Journal of Obsessive-Compulsive and Related Disorders 7 (2015) 1–6

Contents lists available at ScienceDirect

Journal of Obsessive-Compulsive and Related Disorders

journal homepage: www.elsevier.com/locate/jocrd

Clinical report

Is a specific phobia of vomiting part of the obsessive compulsive and related disorders?

David Veale, Camilla Hennig, Lucinda Gledhill

Institute of Psychiatry, Psychology and Neuroscience, Kings College London and South London and Maudsley NHS Foundation Trust, De Crespigny Park, Denmark Hill, SE5 8AZ London, UK

ARTICLE INFO

Article history:
Received 30 June 2015
Received in revised form
14 August 2015
Accepted 21 August 2015
Available online 28 August 2015

Keywords:
Emetophobia
Specific phobia
Vomiting
Compulsions
Obsessive compulsive disorder

ABSTRACT

Aims: To explore whether the phenomenology and co-morbidity of a specific phobia of vomiting (SPOV) (also known as "emetophobia") might best fit within the group of obsessive compulsive and related disorders.
Method: Case review of individuals who were assessed for a SPOV ($n=83$).
Results: Sixty-two per-cent of cases reported being markedly or very severely preoccupied by the fear that they might vomit. A majority of people with a SPOV reported either often or always conducting repetitive behaviors such as compulsive washing; reassurance seeking; self-reassurance, counting or superstitious behaviors to prevent vomiting; checking others for signs of illness or checking sell-by dates. Cases that had more frequent hand washing were associated with higher scores on standardized questionnaires for a SPOV and a later age of onset. The diagnosis of OCD formed the highest degree of co-morbidity.
Conclusions: The results have implications for future research into the nosology and treatment of a SPOV. Clinicians should assess for repetitive behaviors in a SPOV and include them in a formulation and treatment plan. Future research should conduct prospective studies to determine which aspects of the phenomenology of a SPOV might best fit under OC and related disorders.

1. Introduction

Obsessive Compulsive Disorder is characterized by the presence of obsessions and/or compulsions; avoidance behaviors are common. DSM-5 has a new section of obsessive compulsive and related disorders (OCRD) which includes body dysmorphic disorder, hoarding disorder, trichotillomania and skin-picking disorder (American Psychiatric Association, 2013). Stein and Philips (2014) noted that when considering the overall structure of DSM-5, 11 validators guided the workgroups. These were shared symptom similarity, neural substrates, comorbidity among disorders, biomarkers, course of illness, temperamental antecedents, shared familial ties, cognitive and emotional processing abnormalities, genetic risk factors, environmental risk factors, and treatment response. Based on these validators, it was decided to include a grouping of obsessive–compulsive and related disorders (OCRD), consisting of disorders that appear closely related to OCD.

The development of ICD-11 has also focused on the clinical utility of grouping certain disorders within the same chapter as well as validators (First, Reed, Hyman, & Saxena, 2015). Differences are emerging between the DSM-5 and planned ICD-11 in the group of OCRD. Thus, in contrast to DSM-5, there are plans to include hypochondriasis (illness anxiety disorder) in the OCRD section of ICD-11 (van den Heuvel, Veale, & Stein, 2014). For both DSM-5 and ICD-11, conditions such as obsessive–compulsive disorder (OCD), body dysmorphic disorder (BDD) and hypochondriasis are regarded as being more related to the anxiety disorders end of the spectrum than others, such as tics or trichotillomania.

We explore in this paper whether a specific phobia of vomiting (SPOV) (also known as emetophobia) should also be investigated as a potential OCRD. A SPOV is currently classified as a specific phobia ("Other type") in DSM-5 (American Psychiatric Association, 2013) and in ICD-10 (World Health Organization, 1992). There are no plans to alter this classification in ICD-11 (Emmelkamp, 2012). However it is possible that ICD-11 working group may remove the sub-typing of specific phobias believing that there is no significant evidence for classifying subtypes (Emmelkamp, 2012).

A fear of vomiting is common in the community, affecting up to 7% of women and 1.8% of men (van Hout & Bouman, 2012). It appears, though, that a SPOV is rare. The only epidemiological survey that has specifically asked about a phobia of vomiting (Becker et al., 2007) found a prevalence of 0.1%. This may be an underestimate as clinical observations suggest that the symptoms may sometimes be confused with those of hypochondriacal

E-mail address: David.Veale@kcl.ac.uk (D. Veale).

http://dx.doi.org/10.1016/j.jocrd.2015.08.002
2211-3649/

disorder, obsessive–compulsive disorder and anorexia nervosa (Boschen, 2007; Manassis & Kalman, 1990; Veale, 2009). However, a co-morbid diagnosis of OCD should only be made in the presence of additional obsessions, unrelated to a fear of vomiting. An example could be the occurrence of additional checking behaviors to prevent harm, or magical thinking, designed to stop other bad events (not just vomiting). The avoidance behaviors in SPOV are well documented and are consistent with a phobia. People with a SPOV are likely to avoid situations or activities that could increase the risk of vomiting, such as being near people who are ill or drunk; fairground rides; boats; holidays abroad; travel by airplane; drinking alcohol; crowded places; public transport; eating from salad bars or buffets, or using public toilets (Lipsitz, Fyer, Paterniti, & Klein, 2001; Veale & Lambrou, 2006). They also use safety seeking behaviors when they feel nauseous and think they may vomit; for example they may look for an escape route; keep very still or try to keep tight control of their body; take anti-nausea medication; or try to distract themselves. They may also avoid certain foods or restrict their eating in order to reduce the risk of vomiting or amount of food vomited (Veale, Costa, Murphy, & Ellison, 2012). The phenomenology of repetitive behaviors or compulsions in SPOV has not been explored in detail. In his model, Boschen (2007) suggested that a preoccupation with one's gastrointestinal state resembles the bowel obsessions seen in some OCD cases. Some checking behavior (e.g., of whether food contains certain ingredients) was also noted in a non-clinical survey of individuals with SPOV (Lipsitz et al., 2001). A recent study found that the most common comorbid diagnosis in 64 individuals recruited over the internet with SPOV was of generalized anxiety disorder (28.1%), OCD (12.5%) and hypochondriasis (12.5%) (Sykes, Boschen, & Conlon, 2015). The aim of this study was to explore the comorbidity and frequency of repetitive behaviors and compulsions in more detail from the case notes in a clinical sample with SPOV. The study was therefore hypothesis generating to determine whether future studies on characteristics and validators of OCRD should include a group with a SPOV.

2. Methods

The study consisted of a review of individuals who attended for an assessment and fulfilled diagnostic criteria in DSM-IV for a specific phobia of vomiting (American Psychiatric Association, 2000). DSM-IV was used as the interviews took place before the publication of DSM5.

2.1. Participants

83 Cases, consisting of 11 males (13.3%) and 72 females (86.7%) were reviewed for the study. Their age ranged from 9 to 68 years old, with a mean of 29.42 years and standard deviation of 10.42. Eight of the cases were children and adolescents ($\leq$ 17 years old). The mean age of onset when cases became aware of their fear was 8.2 years old (SD 5.21), while the mean age at which their fear of vomiting became a problem was 14.8 years old (SD 7.89). The mean duration of the disorder before presentation was 14.25 years (SD 11.69).

In terms of marital status, 40 (48.2%) were single, 40 were “cohabiting/married” (48.2%) and 3 had missing data. For employment, 2 cases were “unemployed”, 18 were “students”, 38 were “employed/self-employed”, 8 were “homemakers”, 2 categorized their employment status as “other”, and data for 5 were missing. 81 Cases were Caucasian, 1 was Arabic, and 1 stated their ethnicity as “mixed”.

2.2. Materials

A Structured Clinical Interview (First, Spitzer, Gibbon, & Williams, 1995) was used for a diagnosis of a specific phobia and for any other presenting problems. The following information was systematically recorded in the case notes:

2.2.1. Repetitive thinking

The extent to which their worry about vomiting had preoccupied the individual over the previous week was rated by the individual on a scale between 0 and 8, where 0=not at all, 2=slightly, 4=moderately, 6=markedly, 8=extremely.

2.2.2. Repetitive behaviors

The following questions were rated by the individual on a scale from 0 to 3 where 0=never; 1=sometimes; 2=often; 3=always:

1. When you feel nauseous, do you reassure yourself that you are not going to vomit?
2. When you feel nauseous, do you seek reassurance from others about whether you are going to vomit?
3. Do you seek reassurance from the person/people you live with about whether they look ill or could vomit?
4. Do you recite a phrase to stop yourself from vomiting?
5. Do you excessively smell or check sell by dates of food?
6. Do you check if others are looking or feeling unwell or sick?
7. Do you wash your hands frequently or use special measures (e.g. anti-bacterial soap or very hot water) or wash them for an extra-long time?
8. Do you get any children in your care to wash their hands frequently, or to use special measures or to wash their hands for an extra-long time?
9. Do you engage in any other repetitive behaviors or counting in an effort to stop yourself vomiting?

While not all questions focused on the motivation, responses were clarified that they related to the patients' fear of vomiting, for example hand washing or checking of food to reduce the risk of vomiting rather than any other feared consequences.

In addition, cases routinely completed the following series of questionnaires as part of their initial assessment: The Specific Phobia of Vomiting Inventory (SPOVI) (Veale et al., 2013); the Emetophobia Questionnaire (Emet-Q) version 13 (Boschen, Veale, Ellison, & Reddell, 2013); and the Health Anxiety Inventory (HAI) short version (Salkovskis, Rimes, Warwick, & Clark, 2002).

The SPOVI consists of 14 items that are scored for frequency ranging from 0 (not at all) to 4 (all the time). The total score is the sum, which ranges from 0 to 56. The scale has a two-factor structure, with one factor characterized by avoidance behavior (e.g. “I have been trying to avoid or control any thoughts or images about vomiting”) and a second factor comprised of threat monitoring (e.g. “I have been focused on whether I feel ill and could vomit rather than on my surroundings”). Cronbach's alpha of the SPOVI for a group with emetophobia was 0.91.

The Emet-Q is a 13-item scale with a possible range of scores from 13 to 65. The Emet-Q-13 has 3 factors. Factor 1 had 6 items focused on avoidance of travel, movement, or locations. Factor II was comprised of 3 items that centered on themes of dangerousness of exposure to vomit stimuli. Factor III consisted of 4 items that were focused on avoidance of others who may vomit. Cronbach's α for this measure is 0.82.

The HAI (Salkovskis et al., 2002) (Short-Version) is a 14 item self-report scale, which has been found to have high internal consistency in both non-clinical (α=0.94) and clinical (α=0.95) samples. The possible range of scores for the total is 0–42. In a previous sample, emetophobia was most strongly associated with