

EFFICACY OF EMDR: CASE STUDY OF A CHILD WITH CHOKING PHOBIA - CASE REPORT

Ivana Kokanović¹ & Ian Barron²

¹Gymnasium Vaso Pelagić, Brčko, Brčko District of Bosnia and Hercegovina

²Trauma Response Network and International Centre for Child Trauma Prevention and Recovery,
University of Dundee, Nethergate, Dundee, Scotland, UK

* * * * *

INTRODUCTION

Certain dysfunctional behaviors at early ages are normal phenomena in childhood and mild and moderate fears are part of normal development. Typically, at age 7-8 months children first become anxious when separated from their mothers or when facing strangers. Later, children (aged two to four) become fearful of animals and social situations. Usually, these fears are transitory and can be regarded as adaptive and protective responses. Changes in the nature of childhood fears are related to cognitive development and their perception of their physical and social environment (Emmelkamp & Wittchen 2009).

Adverse childhood experiences, when they occur can cause considerable anxiety. Fear, indeed terror caused by a traumatic incident for some children tends not to resolve with development alone (Muris et al. 2002, Fleming 2012). Such a trauma response can have long term consequences into adulthood (Trickey & Black 2000). Sometimes an everyday activity such as eating can become a terrifying moment when a child chokes on food or an object (de Roos & de Jongh 2008). Choking phobia's usually develop within the first 10 years of life.

Recent studies found that phobias are common among four to six-year-olds (71%), peak between the ages of seven to nine (87%), and then decline with 10 to 12 years old (68%) (Merckelbach & Muris 2001). According to de Roos and de Jongh, individuals wait from two to 45 years to get the appropriate treatment for their problems (Roos & Jongh 2008). On the other hand, others seek help for years until they can get a diagnosis. It is estimated that 50% of patients do not receive an accurate diagnosis and only half of diagnosed patients receive adequate treatment. Around 25% of patients receive adequate treatment for a diagnosed psychological conditions (Overbeek, Vermetten & Griez 2001).

Choking phobia is categorized as a specific phobia within DSM-V (APA, 2013). It is defined as a marked fear or anxiety about a specific object or situation. DSM-V includes five main specific phobia types: animal, natural environment, blood-injection-injury, situational, and others (Antony & Barlow 1998). Choking phobia is a disabling condition that results in fear, and

avoidance of swallowing food, fluids, and pills (de Jongh & ten Broeke 1998).

Eating is no longer experienced as safe and involves the child keeping to perceived safe foods, eating alone, or only eating with people perceived as supportive. A core consequence of choking phobia is food refusal which can lead to malnutrition and in the long-term, serious damage to a child's vital organs (de Roos, & de Jongh 2008).

Existing literature on this specific phobia is limited to a handful of case studies

Especially rare are studies of children under 5 years of age. Hensel (2009), however, showed that age-modified EMDR can be used with preschool-age children (n= 14) just as effectively as with school-age children. On average, three 50-minute sessions were conducted and resulted in significant improvements (Hensel 2009). Joan Lovett developed a new strategy for the use of EMDR, one that incorporates storytelling along with play therapy (Lovett 1999). Preschool children are often not able or ready for verbal interactions in therapy, whether because they are embarrassed or dysregulated by the content of conversation. In contrast, play, storytelling, drawing, and the use of symbols offer preschool children a meaningful and engaging way to participate in therapy (Crenshaw 2009).

Several treatment strategies have been used to reduce phobic symptoms, however, there is no common consensus over which approach is most effective. Most case studies support the use of either EMDR or behavior therapy. Exposure-based treatments and cognitive restructuring have been effectively used to treat most types of specific phobia. Studies indicate that for a number of phobias, a single, prolonged sessions, 2 to 3 hours, of in vivo exposure may lead to a clinically significant improvement in up to 90% of patients (Antony & McCabe 2002). Nevertheless, the use of in vivo exposure for a variety of phobias, e.g. flight and wasp phobias, may be difficult to carry out, whereas EMDR provides a more accessible brief exposure route to therapy (de Jongh & ten Broeke 2009).

Shapiro's adaptive information processing (AIP) model posits that a particularly distressing incident may become frozen in time in its own neural network, unable to connect with other memory networks that hold adaptive information. AIP suggests dysfunctional stored memory is the foundation for future maladaptive responses because perception of current situations automatically linked with associated memory networks (Solomon & Shapiro 2008). EMDR can be used as a treatment of specific phobias caused by traumatic experience. Some types of specific phobias (e.g., those involving fear of choking, road traffic accidents, and dental treatment) display remarkable commonalities with PTSD, including the re-occurrence of fearful memories of past distressing events that are triggered by the phobic situation or object but may also occur spontaneously. EMDR is capable of resolving disturbing memories of traumatic events that are critical in the development and maintenance of PTSD. It could be asserted that other types of anxiety disorders that develop following a distressing events could also be responsive to EMDR (de Jongh & ten Broeke 2009). It is hypothesized that EMDR successfully creates new memory associations and integrates previously isolated traumatic elements within the healthy neural network (de Jongh & ten Broeke 2007).

Adler-Tapia & Settle (2009) in their review, investigated the treatment of 391 participants from 19 studies and found that EMDR with children is a promising treatment for a variety of diagnoses. Of the 19 studies, 15 reported providing 6 or fewer sessions of EMDR (mean = 2.28 sessions), with 5 studies including only one EMDR session. The authors reported significant improvements or benefits from the treatment. De Roos & de Jongh (2008) used the phobia protocol to treat choking phobia in four children from different periods of development. They targeted distressing memories that were related to the genesis of the phobia. All four children demonstrated symptom elimination following just one or two sessions of EMDR, and indicating that EMDR could be effective for trauma-related choking phobia (de Roos & de Jongh 2008). In short, EMDR may be an efficient and importantly non-invasive therapeutic approach for children who have developed a choking phobia after a fearful experience of choking on food (de Roos, & de Johgh 2008, Schurmans 2007). The current study seeks to add to the literature on the application of EMDR for a preschool child with a choking phobia.

METHODOLOGY

Study design

We used a quantitative single-case study design to examine the efficacy of early intervention EMDR following an incident of choking on a fishbone. Age-adapted standard EMDR protocol was used during the treatment with a four-year-old client who did not meet the criteria

in the Diagnostic and Statistical Manual of Mental Disorder (DSM-5) for Specific phobia (American Psychiatric Association-APA 2013). Data was obtained from career, child, and session including therapist session notes and reflective notes, observations, and child drawings. The data was explored narratively, including assessing validity and standard protocol adherence.

Subject

The client was a 4-year old girl called Sarah (not her real name). Sarah was described by her mother as normally as healthy, happy, imaginative, and intelligent. She lived with her mother, father, older brother (aged twelve years), and her grandparents. She was described as the favorite in the family.

Sarah's mother came to see me terrified and in tears because Sarah had refused to eat solid food for two weeks. Sarah had eaten one chocolate pudding, sipped milk, and water.

Following the incident, Sarah was described as nervous, moody, and weak with a loss the energy and eventual ill health. Her immune system reacted and she got virosis. The mother sought help from a pediatric service but was informed she was overreacting, and that children can survive for 3 months without food. Sarah was labeled as „spoiled“, and the mother was informed that the problem would pass.

Treatment

Treatment started two weeks after the choking episode. The standard EMDR protocol was adapted for age including drawings, storytelling, and playing with clay. Two 90 minutes sessions were conducted with Sarah. The first session was used to build trust, explore the level of Sarah's traumatization and teach Sarah regulatory techniques. The story was constructed with the mother from what was reported about Sarah's experiences during the incident, her current positive experiences from everyday family life where she is loved and cared for, and ways and ideas of how to overcome anxiety in the future. One 90 minutes standard EMDR protocol session with the mother was conducted in order to eliminate her emotional arousal about the incident and to make her more able to participate in Sarah's session. One session of psychoeducation was arranged to educate Sarah's mother in the ways of tapping and how to communicate with Sarah about food. During the second session, Sarah's mother did the tapping.

History of trauma

Sarah's mother presented as upset during the history taking. I spontaneously start to tap her knees. She was confused including mixing updates. To help, I had to draw a line and made a timeline of events with her. The incident happened during a family lunch. Every weekend

Sarah's grandmother prepares fish for lunch and the whole family gathers around the table. Sarah loved to eat fish. As her mother was feeding her, Sarah got restless. In one bite a fishbone stuck in her throat. She started to cry and screamed that something was hurting her. They gave her a few sips of water but it did not help. Then her mother gave her a piece of bread to help her swallow the bone. As the piece of bread was too large she started to suffocate. Her mother rushed her into a car, and her grandfather drove maniacally to the hospital.

During the drive, Sarah fainted. At that moment, her mother put two fingers in her mouth hoping that she would vomit, or swallow. Suddenly Sarah managed to swallow the bone, inhaled deeply, and said: "I feel sleepy". Sarah and her mother stayed in the hospital overnight and were released the next day. During the hospital stay, Sarah was reported as reacting normally, communicative, and happy. Sarah accepted all the procedures with no fear and ate all food normally, but carefully chewing quietly. On 11th November they held her birthday celebration. She was very happy. The day after, they went on family lunch again. Her grandmother prepared fish again. Just as she saw the fish on the table, she started to react regressively. She started to scream, made strange faces, put her fists on her mouth, bent her body, and rocked left and right. The next day Sarah refused food, eating only small amounts of her favorite, preferably fluid food like soup, puddings, soft cottage cheese, sour cream, and chocolate favored pediatric formula. On Sunday 19th November, her father left for Iraq for a three months job, and she stopped eating altogether.

CASE REPORT

Preparation and assessment

By the time the family came to see me, Sarah was eating soup, milk, and a chocolate pudding very carefully. I've decided to use the storytelling technique (Lovett 1999) After taking we made the first version of the narrative together. The first part of the story showed her happy life, the nice things she likes to do, so that she could identify with the character (Appendix 1). The second part described the incident in details and was followed by the positive part of the story, the celebration of her birthday. Originally, the plan was to stop the reprocessing then and continue in the next session. But Sarah was keen to continue the storytelling so we continued with the narrative. The story continued with a description of the new experience with the fish that triggered the traumatic memory. For the last part, I gave her positive ideas on how to overcome the experience and explained a few positive experiences of eating food with the positive cognition "I'm brave." The happy ending for the last part of the story gave her the idea that she is able to cope with unexpected incidents, can make resources, and find support. Her favorite cartoon characters and food were incorporated in the story for

ease of identification. The first version of the story involved her father leaving but during the first session, it was highly noticeable that Sarah was obsessed with fish. She spoke about her father openly, and drew a happy picture of him, and showed no stress about his leaving. I've decided to focus on the fish incident in the whole story (Appendix 1).

Sarah's mother was an important part of the sessions but she was emotionally hyper-aroused by talking about the incident. An EMDR session was conducted with her first in order to overcome her emotions so that she could help her daughter to heal. The mother identified the worst picture easily. It was a moment when Sarah collapsed in her lap. She felt extreme guilt, fear, lost confidence, and could not feel her legs and arms, and could not breathe. The negative cognition (NC) was "I'm guilty" because I put that piece of bread in her mouth". The positive cognition was (PC) "I did the best I can." On the validity of cognition (VOC) scale (from 1 being completely false to 7 being completely true) she reported her PC as a 4, as she was partly conscious of her role in saving her child. After EMDR reprocessing she increased the VOC to 6. Sarah's mother was still too worried about her daughter and could not go higher. The level of emotional disturbance was initially rated 10 (SUDs) and decreased to 3 after one reprocessing session. Even though she felt calm, and the session gave her insight into saving her child in a terrifying moment, she explained 3 because she is still frightened. After all, her daughter does not eat yet. It was enough for me to decide that the mother could be part of the process with Sarah. Since Sarah was restless and moved around all the time, I taught her mother different tapping techniques (knees, shoulders, butterfly hug, caressing calves), so that she could adapt ways of tapping as Sarah moved her body. The agreed sign to start tapping was nodding and moving my head from right-left to stop tapping.

Course of treatment

Session 1

The first session with Sarah was on Wednesday 28th November. The session aimed to become acquainted, and discover the most frightening picture, install resources, investigate the width of her food refusal, and prepare for the storytelling. The session was conducted in her aunts' apartment because she felt calm and safe there. I prepared myself for a play session and planned to incorporate talking about the incident into the game. She was waiting for me at the doorstep and as I stepped in, Sarah took my hand and led me to the table. When I got on my knees, next to her, she pointed at the drawing on the table and said to me: "This is a bad fish. It has a sharp bone. It stuck in my throat and hurt me. Did you know that?" (Figure 1). Spontaneously we started talking about the incident and she freely talked, explaining the whole incident in detail.



Figure 1. Drawing the worst picture

Before the treatment, no-one in the family spoke with Sarah about the incident afraid that they could re-traumatize her. The session was the first opportunity for Sarah to explain what happened to her. The worst part was a pain in her throat, and not being able to breathe normally. She got the idea that food is dangerous and it can hurt you. To establish the SUD level I've asked her to show me how scary it was by spreading my arms as much as I could for 10 and touching my pointer finger and thumb for 0 disturbance. She spread her arms as wide as she could and changed a conversation to another topic. She drew me her favorite cartoon character, a Viking princess (Figure 2). Talking about the character she

identified herself with the princess's bravery and I used the moment to install resources by tapping her palms and saying "You are as brave as a Viking princess."

At that point, I discovered that food refusal had expanded to refusing to talk about food, touch food, and even to look at food. Every time I tried to talk about food she immediately started to regress and diverted my attention to something else. At that moment I've decided to involve clay and an imaginary game. I made a fish and started using a plastic knife to pull out bones. In the beginning, she ignored me, and then after a while, she carefully started to touch the fish, took my knife and started cutting it, and then pulling bones out. Sarah started to make her own fish and repeated the activities. When she cleaned all the parts of bones we would imagine how we swallow fish. She would grab my hand and imagine swallowing a bite and after that, she would touch her throat and say it's okay, nothing hurts me. I used that moment to install resources. How do you feel now? She would say: "Strong", and showed her muscles. "Do you feel that in your body, that strength? " She looked proud, and I tapped her palms. She was very focused on the game and I used the opportunity to get salami and start doing the same. Touching it with my fingers, smelling it, and cutting it.

She froze for a moment and pulled her hands towards her body. I continued playing with salami and after a while, she followed my behavior. During the game of touching food, I installed the positive cognitions "The food is smooth and safe" and "The food is not dangerous" by tapping her palms. The whole session lasted for 90 minutes and we stopped it when she got tired. During the session, Sarah was surprisingly receptive.



Figure 2. Drawing of best part of the story / Viking princess wins

After the session, I've conducted a psycho-education interview with the mother suggesting to her to play with food, and to stop being obsessed with feeding Sarah. After which they had a family meeting where they agreed on the way to communicate about food, i.e. stop focusing on food, just prepare the meal and leave it on the table, leave her to take it when she wants, and play imaginative games with food, and about food.

During the next morning, Sarah repeated the imaginative games with food from the session. She started to feed her grandfather and in the evening while they were not looking she took three cookies and carefully ate it. She was chewing it longer than usual, and touching her throat but she did it. On Friday her mother made a cheese pie with her, and two of them played along with cheese, flour, eggs, and milk. She tried to find bones in everything, melting the food in her fingers. She still was refusing to eat. But she expanded the food she ate to cookies with milk and sour cream.

Session 2

The second session was conducted on Saturday, 1st of December. After drawing her family, she placed it in her mother's lap and I started to read her story. In the beginning, after every sentence she would happily comment: "That's like me." During reading the parts with traumatic memories she was frozen, not moving at all, and while I was reading happy parts she jiggled a lot and the mother had to change the way of tapping. Even though originally the plan was to cut the story into two sessions, Sarah was extremely receptive and

when I stopped with the birthday party she told me: "Read more, that's not all." I continued reading. At the moment when I read that "bad picture stayed in Alice's head," Sarah said "So in my." When I finished the whole story, for a moment, she stayed frozen and then said: "Now I'm going to tell you a story." She imagined her story in which she just retold us the same story again but with different characters. She was imagining at the moment, a tyrannosaurus that put a bad bone in her throat, and the brave Viking princess with a sword who pulled the bone out. I gave her mother a sign to tap her while she was talking about successful coping.

Sarah drew the best part of the story, when the princess overcame fear and started to eat because she is brave. I installed the positive cognition "I'm brave."

While she was looking at the drawing and imagining the scene, and her mother was tapping her shoulders. In one moment Sarah said "Stop tapping me I cannot see the picture in my head." It was clear at that moment that the processing was really happening.

In the end, I decided to draw her favorite food, and she gladly accepted the picture. She drew me happy eggs and I taught her the butterfly hug (Figure 3). I told her a secret story about a magical touch my princess taught me to use. When she feels afraid and cannot do something, just close her eyes and think how brave she is and tap herself. She closed her eyes and tried the butterfly hug and said "It feels nice." I declared how hungry I am after this game, but afraid to eat. She opened the pudding saying „Food is not dangerous, it will not hurt you”.



Figure 3. Favourite food happy eggs



Figure 4. Clay container - green snake inside and pink padlock on it

She took one spoonful, put it in her mouth carefully, and swallowed. Now it was my turn. I acted regressive and scared. She took my hand, explained how brave I have to be, to remember the Viking princess, and started feeding me. After every bite, we checked my throat and she happily screamed "We are brave, nothing happened!"

I'd planned to finish the session but Sarah was so enthusiastic and wanted to play more. I've decided to do more resources. We played with clay. We made a container in Figure 4: Clay container - green snake inside and pink padlock on it and in which she can put all her fears, bad thoughts, and feeling. She was making a lot of snakes, bones, and kept tearing the clay into small pieces saying "I'm strong and brave" which I used to install the positive feeling in her body. "What kind of girl are you?" I would ask, and she would scream "Brave and strong". "Where do you feel it"? "In my arms and head", and I did the tapping. She made a padlock, put everything in a container, and closed it so that nothing could get out. She wanted me to take her container and put it in a safe drawer at my place.

When we finished the game with the container she told me: "Now you can go home". In the end, I asked her to remember the bad incident and show me with her hands how scary it sounds now. She told me "Did you forget that I'm a Viking princess, nothing's scary for her, she always wins". SUDs were 0. The session lasted more than 90 minutes.

After only 2 sessions, one of reprocessing, the girl started to eat normally. The day after the second session Sarah started to eat her favorite crunchy cookies with milk and cheese pie, and from Monday morning she started to eat normally all types of food. Her mother

reported that Sarah became joyful, energetic, and positive again. At the follow-up interview with her mother three months after the last session improvement was maintained.

DISCUSSION

This study case shows how an age-adapted standard EMDR protocol can efficiently resolve dysfunctional symptomatology, within one month of its occurrence. Sarah's mother reported a significant and quite dramatic disappearance of symptoms after just two EMDR sessions. The whole treatment was well-tolerated emotional and had rapid effects. Sarah considered both sessions as interesting games, not even noticing spontaneous cognitive, emotional, and behavioral changes occurring as a result of adaptive processing and incorporating the new materials into the adaptive memory network. The storytelling technique and drawings appeared to be successfully integrated into the AIP model with good replacement for imagined exposure at early ages. It appears the stories of bravery and survival gave new meaning to Sarah's life experiences. Incorporating elements from the child's life enabled the story to be relevant and familiar. Such familiarity facilitates the process of internalizing and recognizing the parallels with the child's life (Painter 1997). The inherent value of this process resides in the facilitation of the child's identification with the story and integration of the proposed coping techniques in the new memory network. Unprocessed memories became resolved and symptoms relieved. Previous case studies have evidenced the same success of age-appropriate adaptation of

the standard EMDR protocol resulting in a rapid reduction of symptoms after a relatively small number of sessions, 1-4 EMDR sessions. Improvements were also maintained at 3, 6, and 12-month follow-up (Fleming 2012).

Single-incidents traumas, such as choking phobia caused by a fishbone, can lead to a number of unpleasant symptoms that disable everyday functionality and can cause disruption of children's development. Hansel (2009) showed that very young children can benefit from, on average, three EMDR sessions. In the case of eight children, a parent was treated successfully using EMDR prior to treatment of the child, as they were too upset to become a part of the EMDR session with their child, and stabilization of their emotions as needed. The parent is an important part of the treatment and can be hyper-aroused by the incident. The parents' emotional stability and ability to provide a safe and secure environment, and their capacity for affect regulation needs to be addressed and explored (Gomez 2013). If a parent is to be a partner in an EMDR session, there may be a need to stabilize their emotions and cognitions and help them overcome their fears in order to be able to support the children during the process. The inclusion of parents throughout the EMDR therapy process is essential for the best treatment outcome (Gomez 2013).

In Hansel (2009), the majority of children received treatment within the first month or 30-90 days after the incident. Schurman (2007) in a complicated case of choking phobia treated the child prior to EMDR with different psychotherapeutic approaches. However, it wasn't till after EMDR that there was a remission of the symptoms. EMDR provoked chains of associations and adequate processing of relevant childhood memories and related affective materials. Although EMDR is a psychotherapy that was originally developed to resolve traumatic memories from our past, it appears EMDR can also be effective in resolving trauma-based phobias. Recent studies indicate EMDR can also be used effectively with recent traumatic events (Shapiro 2009). As Shapiro says EMDR is not simply a trauma treatment, it helps our clients to connect with themselves (Shapiro & Luber 2009). EMDR intervention in the days and weeks following a traumatic incident can rapidly reduce intrusive symptoms, pain, and suffering. Although early symptoms may be part of a normative adaptive response to a trauma, there is also evidence that early signs may be indicative of accumulated traumatic memories over time in developing PTSD (Shapiro 2009). As such, the advantage of early intervention is that it may pre-empt the development of

later complications and reduce suffering and risk of developing later serious psychopathological symptoms. And isn't the aim of every psychotherapeutic approach to reduce pain and suffering even if existing symptoms are not sufficient for a specific diagnosis?

Limitations

Case studies evidence specific examples of practice in-depth, however, they do not provide sufficient evidence to generalize to other cases. Despite the detailed narrative of the process of therapy provided, the current study was written from the perspective of the therapist and therefore gives primacy to the therapist, rather than child or parent views. Standardized measures are rare for preschool children with the study relying on subjective measures of disturbance to quantify change.

CONCLUSIONS

This study adds to the limited literature on the early intervention of EMDR for young children with a trauma-related phobia. Phobic symptoms were efficiently resolved within a small number of sessions. EMDR was well tolerated as a therapy. Corroborating evidence in support of the child's positive change in subjective experience was provided by the child and parental reports of behavioral change in everyday life.

Recommendations for practitioners and researchers. For practitioners, EMDR should be considered as a potentially efficient and well-tolerated early intervention for children with a choking phobia.

Even though this study showed remarkable improvements after just one reprocessing session, further research with more rigorous designs are needed before early intervention EMDR is a treatment of choice for choking and other trauma-related phobias

Acknowledgements: *None.*

Conflict of interest: *None to declare.*

Contribution of individual authors:

Ivana Kokanović: conception and design of the manuscript and interpretation of data, literature searches and analyses, clinical evaluations, manuscript preparation and writing the paper;

Ian Barron: made substantial contributions to conception and design, literature searches and analyses, participated in revising the article and gave final approval of the version to be submitted.

Appendix 1.

Once upon a time, in a faraway land lived a girl called Alice. She lived in a big castle with her Mommy, daddy, brother, granny and grandpa. They had a doggy and a cat. They lived happily. Alice was a very happy girl. She loved to play computer games with her brother, go to shop with her grandpa to buy herself her favorite chocolate bananas and juice. Every morning she cuddled with her granny, and she would bring her a glass of milk. She loved most when Mommy and daddy didn't work to spend the whole morning cuddling with them. Her cat came every morning to her window and wake her up with a meow. She adored watching cartoons with horses. Alice loved to act as a Viking princess. Even though she was a little girl the princess was very strong and knew how to handle all the bad things that happen to her. Alice loved to meet new friends, was a lively and independent little girl. She always knew what she wanted. One of her favorite moments was when the whole family sat together around the table and ate together. Especially she liked to eat sour cream, eggs, butter, macaroni, croissant, hot dog, and fish. Everything was nice and peaceful around her. One day something terrible happened. It was the weekend and they ate her favorite fish for lunch. She was hungry and liked it a lot. She ate a lot. At the end it started to get boring, she became restless and started jumping around her mother who was still feeding her. They didn't know that in that small piece of fish there was a bone hidden. They didn't carefully check it. When she tried to swallow it that dreadful bone stuck in her throat. It hurt her a lot and she got scared. She didn't know what was happening. She realized that bone stuck in her throat and tried to cough it out. She called her Mommy to get it out. Mommy remembered that piece of bread could maybe eject the bone out. But something horrible happened. The bread stuck and she started suffocating. She was afraid, she couldn't breathe. It was too scary. Her mother got scared too. She was screaming: „Swallow it“, but she couldn't. Everything got stuck inside. Her Mommy grabbed her and rushed in the car. While her grandpa was driving to the hospital her Mommy managed to save her. She bravely put two fingers in her mouth. Alice finally succeeded swallowing the bad bone. It was gross, but at that moment Alice finally inhaled and got very sleepy. She felt fine again. Nothing was hurting her anymore. Nothing was scary anymore. She had to stay in hospital for a night so that doctors can examine her throat. Staying in the hospital was fine. Everybody was nice to her. There was a „green doctor“ who was telling her nice stories. He gave her a butterfly who bit her a little and it hurt for a moment, but everything passed quickly. Mommy was with her all the time and she felt safe. She thought that everything is going to be fine now. Her birthday came soon and she had a great time. She got great presents, a big plastic slide, a cake in the shape of a cat, there were lots of her friends who loved her the most and who she loved. Just as she started to think about how everything was nice something bad happened again. One day she went to her granny to have lunch. She was very hungry. Just as she sat at the table her granny served her fish, because she thought that Alice still likes fish. At that moment, Alice remembered the whole terrifying event when she swallowed a bone and it frightened her a lot. She remembered how she couldn't breathe, and how she was afraid she's going to suffocate, and Mommy's scared face and voice. She just couldn't get that picture out of her head. She even got as scared that she stopped eating. Alice forgot her courage. She didn't dare to swallow anything, even her favorite bananas, cookies, bread. She thought it would get stuck in her throat again. Everybody started worrying a lot and talked about it. She was worried too. She didn't have enough strength because she wasn't eating at all. She somehow forgot her Viking princess and her bravery. She was sad, afraid, confused... And then she remembered, how could she forget that?

She forgot that the „green doctor“ healed her throat and that she could eat and swallow normally, that she got well because she was a brave and strong girl. Somehow she forgot his butterfly who helped her to get well and start eating again. She remembered that when she was released from the hospital, she ate normally and nothing bad happened. She tried to drink water and eat her favorite chocolate pudding and she did. Nothing bad happened. Then her Mommy boiled hot dogs. Together they examined them and there were no bones.

They took each other's hands and putting little by little in their mouth. It was scary, but Alice remembered that she is strong and brave as her Viking princess and that she can fight with all the bad and scary things that happened, even the bad bone which stuck in her throat once and frightened her extremely. She started to chew with her small, strong teeth and swallowed chopped hot dog. For a moment, she closed her eyes. Nothing happened. She touched her throat and everything was okay. Alice was really happy she won. She realized that nothing bad will happen when she eats. She swallowed bone accidentally because she jumped and fooled around. Food is not dangerous. She can eat her favorite food again. She was hungry.

She wished to eat cheese pie, macaroni, and her favorite crunchy food. She called her Mommy: „Quickly make me crunchy chicken and cheese pie“. That was her favorite lunch.

The chicken was warm and soft and smelled good. She touched it and smelled it. Took one piece and put it in her mouth. It was yummy. While biting she enjoyed the taste of it. She could feel her body becoming stronger.

She knew now that everything passed and is going to be okay. She took her mother's hand and they hugged. She knew now she has the strength of a Viking princess and she can win all the scary things. Her Mommy and daddy will always be there to help her and support her in everything. She became that happy, joyful girl again. Her Viking princess came back and stood by her side again, and help her win over bad things that happened to her. Alice rushed to her father to tell him how she fought her fears. He was happy about it. They sat again at the table to have a family lunch. They lived happily ever after.

References

1. Adler-Tapia R & Settle C: Evidence of the efficacy of EMDR with children and adolescents in individual psychotherapy: A review of the research published in peer-reviewed journals. *Journal of EMDR Practice and Research* 2009; 3:232-247
2. American Psychiatric Association: Diagnostic and statistical manual of mental disorders (5th ed.). Arlington: American Psychiatric Association, 2013
3. Antony M & Barlow D: Specific phobia in: *International Handbook of Cognitive and Behavioural Treatments for Psychological Disorders*. Elsevier Science Ltd. 1998: 1-22
4. Antony M, & McCabe R: Specific and social phobia. In: *Handbook of Assessment and Treatment Planning for Psychological Disorders*. New York: The Guilford Press: 2002:113-146
5. Crenshaw D: *Therapeutic engagement of children and adolescents: Play, symbol, drawing and storytelling strategies*. Jason Aronson book, 2008
6. Emmelkamp P & Wittchen H: Specific phobias. In: *Stress-Induced and Fear Circuitry Disorders*. Arlington: APA, 2009: p. 77-101
7. Fleming J: The effectiveness of eye movement desensitization and reprocessing in the treatment of traumatized children and adolescents. *Journal of EMDR Practice and Research* 2012; 6:16-26
8. Gomez A: *EMDR therapy and adjunct approaches with children: Complex trauma, attachment and dissociation*. New York: Springer Publishing Company, 2013
9. Hensel T: EMDR with children and adolescents after single-incident trauma. *Journal of EMDR Practice and Research* 2009; 3:2-9
10. Jongh A & Broeke E: Treatment of Choking Phobia by Targeting Traumatic Memories with EMDR: A case study. *Clinical Psychology and Psychotherapy* 1998; 5:264-269
11. Jongh A & Broeke E: Treatment of specific phobias With EMDR. *Journal of EMDR Practice and Research* 2007; 1:46-56
12. Jongh A & Broeke E: EMDR and the Anxiety Disorders: Exploring the Current Status. *Journal of EMDR Practice and Research* 2009; 3:133-140
13. Lovett J: *Small wonders: Healing childhood trauma with EMDR*. New York: The Free Press, 1999
14. Merckelbach H & Muris P: Specific Phobias In: *Epidemiology of Anxiety Disorders. In: Anxiety Disorders-An Introduction to Clinical Management and Research*. John Wiley & Sons Ltd. 2001: p.104-135
15. Muris P, Merckelbach H, de Jongh P & Ollendick T: The etiology of specific fears and phobias in children: a critique of the non-associative account. *Behaviour Research and Therapy* 2002; 40:185-195
16. Overbeek T, Vermette, E & Griez E: Epidemiology of Anxiety Disorders. In: *Anxiety Disorders-An Introduction to Clinical Management and Research*. John Wiley & Sons Ltd. 2001: p.3-23
17. Painter L: *Effects of therapeutic storytelling and behavioral parent training on the problem behaviors of children and on parental stress*. Theses, Dissertation, Professional Papers. Paper 5710. The University of Montana, 1997
18. Roos C & de Jongh A: EMDR Treatment with Children and Adolescents with Choking Phobia. *Journal of EMDR Practice and Research* 2008; 2:201-211
19. Schurmans K: A Clinical Vignette: EMDR Treatment of Choking Phobia. *Journal of EMDR Practice and Research* 2007; 1:118-121
20. Shapiro E: EMDR treatment of recent trauma. *Journal of EMDR Practice and Research*, 2009; 3:141-151
21. Shapiro F & Luber M: Interview with Francine Shapiro: Historical Overview, Present Issues, and Future Directions of EMDR. *Journal of EMDR Practice and Research* 2009; 3:217-231
22. Solomon R & Shapiro F: EMDR and Adaptive Information Processing Model. *Journal of EMDR Practice and Research* 2008; 2:315-325
23. Trickey D & Black D: Long-term psychiatric effects of trauma on children. *Trauma* 2000; 2:261-268

Correspondence:

Ivana Kokanović, MA
Gymnasium Vaso Pelagić
Brčko District, Bosnia and Hercegovina
E-mail: ivana.kokanovic@gmail.com