EMDR With Choking Phobia: Reflections on the 2008 Study by de Roos and de Jongh

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"Translating Research Into Practice" is a regular journal feature in which clinicians share clinical case examples that support, elaborate, or illustrate the results of a specific research study. Each column begins with the abstract of that study, followed by the clinician's description of their own application of standard eye movement desensitization and reprocessing (EMDR) procedures with the population or problem treated in the study. The column is edited by the EMDR Research Foundation with the goal of providing a link between research and practice and making research findings relevant in therapists' day-to-day practices. In this issue's column, Keith J. Myers references de Roos and de Jongh's study, which investigated EMDR treatment of choking phobias. Illustrating the treatment considerations and treatment results reported by de Roos and de Jongh, Myers describes the successful treatment of an adult client who presents with choking phobia and secondary depression using the EMDR protocol for phobias. The case example is followed with a discussion of specific treatment considerations in the addressing phobias within the eight phases of EMDR therapy.

Keywords: EMDR; specific phobias; choking phobia; depression; trauma; bridging research and practice

Abstract by de Roos and de Jongh (2008)[1]

Given the limited number of reported cases in literature, it might be concluded that it is rare to develop a choking phobia in childhood. However, it appears as though confusion in terminology and the time lapse between the onset of the disorder and treatment often results in the diagnosis being missed. In this article, we discuss a review of the clinical symptoms, differential diagnosis, comorbidity, etiology, and treatment options for choking phobia. We present a case series, describing the successful EMDR treatment of choking phobia for 4 children and adolescents, with positive outcomes achieved in 1 or 2 sessions. In addition, a detailed transcript is presented of a 15-year-old girl with a choking phobia related to an incident that occurred 5 years previously. The rapid elimination of symptoms in all 4 cases indicates that EMDR can be an effective treatment for choking phobias resulting from previous disturbing events. Randomized research on this promising intervention is strongly suggested.

When "Gary" arrived at my office for our intake session, he presented with several issues that included significant weight loss, avoidance of eating solid foods, and anxiety associated with eating in front of others. My initial thoughts were to screen for a possible eating disorder. As we progressed through the session, however, it became more evident that a phobia may be the source of his disturbance. During the initial history taking, he described his fear of choking at various times in his life. This fear would normally be followed by 3–7 days of food avoidance, particularly solid food. Gary explained that even though this phobia of choking had occurred at different times of his life, it had not significantly impacted his life more than a few days at a time. This was true until a little over a year ago when it became more severe, and his avoidance of food persisted for almost a month. He lost almost 20 lb within a month. His social functioning and work relationships were also impacted. He experienced significant anxiety and physiological sensations in his throat each

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time he ate with a colleague or when socializing at dinner with friends. Furthermore, when this anxiety would be activated by the sight of eating solid food or even thinking of eating food, he reported that it felt like his "throat was closing."

A couple of years ago, I began reading articles on eye movement desensitization and reprocessing (EMDR) for the treatment of phobias and was intrigued, although at the time the research was scarce. De Roos and de Jongh stated that there were only three case studies that examined the treatment of choking phobia with EMDR prior to their case series of four children and adolescents (Lovett, 1999; Schurmans, 2007). Since their article in 2008, studies of EMDR therapy with other phobias have been published. A randomized clinical trial now exists on the use of EMDR with dental phobia (Doering, Ohlmeier, de Jongh, Hofmann, & Bisping, 2013). Also, a nonrandomized clinical trial comparing EMDR treatment to trauma-focused cognitive behavioral therapy (TF-CBT) was published (de Jongh, Holmshaw, Carswell, & van Wijk, 2011). When I started seeing Gary, I conducted another search of the literature and was pleased to find the aforementioned studies added to the research since my original inquiry 2 years ago. Hope emerged that I could help Gary.

EMDR Protocol and Treatment for Phobia

Although de Roos and de Jongh's 2008 article focused on successful use of EMDR with youth, it provided a wealth of information about choking or swallowing phobia applicable to clients of all ages. The authors pointed out that the time lapse between the precipitating event leading to the phobia and treatment can range from 2 to 45 years, with the average time of 12 years. Their discussion of differential diagnosis and etiology validated my case conceptualization: Gary suffered from a choking phobia originating from an unprocessed childhood experience over 25 years prior to entering treatment. The article provided in-depth discussion of the reprocessing phases in treatment of phobias with EMDR therapy, naming six phobia-specific steps to be used within the reprocessing phases (Phases 3–6) of the eight phases. These six steps included the following: (a) Desensitize the first memory of the fearful response; (b) desensitize the most painful relevant memory; (c) desensitize the most recent experience of the phobia; (d) develop a positive template for future action in which the client anticipates successful coping in the future, with eye movements until an adaptive, positive belief feels completely true; (e) play a "video" of the situation in his or her mind, paired with the positive belief and eye movements; and (f) ensure successful coping with in vivo exposure and behavioral experiments.

Shapiro described additional steps that were not discussed in the 2008 study (Shapiro, 2001). This included teaching the client self-control procedures in Phase 2 and in the reprocessing phases, targeting antecedent events, present stimuli, and the physical sensations/manifestations of fear. The phobia protocol described by Shapiro (2001) and referenced in the 2008 study included the use of the following six steps:

1. Teach self-control procedures to handle the fear of fear.
2. Target and reprocess the following:
   a. Antecedent events that contribute to the phobia
   b. The first time the fear was experienced
   c. The most disturbing experiences
   d. The most recent time it was experienced
   e. Any associated present stimuli
   f. The physical sensations or other manifestations of fear, including hyperventilation
3. Incorporate a positive template for fear-future action.
4. Arrange contract for action.
5. Run mental videotape of full sequence and reprocess disturbance.
6. Complete reprocessing of targets revealed between sessions. (pp. 204–206)

Based on Shapiro's text and the 2008 study, these additional steps of the phobia protocol were integrated into the eight phases of treatment for Gary. That integration is outlined in the following sections of this article.

Phase 1: History Taking

I conducted a full history with Gary, including positive and negative memories as well as disturbing memories associated with the choking phobia. To identify potential targets for reprocessing, I implemented the "float back" technique; I asked him to bring to mind a recent experience of the phobia, notice the disturbing image, thoughts ("I'm going to die"), feelings (fear), and sensations (throat closing/choking), and float back to an earlier time when he felt similarly (Browning, 2009; De Jongh & ten Broeke, 2007; Shapiro, 2001). Gary described a traumatic experience when he was 5 years old that predated the actual phobia of choking. He said that he choked on a piece of meat, turned "blue" in the face, and was terrified he was going to die. It required his mother to assist him in dislodging the piece of meat. This was one of his earliest memories and was considered to be the antecedent event of the phobia.

As recommended by Shapiro (2001) this memory was selected to be targeted first during the reprocessing phases of treatment. His worst memory associated with the phobia occurred a few months before coming to treatment while he was eating with a colleague and experienced severe anxiety and avoidance when eating solid food. He explained that after this worst incident he experienced the longest period of avoiding solid foods. This was when he began to lose weight. His most recent memory was a few weeks prior to beginning therapy when he experienced the fear of choking when he was eating by himself. Other triggers associated with the phobia included driving alone in the car, eating food with his wife, and eating dinner with friends in a social setting.

De Roos and de Jongh reported that in 80% of children with a choking phobia, the presence of at least one other psychological disorder is evident. It was revealed during history and treatment planning that Gary experienced depressive symptoms. Therefore, I administered a Beck Depression Inventory-II (BDI-II), and his raw score indicated a moderate level of depression (Beck, Steer, & Brown, 1996). Because of the indication of depression, I extended the history-taking phase for an additional session in order to further assess depressive symptoms. He reported that at various times of his life he exhibited depressive symptoms for more than 2 weeks at a time. He was never hospitalized or treated for depression. A total of three history-taking sessions concluded this phase of treatment.

Phase 2: Preparation

In Phase 2, preparation, the focus of our work included continuing to establish the therapeutic relationship, educating Gary about EMDR therapy mechanics and procedures, obtaining informed consent for EMDR reprocessing phases, and preparing him for EMDR processing. With the recognition that Gary's phobia seemed to stem from earlier, unprocessed experiences and with evidence that such phobias can be treated with EMDR therapy, I talked with Gary about his treatment options. After describing EMDR therapy, I explained the possible risks (i.e., limited research available; his symptoms could worsen) and benefits (i.e., brevity of therapy) of using EMDR as a possible treatment for his issue. I stated that based on my literature review, exposure therapy had more research support for treatment of adults with specific phobias (Choy, Fyer & Lipsitz, 2007; Wolitzky-Taylor, Horowitz, Powers & Telch, 2008); however, with choking phobia in adults, there is less research with most of the research coming from just a very few case studies (McNally, 1994). I also explained that he was free to choose those other options, and I could provide him with some referrals for exposure-trained therapists. With all of those considerations, Gary chose EMDR therapy.

I turned our focus to self-control techniques per the recommendation of Shapiro (2001). This included progressive muscle relaxation before encountering the stimuli (i.e., eating solid food), mindfulness while experiencing the stimuli, and the use of safe-place imagery in order to reduce anxiety. Gary reported a significant reduction of anxiety when encountering the stimuli following this preparation session. We spent a total of two sessions on the preparation phase, and the client reported these techniques to be helpful in reducing anxiety between sessions.

Reprocessing Phases 3–6: Assessment, Desensitization, Installation, and Body Scan of Earliest, Worst, and Recent Memories

As we began the assessment of the antecedent memory or earliest trauma (i.e., choking on meat at age 5 years), Gary had difficulty identifying a particular image. However, he reported that the worst part of the memory for him was the sensation in his throat. Subjective units of distress (SUDs) were stated as 10/10. The primary negative cognition (NC) associated with the phobic memories was "I am going to die!" The positive cognition (PC) was a little difficult for him to identify in the beginning. With some additional questioning in different ways, he identified the following PC: "I am brave, and I can handle it." The validity of cognition (VOC) was 3/7; with 1 feeling completely false and 7 feeling completely true. Emotions were explained as fear, anxiety, and helplessness. Sensations were identified as feeling a "lump" in the throat, restricting of the throat, mild nausea, shallow breathing, and tingling in the fingers.

We began Phase 4, desensitization, of this earliest trauma (i.e., the antecedent event). After several sets of eye movements, his negative self-appraisal started to shift from "I'm going to die!" to "I'm stupid," a belief that he later recognized was contributing to his depressive symptoms. After several sets of eye movements, he began to process adaptively and gain new insights ("I am safe now"). His SUDs were reduced from 5/10 to 0/10 within the single session. Initiating Phase 5, installation, his PC remained, "I am brave, and I can handle it," and he rated his VOC scale to be 6/7. After two sets of eye movements, he stated his VOC scale to be 7/7, completing Phase 5. He reported

no residual physiological sensations remaining during the body scan (Phase 6).

For the worst memory associated with the choking phobia, the reprocessing (Phases 3–6) required three sessions to complete. This worst phobic event occurred a few months before coming to treatment when he was eating with a colleague and experienced severe anxiety and avoidance of eating. He stated that simply thinking about this memory caused his anxiety to rise and his throat to tighten. The image that represented the worst part of this memory included his colleague's face staring at him in horror. His NC was "I'm going to die." His PC was "I am brave, and I can handle it." His VOC was 2/7. His emotions included feelings of anxiety, fear, "feeling stupid," and helplessness, and he reported the memory was an SUD of 10/10. Sensations included tightness in his throat, mild chest pain, and tingling in his hands and fingers.

During Phase 4, desensitization, Gary experienced significant physiological arousal in his throat, chest, and stomach areas. He later described this reprocessing session as hard and exhausting. He seemed to loop during his reprocessing, leading me to use cognitive interweave (CI) interventions and frequent returns to target. This ensured dual awareness and facilitated the linking of adaptive positive memory networks with the original memory. For example, one CI that seemed to be helpful was "What sensations are you noticing in your body now?" This seemed to help Gary observe his current physiological state instead of being absorbed in the memories of the past choking sensations. This session was closed as an incompletely processed memory because of time constraints. Following proper Phase 7 closure procedures, I guided him in the safe-place imagery activity in order to reduce his anxiety and physiological disturbance before he exited this session.

At the next session, he reported experiencing new insights between sessions: "I realized that I have handled other difficult things in my life that were scary. I was brave other times." He reported that his SUDs were now reduced to 7/10 from the original 10/10. We resumed reprocessing of the worst memory. During the continued Phase 4 reprocessing, he reported physiological disturbance, although less than in the first session. I used one CI and two instances of returning to target during this session. The reprocessing seemed to have more of a chronological flow to it this time. Again, we closed the session with an incomplete target after he reported his SUDs were 3/10.

During reevaluation (Phase 8) at the beginning of the next session, Gary reported no new insights or observations between sessions. When asked to bring the worst memory to mind (choking at a meal with a colleague), he reported his level of disturbance to be at 5/10. We resumed the Phase 4 reprocessing, and the memory reprocessed without looping or blockages, requiring no additional cognitive interventions by me. He cited times when he was brave and also recognized, "Just because it was scary didn't mean I was going to die. I have never died from this fear." He proudly said, "I have been brave through all of this." At the end of this third reprocessing session, his SUDs were 1/10. He reported that he was not sure this memory would ever be "neutral" (i.e., 0/10) until all of his symptoms ceased to exist. Determining that this 1 SUD was ecologically valid, I moved from Phase 4, desensitization, to Phase 5, installation. The PC continued to be "I am brave, and I can handle it," and he reported his VOC to be 5/7. We installed the PC over three sets of eye movements, and the positive belief became "completely true" with a VOC of 7/7. During the body scan (Phase 6), he reported some lingering "tingling" in his throat. After four sets of eye movements pairing the PC with the body sensation, the tingling ceased. He reported no other residual physiological symptoms.

The most recent phobic memory involved Gary eating alone a few months before entering treatment. As outlined in our original treatment plan, we completed the Phase 3, assessment. He reported the negative cognition "I'm going to die!" The PC was "I am brave, and I can handle it." His VOC was 2/7. His emotions included anxiety and helplessness, and the SUDs were 5/10, noting that he found this recent experience less disturbing since we reprocessed the other memories. His sensations included tingling in his hands and fingers and the same sensation in his throat. We began to reprocess this most recent memory. The reprocessing went quite smoothly, and by the end of the session, Gary reported the SUDs reduced to 0/10, the VOC was 7/7, and no physiological symptoms were present during body scan.

Phases 7–8: Closure and Reevaluation

There were times in closure (Phase 7) when we ended the sessions with an incompletely processed target memory because of time constraints. When that happened, I would facilitate safe place or another self-control activity with Gary to shift his emotional state and thereby reduce his anxiety before leaving the session. The reevaluation phase (Phase 8) went as planned without any surprises. At each session, I evaluated his symptoms and progress, checked the work from the prior session, and continued the treatment plan.

Phase 8: Reevaluation—Behavioral Symptoms Improved

In 2 weeks, I met with Gary again. He reported that he had started to eat most solid foods with no symptoms of anxiety in most situations. However, he continued to have some mild anxiety associated with the thought of eating meat (i.e., chicken or steak), even though he no longer actually avoided eating meat. He reported that after the previous session of reprocessing, he began to regain the weight that he had lost during the most severe period of phobic avoidance of eating. He no longer experienced anxiety when eating with colleagues or eating alone. He denied any physiological symptoms in his throat over the past 2 weeks. I conducted a midterm BDI-II, and his raw score had decreased to indicate a mild level of depression.

Reprocessing of Triggers Using Phases 3–6

After we finished reprocessing the memories, we reprocessed the present triggers (i.e., the associated stimuli of the phobia). Most of these included the following: (a) eating alone, (b) eating with colleagues, (c) driving alone, and (d) eating meat. Reflecting on the 2008 study by de Roos and de Jongh, I used some of these triggers as the basis for mental videotapes to be used in the future templates. All but one of the present triggers were reprocessed in a single session. Gary experienced the most anxiety during a session when we reprocessed the thought of eating meat. This residual anxiety may have been related to his touchstone memory when he choked on a piece of steak at age 5 years. This trigger required an entire session of reprocessing. At the end of this session, his SUDs reduced to 1/10. He explained that this trigger would never be neutral because a throat doctor once told him that meat has the texture to increase the risk of choking. I wondered if this information might hinder his recovery in the future, but for now, it seemed somewhat ecologically valid.

Future Templates and Further Reevaluation (Phase 8)

The article provided some helpful instructions with examples of future templates (i.e., mental videotapes). During the sessions, Gary was asked to run a mental videotape of the future—handling a difficult situation well. For the first future template, I had him run the mental videotape of being presented with a large steak while having dinner with his professional colleagues. I chose this scenario first because when he began therapy this social situation produced the highest level of anxiety and was the most difficult trigger. For Gary, the first challenging part of the videotape was eating with colleagues in a social situation. The next difficult part in the tape was seeing the image of the steak. Then the tape included him seeing himself experience the physiological sensation in his throat. Each disturbing aspect of the imagined experience was processed as a distinct target, with Gary focusing on the noted tension and the PC ("I can handle it") and my adding sets of eye movements until the disturbance resolved. The remaining future-focused targets included triggers and other common situations (i.e., driving alone in the car) that provoked anxiety for him in the past. The future template section of treatment required four sessions, which concluded our EMDR therapy.

Gary asked to continue counseling for ongoing existential support in other issues of his life, and I agreed to keep seeing him. Once the treatment was nearing completion, I conducted another reevaluation (Phase 8) of the choking phobia. He reported that rarely he would experience mild anxiety when eating a piece of steak but added that he was satisfied with this outcome because all of his other behavioral symptoms had ceased. We conducted two more sessions to reprocess this as a current trigger, and his anxiety was eliminated. Our EMDR treatment consisted of 16 sessions.

In their treatment of youth with choking phobias, de Roos and de Jongh found that not only was there a resolution of the complaints related to swallowing and eating, but the secondary consequences of the phobia—including fatigue and sadness—diminished as well. Gary experienced a similar reduction in his depression symptoms. At the conclusion of the therapy, another BDI-II was administered. His raw score measuring depressive symptoms remained at the mild level it had been after reprocessing the first, worst, and most recent memories.

Discussion

As I reflected on the 2008 study by de Roos and de Jongh within the context of my clinical work with Gary, a few significant aspects emerged. All four of their cases (three children and one adolescent) required only two EMDR reprocessing sessions to resolve the choking phobia following the initial intake session(s), whereas my client required many more sessions. My client's presentation was more complex, in part because of the need for additional sessions to rule out an eating disorder and measure for the comorbidity of depression, and also because of the time since the original traumatic event (25 years) and the

powerful second-order conditioning of his phobic experiences. Consequently, with the same diagnosis, we can expect that an adult client with a childhood antecedent event would possess more past, present, and future targets than a child.

Initially, I thought the presenting problem could be an eating disorder, prompting me to conduct a more thorough evaluation to rule out the possibility of anorexia. I determined that the avoidance of eating solid foods could be traced back to a traumatic event by using the float back technique. From the float back, it was clear that a traumatic experience at age 5 years of choking on meat included the physiological sensation, beliefs, and emotions that formed the basis for the development of a phobia. I found no other history of disordered eating or body image issues and concluded that Gary was suffering from a choking phobia. Once the phobia was identified, additional history-taking sessions were needed to evaluate the significance of his depressive symptoms. I administered the BDI-II. The length of the untreated phobia and complex nature of Gary's presentation contributed to the reality that my treatment consisted of a total of 16 sessions—far more than necessary for de Roos and de Jongh's young clients.

Consistent with the three-pronged approach of EMDR therapy and because avoidance is so integral to the continuation and maintenance of phobias, I followed the authors' targeting recommendations and gave thorough attention to processing of the present triggers as well as potential fear-inducing future situations. This included the running of a mental video of current triggers in the future while focusing on each disturbing component (i.e., image, emotion, physiological sensation, etc.). The article's clear guidance for implementing future templates assisted in the comprehensive treatment of choking phobia with EMDR therapy. The study definitely provided me with a clearer direction when treating such a rare clinical problem. Without these reflections, I would not have been properly equipped in helping Gary significantly improve his quality of life.

A limitation of this case review is that no formal outcome measures were given to measure his phobia symptoms. Only SUDs were given to measure his disturbance level and anxiety with regards to the stimuli. However, it seems evident that significant change occurred because of the improvement of his severe behavioral symptoms. Additionally, only one measure was given to examine depressive symptoms (i.e., BDI-II). Furthermore, because depression was not originally presented as a significant issue and was only later assessed, limited conclusions can be made regarding the efficacy of EMDR for depression. As reported in 2013 by Wood and Ricketts, although EMDR studies treating PTSD have usually found that EMDR significantly reduces depression along with PTSD symptoms, it is unknown whether the EMDR therapy is responsible for the reduction in depression or if the improvement is only a byproduct of the reduction in PTSD (Wood & Ricketts, 2013). Additional research is needed exploring EMDR as a viable treatment for depression.

As de Roos and de Jongh concluded in their 2008 case series, although this case provides hope for EMDR treatment and its possible efficacy for choking phobia, additional rigorous research is needed before definite conclusions are made. Randomized controlled studies would be helpful when measuring the efficacy of EMDR for treatment of choking phobia. Even though limitations exist in drawing definite conclusions, this case example could prove beneficial for the treatment of choking phobia given the scarcity of research available on treatment for this debilitating issue.

Note

1. De Roos, C., & de Jongh, A. (2008). EMDR treatment of children and adolescents with a choking phobia. *Journal of EMDR Practice and Research*, *2*(3), 201–211. http://dx.doi.org/10.1891/1933-3196.2.3.201

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