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Exposure therapy for emetophobia: A case study with three-year follow-up

Danielle J. Maack[a,*], Brett J. Deacon[b], Mimi Zhao[a]

[a] University of Mississippi, Department of Psychology, 205 Peabody Building, University, MS 38677, United States
[b] University of Wyoming, Department of Psychology, Department 3415, 1000 E University Avenue, Laramie, WY 820711000, United States

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ABSTRACT

Emetophobia, also referred to as a specific phobia of vomiting, is a largely under-researched and poorly understood disorder with prevalence estimates of ranging between 1.7 and 3.1% for men and 6 and 7% for women (Hunter & Antony, 2009; Philips, 1985). The current case study, therefore, sought to methodically apply exposure-based behavioral treatment to the treatment of a 26 year-old, Hispanic, female suffering from emetophobia. Although not as powerful as a randomized design, this description may still add to the existing emetophobia literature through the illustration of adaptation of published behavioral treatments for other specific phobias. The case presented was successful in terms of outcome, and includes a three-year follow up wherein treatment gains were measurably maintained.

1. Introduction

Emetophobia, a specific phobia of vomiting, is an under-researched and poorly understood anxiety disorder (Boschen, 2007; Marks, 1987; van Hout & Bouman, 2012; Veale & Lambrou, 2006). Prevalence estimates of emetophobia range between 1.7 and 3.1% for men and 6 and 7% for women (Hunter & Antony, 2009; Philips, 1985), yet few empirical data are available regarding this specific disorder. Emetophobia is considered to be a chronic problem with early onset (Lipsitz, Fyer, Paterniti, & Klein, 2001), and it often produces clinically significant distress and impairment in social and other areas of functioning.

Fear of vomiting can be triggered by both internal and external stimuli such as sight of another person vomiting, nausea, or concerns with contaminated food. Most individuals with emetophobia tend to avoid stimuli associated with vomiting such as eating specific foods, strenuous exercise, and drinking alcoholic beverages (van Hout & Bouman, 2012; Veale & Lambrou, 2006). Other research also supports the notion that triggering stimuli are diverse, with previously demonstrated cues ranging from the more innocuous and cognitive (e.g., hearing or seeing the word "vomit") to the more behavioral and contextual (e.g., eating in public, which precipitates a fear of becoming nauseous; Lipsitz et al., 2001; Veale & Lambrou, 2006). In the limited research that exists it has also been noted that these cues result in potentially serious behavioral sequelae; for example, 44% of all female emeotphobics from an online survey reported that they avoid or delay becoming pregnant (Lipsitz et al., 2001).

Although relatively little is known about this phobia, preliminary research suggests that it is not a rare condition seen in clinical practice (van Hout & Bouman, 2012), and as such warrants further attention. With its documented course as chronic, with an early onset, along with different manifestations in presentation (van Hout & Bouman, 2012), the overall conceptualization of emetophobia is in its early stages. The paucity of attention to this disorder may be exacerbated by clinicians' anecdotal impressions of emetophobia as a difficult disorder to treat, as elucidated by previous surveys that cited high dropout and poor treatment response (Veale & Lambrou, 2006). Additionally, there are no randomized controlled trials (RCTs) examining treatment approaches for this disorder; in fact, few developed treatment models for this type of specific phobia exist without consideration of level of scientific examination or empirical support (see Boschen, 2007). As such, treatment of emetophobia continues to be unstandardized, although several therapeutic approaches have been employed to mixed results, including the following: hypnotherapy (McKenzie, 1994; Ritow, 1979), imaginal coping (Moran & O'Brien, 2005), interoceptive exposure and "analog vomiting" (McFadyen & Wyness, 1983), and psychotropic medication (Lipsitz et al., 2001).

There is substantial support for exposure therapy as a highly effective treatment for a number of specific phobias including animal phobia (Bandura, Blanchard, & Ritter, 1969; Gilroy, Kirkby, Daniels, Menzies, & Montgomery, 2000; Gotestam & Hokstad, 2002), claustrophobia (Booth & Rachman, 1992; Ost, Alm,

* Corresponding author. Tel.: +1 662 915 1775/769 610 8991; fax: +1 601 915 5398.
E-mail addresses: djmaack@olemiss.edu, daniellemaack@gmail.com (D.J. Maack).

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Brandberg, & Breitholtz, 2001), flying phobia (Walder, McCraken, Herbert, James, & Brewitt, 1987), and height phobia and driving phobia (Williams, Dooseman, & Kleinfield, 1984). From the limited research regarding emetophobia, specifically what is known about maladaptive beliefs and safety behaviors suggests that it presents much like other phobias and would likely respond to the same exposure-based treatment approach known to work well for phobias in general. Existing treatment studies (i.e. case studies) are few in number, as previously mentioned, and have generally examined treatment approaches disparate from what has been demonstrated to work in the treatment of other specific phobias (i.e., exposure).

2. Present study

The current case study, therefore, sought to methodically apply exposure-based behavioral treatment to the treatment of a young woman suffering from emetophobia. Although not as powerful as a randomized design, this description may still add to the existing emetophobia literature through the illustration of adaptation of published behavioral treatments for other specific phobias. The case presented was successful in terms of outcome, and includes a three-year follow up wherein treatment gains were measurably maintained.

2.1. Client information

"Lindsey" (a pseudonym) presented to an outpatient university-based psychology clinic as a 28 year-old, single, Catholic, Hispanic female. She completed a high school education and was living with her partner in a small rural, western town. She was referred by a community mental health provider specifically for treatment of emetophobia in January of 2007. Consent for treatment was obtained prior to beginning services, and she subsequently provided her separate, explicit consent to have her case presented for publication.

2.2. Presenting complaints/history of problem

Lindsey's primary presenting problem was emetophobia. She reported that she wanted to become pregnant and start a family with her fiancé, but that she was unable to attempt to conceive due to apprehension and fear about the possibility of experiencing morning sickness (and thus vomiting). She explained that if she were to conceive her morning sickness might cause her to vomit, and she would likely choke on the vomit and subsequently die. Lindsey also indicated experiencing intrusive images and thoughts surrounding vomiting. She stated that when she thought about vomiting, she felt as if she were choking or suffocating, and that if she vomited she might swallow her tongue, which would be fatal. She reported experiencing these thoughts when encountering stimuli reminiscent of vomiting (e.g., seeing or hearing others vomit or gag). She stated that she had not vomited since the 6th grade at which time she endured a "traumatic vomiting experience." She said that she came home sick from school, and at one point ran to the bathroom and proceeded to repeatedly vomit. During this time, she began to choke on pieces of the expectorant and felt as though she was going to die. Since this time, she reported continuous rumination about this experience, and as such, at the beginning of treatment she endorsed being hypervigilant to any cues or stomach sensations that might be associated with vomiting. She indicated that she had explicitly trained herself for this avoidance over a long period of time in order to prevent herself from vomiting or being in a situation where she could possibly vomit. When asked, she reported that her "gut" feeling was that there was a 50% chance she would die if she were to throw up, although she also stated that logically, the chance of death was more likely in the range of 10%.

Lindsey stated that the clinically significant impact of emetophobia was the avoidance of becoming pregnant. She said that until she could believe she would be able to deal with morning sickness without the fear or ultimate outcome of death, she would not actively attempt to become pregnant. Additionally, as a secondary goal/concern, she reported that she would like to be able to be supportive of others (i.e. her fiancé, family, friends) when they were sick. She stated that in the month prior to presenting for treatment her fiancé was sick and vomiting, but she was unable to help. Instead, she reported plugging her ears and staying away from him as much as possible, which was consistent with her reported avoidance of cues associated with vomiting. She also stated that she revolved her daily routine around heightened sensitivity to her stomach issues, which resulted in routine avoidance of many other activities including: exercise, amusement park rides, cooking chicken at home, and drinking alcohol, all of which led to a constant monitoring of any symptoms related to nausea. On rare occasions that Lindsey chose to engage in these activities, she reported always being careful to constrain her behavior such that she did not eat anything beforehand. Additionally, she indicated that she carried antacid tablets with her at all time, for use in the event that her stomach felt disrupted.

Lindsey reported previously seeking treatment for emetophobia with no symptom alleviation. Her accounting of the nature of this previous treatment included a diverse array of approaches, including: eye movement desensitization reprocessing, hypnotherapy, various forms of pharmacotherapy, and an unspecified "talk therapy." She reported that although prescription medications appeared to be of benefit for relief of symptoms of depression, OCD and Tourettes, no type of therapy (pharmacotherapy, psychotherapy or other) to date had been effective in touching the emetophobic symptoms. Additionally, Lindsey reported consistent attendance and adhering to treatment protocols; however, she reported continued difficulty with the experience of emetophobia.

3. Initial assessment

As part of the intake session (3.25 h) at a University-based psychological treatment center the Mini International Neuropsychiatric Interview – 5th edition (M.I.N.I.-5; Sheehan et al., 1998) was administered. In addition, Lindsey completed a number of self-report measures of broad psychiatric symptoms (see Table 1). The assessment and direct treatment of this client was concurrently provided by both a Master's level graduate student and the supervising psychologist.

3.1. Measures related to emetophobia, differential diagnosis and symptoms

The anxiety sensitivity index-3 (ASI-3; Taylor et al., 2007) is an 18-item measure constructed to assess an individual's fear of arousal-related sensations that arise from the belief that these

Table 1
Outcome measures at pretreatment and 3 year follow-up.

Measure	Pretreatment	3 year follow-up
ASI-3	34	2
OCI-R	12	4
BVS		
Attention to internal body sensations	10	8
Sensitivity in changes in internal body sensations	8	3

Note: ASI-3, Anxiety sensitivity index-3; OCI-R, obsessive compulsive inventory, revised; BVS, body vigilance scale.