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DOI
10.4081/mi.2012.e3

Publication date
2012

Document Version
Final published version

Published in
Mental Illness

Citation for published version (APA):
de Jongh, A. (2012). Treatment of a woman with emetophobia: a trauma focused approach. Mental Illness, 4(1), 10-14. [e3]. https://doi.org/10.4081/mi.2012.e3
Treatment of a woman with emetophobia: a trauma focused approach

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Abstract

A disproportionate fear of vomiting, or emetophobia, is a chronic and disabling condition which is characterized by a tendency to avoid a wide array of situations or activities that might increase the risk of vomiting. Unlike many other subtypes of specific phobia, emetophobia is fairly difficult to treat. In fact, there are only a few published cases in the literature. This paper presents a case of a 46-year-old woman with emetophobia in which a trauma-focused treatment approach was applied; that is, an approach particularly aimed at processing disturbing memories of a series of events which were considered to be causal in the etiology of her condition. Four therapy sessions of Eye Movement Desensitization and Reprocessing (EMDR) produced a lasting decrease in symptomatology. A 3-year follow up showed no indication of relapse.

Introduction

A phobia of vomiting, or emetophobia, is a condition characterized by a disproportionate fear of vomiting or other people vomiting, and is generally associated with an overwhelming sense of losing control, becoming very ill, or that others will find them repulsive. Individuals with this condition have a tendency to check and monitor interoceptive stimuli such as nausea that in turn makes them more likely to feel sick.1

Estimates about the prevalence of emetophobia suggest that it is a rare condition occurring in about 0.1% of the population.2 Conversely, in its milder form, fear of vomiting is fairly common in the community with estimates of point prevalence rates ranging from 3.1 to 8.8%, and women being four times more likely to suffer from fear of vomiting than men.3,4

Emetophobia belongs to the category of specific phobia (Other Type) according to the current edition of the Diagnostic and Statistical Manual of Mental Disorders.5 To be diagnosed with emetophobia, the avoidance response must be very distressing and have a significant impact on the person’s life. As a result, emetophobics have a tendency to avoid a wide array of situations or activities that they believe might increase the risk of vomiting. For example, they may avoid crowded places from which they fear they cannot quickly escape in case of nausea or vomiting, such as shops, boats, airplanes, concerts and hospitals. In addition, they may not be able to go on holiday or travel on public transport, but the avoidance behavior could also pertain to avoiding adults or children who may be ill (and, therefore, regarded as contagious) or who are at risk of vomiting (e.g. people who are drunk). The avoidance might extend to using public toilets or door handles, medication, going to the dentist, restricting the activities of their children who may be in contact with other children, or to certain food which they believe could cause vomiting, which may lead to being significantly underweight.5,6

The sudden nausea and anxiety in emetophobia seems to have many similarities with panic disorder6 and agoraphobia.6 The difference between emetophobia and panic disorder, however, is that the panic caused by emetophobia is usually of much shorter duration than that of panic disorder. Furthermore, the avoidance behavior of emetophobics covers a much wider range of situations than seen in agoraphobia, including the avoidance of drinking alcohol, becoming pregnant, contact with sick people and people with a degree of unpredictability, like children or the mentally handicapped.6 More specifically, the behavior of emetophobics is primarily aimed at the prevention of nausea and vomiting and not, as is the case of agoraphobia, to avoid situations where the thought comes to mind of not being able to get help when misinterpreting bodily signs of anxiety.

If left untreated, emetophobia is likely to persist. Knowledge on how emetophobia should be treated is limited, partly because of the lack of any controlled trial on the (relative) efficacy of treatment strategies for this condition. In fact, there are only a few published cases in the literature. Treatments that have been reported include the use of (combinations of) hypnotherapy,8-10 cognitive behavior therapy including stimulation of nausea or vomiting,11,12 the use of counter conditioning,13 interoceptive exposure,1,14 exposure in vivo to cues of vomiting, re-writing of past aversive experiences of vomiting, behavioral experiments, dropping of safety-seeking behaviors, and role play of vomiting using the smell of vomit.15

It would seem that emetophobia is a condition that is relatively hard to treat. The most comprehensive treatment study used repeated exposure to film footage of people vomiting among a group of 7 patients.3 Up to 13 sessions were conducted in which the participants were asked to repeatedly view video sequences. The author noted that a subgroup of patients required a greater number of sessions because fear returned between the exposure sessions. This observation is in line with the results of an internet survey among 56, mostly female, individuals which showed that those who suffer from emetophobia are likely to have undergone a wide range of previous treatments but with fairly limited success.6

Eye Movement Desensitization and Reprocessing (EMDR) is a recommended treatment for posttraumatic stress-disorder or PTSD.16,17 Given that emetophobics frequently report a childhood onset, often following exposure to distressing experiences of vomiting or seeing others vomit,6 and that EMDR is capable of resolving disturbing memories of a wide variety of events, including those that explain the onset of phobic conditions,18 one might argue that emetophobia is also responsive to EMDR. Among the types of phobias that have been reported as being successfully treated by using EMDR (e.g. phobias of traffic, snakes, moths, spiders, mice, injections, dental treatment, and choking),19-21 there is one case report in the literature in which EMDR was used to treat a fear of nausea and vomiting.22 This approach led to complete remission of complaints following only one session of EMDR.

The aim of the present case study was to further explore the clinical usefulness of EMDR for treating emetophobia. To provide the reader with an impression of how the therapy was experienced by the client, special attention was paid to her personal notes and the cognitive, emotional and behavioral changes that she reported by e-mail both during the period she was in therapy and at follow up.

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Key words: specific phobia, vomiting phobia, emetophobia, EMDR.

Received for publication: 28 August 2011. Revision received: 2 December 2011. Accepted for publication: 2 December 2011.

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Case Report

Subject

Debbie is a 46-year-old office worker who had been suffering from an excessive and unreasonable fear of vomiting for as long as she could remember. She had always done everything in her power to avoid seeing other people vomit, including her own children, as she was afraid that it would make her want to throw up herself. Debbie, therefore, avoided all kinds of situations, among which visits to hospitals, and watching certain television programs and films, from fear of seeing people that might feel unwell, and who therefore might vomit. Because Debbie had gradually been avoiding more and more of these situations in her daily life, her world had shrunk considerably.

Assessment

To assess whether Debbie’s fear of vomiting would meet the diagnostic criteria for specific phobia (emetophobia) in terms of DSM-IV-TR, the diagnosis was established with a standardized diagnostic interview: the Mini International Neuropsychiatric Interview, version 5.0.0.25,24 This also evaluates the presence of coexisting disorders and helps clinicians make a differential diagnosis between emetophobia and, for example, panic disorder. Emetophobia appeared to be Debbie’s only diagnosis.

To determine the severity of Debbie’s symptoms, she was asked to fill out the Dutch version of the Symptom Check List-90-Revised version (SCL-90-R).25,26 This consists of 90 items providing an indication of psychological dysfunctioning on eight dimensions: agoraphobia (7 items), somatization (12 items), anger-hostility (6 items), depression (16 items), interpersonal sensitivity and paranoid ideation (18 items), anxiety (10 items), cognitive-performance difficulty (9 items), and sleep disturbance (3 items). The Dutch version differs from Derogatis’ original version in that patients are requested to indicate the number of complaints they experienced during the previous week on a 5-point scale (1=none; 5=very many). The total score is the sum of the items of the eight subscales, including nine non-scalable items, and can vary between 90 and 450. Debbie’s total score was 275. This fell in the very high range (norm group 2) on the dimensions anxiety, agoraphobia and interpersonal sensitivity.

Procedure

EMDR is a protocolized, 8-phase psychotherapeutic approach aimed at resolving symptoms resulting from disturbing and unprocessed life experiences.27 It begins with a focus on the traumatic memory itself by asking the client to recall the memory and to concentrate on various aspects of it. The client must focus specifically on the most distressing image and a dysfunctional negative belief of oneself in relation to the image, as well as accompanying emotions and bodily sensations. A core feature of the procedure is the performance of eye-movements. Typically, the therapist moves his or her fingers back and forth in front of the client, asking him or her to track the movements with the eyes while concentrating on the trauma memory.27 Following the image and negative cognition (NC), access to the emotional and somatic aspects of the memory takes place. After each series of eye movements (termed a set) the client is asked to report emotional, cognitive, somatic and/or imagistic experiences until internal disturbances reach a SUDs (subjective unit of disturbances scale ranging from 10 to 0) of zero and adaptive and positive cognitions (PC) are rated strong on a VoC (validity of cognition) scale, ranging from 1 (feels completely untrue) to 7 (feels completely true). For the application of EMDR with phobias, there are a number of elements added to the procedure, including a preparation for future confrontations with the phobic stimulus.28

A wide range of experimental studies demonstrates that eye movements during recall of aversive memories reduce their vividness and emotional intensity.28-29 Recalling a traumatic memory is assumed to tax the working memory capacity which is reduced. If another task is executed during recall, less capacity will be available for recalling a distressing event.30 This means that the memory is experienced as less vivid and emotional. Although eye movements are believed to serve as such a secondary task,28-29 also other modalities can be applied to tax working memory. In the present case, EMDR was carried out using headphones connected to a CD-player on which alternating tones (clicks) were played.

Case conceptualization

EMDR is based on a model that focuses on distressing events in the individual’s life that remain unresolved and that are causal in the etiology of the psychological disorder. Initially, Debbie indicated that she could not remember when she had started being afraid of vomiting. To help Debbie access memories that are considered crucial with regard to the origins and maintenance of her symptoms, the Trauma Method model was used.31 Debbie remembered an occurrence that had taken place while she was in kindergarten in which a child in her class threw up over a table. According to Debbie, she must have been about four years old at that time. It was decided to reprocess this memory first.

The first treatment session

The most disturbing picture of Debbie’s memory of the kindergarten appeared to be the mess on the table, the moment that my classmate vomits all over the table. The feeling that this picture evoked in Debbie was one of pure powerlessness (NC=I am powerless), and appeared to be emotionally charged (SUD=8). After starting the EMDR procedure, an intense flow of thoughts immediately started in Debbie’s mind. She quite rapidly associated the event at the kindergarten with other relevant events related to the main one. Thoughts and memories arose that were associated with Debbie’s early school years. During the second set, she suddenly burst into tears when she realized how much fun she had actually missed because as a child she was always so fearful. In the following set, Debbie saw all kinds of nice things, jars of paste and such that had once been present in her kindergarten class. At the end of this chain of associations, when going back to the initial target memory, she indicated: It is really a strange thing when I see the event, it seems as if I saw it changing from very small and detailed into something much broader. Not only the perspective of that table, where it happened, but also everything around it, but in their normal proportions. After the following set, new memories arose. Then, suddenly, there was an expression of calm on her face: Yes, what is actually disgusting about it? ...The picture that I had always had of it in my mind’s eye seems to be simply disappearing. But this amazement was rapidly followed by a new memory that came to mind: My parents were away and I had to babysit. He felt nauseated and thought he would make it to the bathroom, but only made it to the kitchen.

What a disaster!

Debbie added that she had panicked and had run to the woman who lived next door to ask for help. But she had replied that she was not able to help either, as she herself could also not tolerate vomiting and vomit. Debbie could still remember very clearly that she was allowed to use the neighbor’s telephone to call her parents: Then father came home to clean it up, but afterwards he left again. In a clearly emotional way, Debbie said that with the return of this image she felt fearful and deserted again: I lay frozen stiff with fear in my bed, listening carefully in case I heard anything. But above all, what was really painful about the event for Debbie was the fact that her father did not see her problem: No one even saw my fear. The entire vomiting situation was even driven into the background by this.

After this interlude, the EMDR was started up again to process the memory of the kindergarten until Debbie was able to look at this event without experiencing any disturbance. Next, it was agreed with Debbie to conclude the session, and that she would keep a journal for the next few days with the request to e-mail this to the therapist.
After the first treatment session

Four days later Debbie e-mailed the follow-
ing text: “It was an exceptional experience. That you can take a memory that you have and it has al-
ways been the same, but that it gradually en-
larges. The sound in your ears has such a
"case report" effect and it seems as though it helps
you process a memory in a positive way. I don’t
know whether I am describing it well, but that is
how I experienced it. I was dead tired from
all the emotions that arose during the treat-
ment. Yet, I can already tell you now that my
first memory of kindergarten already feels very
neutral. That I even thought back with pleasure
on it today. The image of filling the paste jars
came up again, which I always enjoyed so
much, and also the sweet face of the teacher.

The second memory that we dealt with:
home – apartment – brother that vomited and
my father... this is not yet really neutral, I must
say. Although I do find it surprising that I could
suddenly remember many details of my room
back then, and that was actually nice. But with
this memory, in addition with the vomiting sit-
uation another feeling came more strongly for-
ward, it seems...; not heard, not seen. I am not
there. I will keep a journal and look forward to
the next time.

The second treatment session

In the journal that Debbie had kept since the
previous session, a number of other events
came up that possibly have played a role in
worsening or maintaining her fear. She
described an event that happened a few
days earlier when a car suddenly slowed down
in front of her and drove into the bicycle lane:
"an unusual place. At that moment I felt a rush of
adrenalin and my thoughts flashed back to I
don’t know how many years ago (as I write this,
I see the images before me again). A car stops. I
see that someone is just getting back in, and
then opens his door again and vomits.

It was decided to also make this memory
part of the treatment. But first the memory of
Debbie’s father that cleaned up the vomit of
her brother was targeted once again. The emo-
tional burden of this memory (SUD) could also
be brought down to 0. Then, five minutes later
after the installation phase, she could project
the image in her mind and feel that she was
definitely worth something after all. This was
followed by the vomiting scene of the car that
had stopped, and this memory was also suc-
cessfully processed.

After the second treatment session

Debbie wrote in her journal: "This week in
the train I was sitting reading a newspaper.
There was a comic in it about vomiting. It was
a poster on the step (wat bedoel je hiermee? On
the step?), at least that is how it was drawn. I
did not immediately react with fear! Wow! I
even turned the page back another time and
continued to look at the picture for a few min-
utes, while inside myself I said: 'Actually such a
drawing doesn’t mean a thing’. I can hardly
believe it.

The third treatment session

At the beginning of the third treatment ses-
sion, Debbie reports that she had noticed that
she could stand up for herself much more than
in the past. Her husband had noticed it, too, as
had her colleagues: "We are understaffed where
I work. And this is not the first time. The last
even few times I worried about the work that had
to be done and worked overtime for hours.
Nothing was ever said about this; no one appreci-
cated it. Now I work my normal hours and just
push whatever is not finished aside: without
any feelings of guilt.

In the last week, she had remembered that,
when she was still in primary school, she had
gone on a school trip with a bus. Someone had
become nauseated while they were traveling
along. At present, the idea of not being able to
get off the bus was still being experienced as
very frightening and had to do with helpless-
ness. After a while, the memory slowly began
to feel neutral, and after one hour this treat-
ment session could also be concluded.

After the third treatment session

A few days later, a poster on the step (wat bedoel je hiermee? On
the step?), at least that is how it was drawn. I
did not immediately react with fear! Wow! I

Fourth treatment session

In the fourth session, a so-called future tem-
plate was installed; a blueprint of a positive
action in the future. More specifically, Debbie
was asked what she, in terms of her fear of
nausea and vomiting, still did not dare to do or
any particular situation she still avoided.
Debbie answered that she now thought she
could deal with virtually all situations related
to vomiting in daily life. However, she still con-
sidered it unpleasant to take long bus trips, as
she would have to accept that she could not
simply get off the bus just like that, for exam-
ple, if someone might have to vomit. Debbie
was asked to imagine how it would feel to take
such a long bus trip, an image that included
herself and one from which she could not sim-
ply walk away. Debbie was requested to hold on
to this image in her mind and at the same time
say to herself: the PC I can handle it. Then a
new series of sets was introduced and this pro-
cedure was repeated a few times. The confi-
dence of being able to deal with the image
increased a little after each set. After a VOC of
7 was reached, Debbie was asked to what
extent she thought she was capable of taking-
such a bus trip, and she answered: "Entirely.

After the fourth treatment session

When Debbie and her therapist met for the
last time, Debbie indicated that she had
planned the bus trip, and that there were no
longer any situations that she still feared. In
fact, over the past few weeks she had not
thought about her vomiting problem at all. To
measure the effects of treatment Debbie was
asked to fill out an SCL-90 again. It appeared
that there were no high subscale scores with
the total score being 121 (average). Accord-
ingly, it was decided to discontinue the
treatment for the time being with the restric-
tion that, if needed, she would contact the
therapist again.

Three year follow up

Three years later, the therapist sent Debbie
an e-mail asking her how she was doing and
how she would evaluate the value of the thera-
py from her current situation. Debbie
answered: ‘I’m still not entirely happy when I
see someone vomit, but the violent panic reac-

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tion doesn’t happen. And that’s so nice! Meanwhile I switched jobs. Nowadays, I work at an undertaker’s business. If I get a notification of death, I go directly to the family and then do the last operations. I can tell you: it’s not always fresh and it often happens that some comes out through the mouth. I am really amazed at myself for doing this!

Discussion

This paper presents a case in which EMDR was used successfully in the treatment of emetophobia. Although cognitive-behavioral therapy (CBT) has been proven to be efficacious for treatment of specific phobias in general, positive treatment effects in case of treating emetophobia are limited to a very small number of case studies. The result of the present case study is in line with previous studies on fear and phobias with people suffering from debilitating fears that have developed following disturbing events in which a trauma focused approach has proven to be a useful treatment, comparably as effective as CBT. An important difference with the latter approach is that, in the present case study, the client was not systematically exposed to situations that she has so far been avoiding (e.g. sick people, TV programs, vomit), but the therapy was aimed at processing a series of memories of past events which were considered to be crucial with regard to the origins and maintenance of her symptoms. These beneficial effects of EMDR should be considered in the light of the working memory account explanation of this approach. There is a wide array of experimental studies demonstrating that the vividness and the disturbance of memories can relatively easily be reduced using a variety of tasks that tax working memory. One might postulate that memories that are less emotional can be assimilated more easily into semantic memory networks leaving more room for functional interpretations.

What the present case study also illustrates is how exposure to distressing or otherwise aversive situations can lay down the groundwork for phobic conditions like emetophobia. This agrees well with the data of a survey for phobic conditions like emetophobia. Although cognitive-behavioral therapy (CBT) has been proven to be efficacious for treatment of specific phobias in general, positive treatment effects in case of treating emetophobia are limited to a very small number of case studies.

The result of the present case study is in line with previous studies on fear and phobias with people suffering from debilitating fears that have developed following disturbing events in which a trauma focused approach has proven to be a useful treatment, comparably as effective as CBT. An important difference with the latter approach is that, in the present case study, the client was not systematically exposed to situations that she has so far been avoiding (e.g. sick people, TV programs, vomit), but the therapy was aimed at processing a series of memories of past events which were considered to be crucial with regard to the origins and maintenance of her symptoms. These beneficial effects of EMDR should be considered in the light of the working memory account explanation of this approach. There is a wide array of experimental studies demonstrating that the vividness and the disturbance of memories can relatively easily be reduced using a variety of tasks that tax working memory.

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