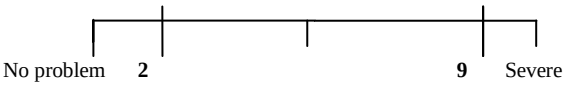
Dysphagia is a medical term that describes a swallowing disorder. It is a symptom of a disease, & therefore is described most often by its clinical characteristics. Dysphagia is defined as the disorders movement of bolus from mouth to stomach due to abnormalities in the structures critical to swallowing or its function. [1] Three types of dysphagia such as neurogenic, mechanical and psychogenic have been reported. Neurogenic dysphagia is the associated with a neurological disorder like stroke whereas mechanical dysphagia is a loss of sensory guidance of the structures necessary to complete a normal swallow. The third type of dysphagia which is of a psychogenic origin is a rare clinical condition. Patients with psychogenic dysphagia presents with no structural or organic cause.

Little information is available regarding psychogenic dysphagia, [2] and its assessment and management by a speech therapist (ST). Fear of swallowing or phagophobia is a type of psychogenic dysphagia which is reported in the literature. [3] It is characterized by fear and avoidance of swallowing food, fluids or pills. The clinicians noted considerable improvement in dysphagia after behavioral therapy. Yet another study addressed the reevaluation of

patients previously diagnosed with psychogenic dysphagia. [4] Among the 23 patients, it was concluded that 65% of the patients were misdiagnosed as having dysphagia due to a psychogenic cause. It is evident from the studies that psychogenic dysphagia is an uncommon condition encountered by the speech therapists and should be cautious while giving a diagnosis. Thus, the present case report highlights the role of swallowing therapist in the identification and management of an individual with psychogenic dysphagia.

CASE REPORT

Mr, X was a 40 year old male who came to us with the concern of swallowing difficulty with solids and liquid since three months. Evaluation by an otolaryngologist revealed normal appearance of valleculae, Pyriform Fossa, Posterior Cricoid and Vocal Folds. Mr. X has been working as a medical transcriptionist where he has to meet targets and is paid low. He reported that the difficulty started three months ago, due to work related fatigue and had swallowing difficulty intermittently. He also reported that the swallowing difficulty subsided while he stopped working. He felt that the problem would relapse if he overworks. He is on a normal diet and reports choking at times. Preferred food consistency is solid. No abnormal and significant weight loss was reported post swallowing difficulty. Self-rating of swallowing difficulty is represented on a visual analog scale. He reported a severity of swallowing difficulty as '9' while he was at work and a severity of '2' when he is not at work.



A detailed assessment was carried using informal and formal test procedures.

Oral Peripheral Mechanism Examination (OPME): Oral peripheral mechanism examination assesses the structural and functional integrity of articulators involved in speech production. A thorough examination of the oral cavity including range, symmetry and strength of the articulators like lip, jaw, tongue and velum was performed. All the articulators are structurally and functionally normal. Findings are given in Table 1.

	Range		*Symmetry*		*Strength*	
	Normal	Abnormal	Normal	Abnormal	Normal	Abnormal
Lip	X		X		X	
Jaw	X		X		X	
Tongue	X		X		X	
Velum	X		X		X	

FUNCTIONS ASSESSED		*RESULTS*
Trigeminal Nerve (CN V)	Jaw Mobility, strength, range open/close against resistance, Exaggerated chewing	Normal
Facial Nerve (CN VII)	Lip retraction, Protrusion, Pursing, Raising Eyebrows	Normal
Glossopharyngeal ((CN IX)	Gag reflex, Feeling of sensation at the posterior part of tongue, faucial arches and Tonsils	Normal
Vagus Nerve (CN X)	Cough strength, Cough Quality (Wet or Dry), Voice on sustained phonation, variation in pitch	Normal
Hypoglossal Nerve (CN XII)	Tongue Mobility, Strength- Protrusion/ Lateralization against resistance	Normal

Cranial Nerve Assessment: Cranial nerves V, VII, IX, X and XII are most critical to deglutition. [5] Mr. X was asked to perform certain tasks to assess the cranial nerve functioning. He exhibited no difficulty in carrying out the tasks ruling out cranial nerves involvement. Findings are represented in Table 2.

Clinical Swallowing Evaluation (CSE): CSE is the most important step in the identification of dysphagia. [5] Mr. X was asked to take different food consistencies such as liquids (water) from a glass and followed by solids (biscuits) to evaluate swallowing function. He did not exhibit no aspiration before, during and after swallowing. Observations are given in Table 3 below.

Observations	Results
Pocketing Leakage Poor bolus formation Slow transport Swallow delay	Normal chewing and mastication and bolus preparation, tongue peristalsis and bolus propulsion
Coughing Throat clearing Wet, gurgly voice Choking Watery eyes Nasal regurgitation	Normal swallowing reflex elicited and normal cricopharyngeal sphincter function

Four Finger Test: Laryngeal elevation was assessed by placing fingers in the neck region.[6] The elevation was strong and a timely rise of approximately one fingers width was elicited.

Swallowing Rating Scale: On a 6 point rating scale, Mr. X was rated as 6 indicative of no difficulty with solid foods

Chewing Rating Scale: On a 5 point rating scale of chewing assessment, X was rated as 5, indicating no difficulty for solid food

After the evaluation by a speech therapist (ST), Mr. X was referred to a gastroenterologist to rule out the occurrence of esophageal dysphagia. Investigation using gastroduodenoscopy revealed normal esophageal functioning. Results of ST evaluation and other medical professional evaluations revealed no evidence of neurogenic or mechanical dysphagia. Swallowing difficulties reported was suggestive of stress related problem. All these findings when put together, Mr X was diagnosed with psychogenic dysphagia.

Management of Mr X involved reassurance and avoidance of precipitating factors. Mr X was explained the normal phases of swallowing and the least probability of neurogenic or mechanical dysphagia. He was counselled to modify his environment which leads to symptom production and also to have a positive approach towards life. He attended three hours of sessions of intensive counselling after which he complained of no difficulty in swallowing. He gave a rating of '0' indicating of no swallowing difficulty at the end of therapy. However, he was asked for a follow up once in every month to monitor the status of swallowing.

DISCUSSION

Psychogenic dysphagia is a rare clinical condition and has to be handled by ST with utmost care. Diagnosis by exclusion is warranted in cases of psychogenic dysphagia which includes a thorough case history, OPME, cranial nerve assessment and CSE. Taking a careful case history is vital as it not only determines the line of assessment but also gives help us in distinguishing the possible site and type of dysphagia. Fear of swallowing, difficulties in swallowing specific consistencies, problems in initiating the pharyngeal swallow and globus sensation are some of the symptoms reported by patients with psychogenic dysphagia. Speech therapists should focus on questions that would help them in identifying the stage of dysphagia that is abnormal. When performing an assessment to differentially diagnose psychogenic dysphagia from the other types of dysphagia, it is important to assess the structure and function of the oral structures.

Structures when examined at rest may provide indications to the physiologic or neurogenic problems, such as flaccidity. Likewise, observations during movement yields information regarding the speed, range, strength and symmetry which is essential for a normal swallow and normal cranial nerve functioning. A cranial nerve assessment helps the speech therapist in understanding upper/ lower motor neuron involvement if any. Status of hypoglossal nerve which is very important for the first three stages of swallowing should be examined carefully. CSE should be the main focus of assessment as it helps the speech therapists in integrating information from the case history and other evaluations by actual swallows. During this evaluation, a speech therapist should be able to rule out the probability of an organic or functional dysphagia. The clinical diagnosis of psychogenic dysphagia should be given only after the investigations by a gastroenterologist (GE). [7] Literature reported esophageal dysmotility in patients who were misdiagnosed as having psychogenic dysphagia as they did not have obvious symptoms. [4] After the ST and GE evaluations, a ST should exclude the possibility of a neurogenic or mechanical dysphagia to confirm the diagnosis of psychogenic dysphagia.

The main focus in the management of individuals with psychogenic dysphagia is counselling as they have underlying psychiatric symptoms, related to anxiety and depression. Psychoeducation and cognitive restructuring [7,8] are found to be beneficial while treating them.

CONCLUSION

The study aimed to create awareness among the speech therapists regarding the assessment and management of patients diagnosed with psychogenic dysphagia. This single case report focused on the identification of psychogenic dysphagia using diagnosis by exclusion and also the management that were used for this patient. In summary, case history, OPME, cranial nerve examination, CSE and report from a gastroenterologist regarding the status of esophagus are essential to establish a diagnosis of psychogenic dysphagia. Management should include a combination of counselling and behavior modification.

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