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Abstract (<=250 words, no sub-headings, objective, methodology, key results, major conclusions) {57 wds}	The objective of this paper was to define a framework for the understanding and treatment of emetophobia. Two broad methods of encoding (limbic system V belief) were discussed in relation to two representative case summaries. It was concluded that an integrated, multi-disciplinary approach to the treatment of emetophobia may result in the greatest level of patient benefit.
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An integrated approach to the treatment of emetophobia

Emetophobia (Andrews, Crino, Hunt, Lampe and Page; Cambridge University Press, 1999; Gelder, Garth, Mayou and Cowen, 1998; Kennerley, 1997) refers to an abnormal and often highly persistent fear of vomiting. The fear is of vomiting one's self, or fear of other people vomiting, which generally tracks back to a fear of one's self vomiting. Persistent sensations of nausea may be present and the patient may routinely take large does of anti-emetics (prescribed or otherwise) to control such sensations. Sometimes symptoms of persistent nausea are caused by physical illness – please note that this article concentrates upon anxiety-based emetophobia where physical illness is absent.

Avoidance of illness in others and one's self will generally be present, as will scanning behaviours to detect evidence of illness in others - this may include persistently enquiring about the health of others. Family members may well have displayed a variety of anxiety-based behaviours during childhood years. The position of a child's bedroom in relation to the family bathroom may also be / have been significant and morning sickness could be / could have been / be an issue if there are younger brothers / sisters.

Symptoms are often present from childhood and are generally quite resistant to many forms of therapeutic intervention. Some contend that there may be a link with childhood abuse in some cases. Left untreated this condition can generalise and lead to agoraphobia, cleaning / avoidant OCDs and hypochondria. Avoidant patterns of living become more and more deeply ingrained as time passes if such behaviours remain unchecked.

Children may refuse to attend school and engage in social activities. Parents may develop cleanliness compulsions and may refuse to assist their children when they are ill. Scanning behaviours may lead to insomnia with some parents if they perceive that their children may vomit during the night. When children are ill parents may refuse to remain in the same house / sleep on the same floor as their children – subsequent feelings of guilt and inadequacy can be substantial.

Long-term emetophobia can lead to the complete suppression of the vomiting reflex and physical illnesses will be tolerated despite great discomfort. Ailments that would otherwise result in vomiting are contained within the digestive system and "forced downwards". There is a considerable focus on the entire digestive process such that even a belch may cause alarm. Perhaps as a consequence of this extreme internal focus, IBS may also be present. Avoidance of nausea generating drugs can lead to avoidance of surgery due to the possible side effects of anaesthetics.

Learning Mechanisms

One-time learning via a seeding event may or may not be present. Where potential seeding events are present the reported intensity of disturbance when recalling the memory (in or out of trance) is often very low. One could speculate therefore that the response has not been strongly encoded by the amygdala as is thought to be the case with many other phobic disorders. (The amygdala lies within the limbic system and is thought to play an active role in one-trial / one-time learning, the generation of immediate stress responses when presented with specific generalised classes of stimuli, as well as scanning for such stimuli). Also, there is often a perceptible thought-process taking place when evaluating stimuli such as photographs or audio / video recordings of vomiting (for example as marketed by the author via www.changingstates.co.uk/shop).

Unlike many phobias (perhaps because it is not common) emetophobia is not generally learnt from family / friends / role models. Sometimes the reverse can be true when family members vomit all too easily and audibly. One should also not disregard the power of kin (brother / sister) relationships and the delight that they sometimes derive from frightening / tormenting one another.

The most frequent method of learning would appear to be a gradual accumulation of effects, particularly when combined with a natural tendency for some to not vomit as frequently as others might. This can result in the concept of vomiting being more or less unknown to the sufferer – they simply cannot imagine how it must feel because they have little or no personal experience. (Emetophobes can often inhibit what is sometimes considered to be an involuntary reflex action – they may feel nauseous, they may retch but they will not vomit).

The role of beliefs

Perhaps the single most common attribute of emetophobia is the presence of a series of interlinked limiting beliefs that are developed over time. (Ellis, 1988, 1993) These may include:

- Vomiting is dangerous and may kill me, I am afraid of me vomiting, I am afraid of other people vomiting because I could catch something and vomit myself
- Nausea in me / others will result in me vomiting
- Illness (of any type) will result in me vomiting
- You can catch vomiting simply by being in the same room as someone that vomits (i.e. vomit = illness)
- I must be in control, when I vomit I am not in control, I must never vomit
- I cannot control how I feel / behave (external locus of control)
- I cannot possibly cope with vomiting (not in my frame of reference)
- I don't know if I can cope with vomiting because I can't imagine / remember how it feels / how I coped
- Vomiting (rather than illness) lasts for days or weeks

Why encoding is important

Setting aside personal belief preferences in terms of how phobic responses are encoded, there appear to be two main categories of theory (with much overlap between the two camps):

Conscious (ways of thinking / self talk usage / limiting beliefs / behavioural choices made …) (Ellis, 1988, 1993)
Unconscious (automated responses coded in the limbic system (amygdala) and or brain stem that generate stress responses on a automatic basis in the presence of generalised categories of stimuli (incident memory / conditioned reflex responses / one trail learning / one time learning / incident memory…) (Russell, 1979)

On top of the above there are also "hemispheric" influences (left = logical / right = creative or logical aspects of personality / creative aspects of personality). One model of phobic responses says that there is am imbalance between the logical control processes and the creative emotionally reactive processes. Someone that walks on hot coals for instance uses logical reasoning to control the natural avoidant response when presented with the prospect of walking on hot coals (as well as other motivational influences such as peer pressure and paying for the pleasure!) (Doman, 1982; Russell, 1979)

One approach to determine where the response has been encoded may be as follows:

(1) Is there a generalised reaction to images / sounds of people vomiting? It takes an intellectual process of careful evaluation to decide that a cartoon of someone actually vomiting is OK and a photo of someone looking as if they might be about to vomit is not OK. If the response has been encoded by the limbic system one might expect strong reactions to all or most challenge images / sounds.

(2) Level of reported nausea on hearing / seeing media associated with vomiting. Mirror neurones in the frontal cerebrum cortex and other mechanisms should generate empathetic responses in the observer that mirror the observed behaviour (see fear in another => feel for them => feel fear oneself) / (see another person vomit => feel for them => feel nausea oneself). If fear is primarily reported rather than nausea this could be due the rapid nature of the thought process (see / hear x => feel nausea => I may vomit => I fear vomit => I feel fear is experienced as see / hear x => I feel fear (as per the NLP synestesia model (Bandler and Grinder, 1972)).

(3) Are there overt reactions to vomit related stimuli in terms of body language / behaviour? If observable reactions are subtle and take time to develop this may indicate that a potentially complex thought process is taking place, often with a substantial level of rapid self-talk prior to a decision being made to express that reaction in a particular way.

The following case histories are representative of the symptomology that is often presented in emetophobia cases:

Case History 1 – Helen – Age 44

Helen responded with perceptible, immediate high levels of disturbance and avoidance when an audio sample of someone vomiting was played via headphones at the lowest audible volume level with the headphones placed 6 feet away.

DETAIL

Helen logically understood and at some level believed that there was no real threat from e.g. a photograph of someone else vomiting, but none the less reacted strongly to all vomit related imagery even if informed that the image was only simulated. She reacted more strongly to auditory stimuli than to visual stimuli and fully understood that the act of vomiting was simply a normal natural response.

Helen avoided contact with her children (2 boys), strongly avoided parent meetings or any situation where large numbers of people (children in particular) might congregate. She perceived herself as being mildly agoraphobic. She was also avoiding outstanding minor surgery because of the risk of reacting with nausea to the anaesthetic. When in the presence of others scanning behaviours looking for signs of illness to avoid were prevalent. Anticipatory anxiety started long before actual exposure to any situation where illness might be present.

Helen had not vomited since the age of approx 10 years old when she was overcome by anxiety when a boy vomited during an assembly meeting. She had been treated for IBS since the age of 25 (fear of being too far from a toilet was also present) / a variety of psychosomatic illnesses by her GP in the past.

Helen's general way of thinking tended to be negative, she worried most of the time and was generally very anxious. Previous treatment approaches had included: counselling, behavioural therapy, cognitive therapy, dream analysis, homeopathy, acupuncture but would accept no medications. She did not drink alcohol or take any form of recreational drug.

A predominantly limbic form of encoding was assumed with underlying anxiety as a major contributing cause.

Case History 2 – Jordan – Age 11

Jordan could listen to any vomiting audio sample and could look at any image without observable or reported levels of disturbance or avoidance. Marginal reactions were present with some of the more literal images but only after “yes” was the reply to the question “is this real?” (even if they were very clearly simulated).

DETAIL

Jordan believed that vomiting would always result from illness and strongly feared the concept of herself vomiting. She was unconcerned about other people vomiting unless there was a possibility of her catching an illness from others, in which case she was concerned for her own safety. She strongly believed that where there was vomiting there was illness and that contact with / close proximity to vomit was a certain way to catch illness.

Her bedroom was next to the family bathroom and at least one brother enjoyed the process of tormenting her with simulated vomiting (which Jordan did not appear to react to). Her mother suffered from IBS / anxiety / panic attacks and was affected by morning sickness when pregnant with Jordan’s younger brother. Other family members’ responses were normal in relation to vomiting.

Jordan was refusing to attend school lessons was using every delaying tactic she could think of to avoid attending school. There were no known bullying issues at school and Jordan was otherwise an able, intelligent, relatively mature and popular student. She was also avoiding seeing friends and going out generally. Anticipatory anxiety started as soon as she awoke and increased during the day until she returned to the sanctuary of her bedroom where she felt most safe. Scanning behaviours were present whenever with other people. Emetophoic reactions aside, Jordan’s anxiety levels were negligible in most other situations.

Jordan did not recall any particular initial seeding event and was not aware of ever having vomited. She was generally quite resilient and was rarely ill. She perceived fear in a very intellectual was i.e. without associated internal bodily sensations.

A predominantly belief based form of encoding was assumed.

Where the encoding is primarily belief based therapists may need to work (hard) on those belief systems before attempting any form of desensitisation (Kroger, 1977) – especially if motivation is low. Where limiting beliefs directly associated with vomiting are less dominant, motivation is high and lower level encoding is present most forms of desensitisation should be effective.

The diagram below summarises a proposed interrelationship between the various ways in which emetophobia may be encoded by patients and treatment approaches that may be effective. Please note that (1) all elements may be actively involved in the condition to varying degrees in all patients – at the same time, and (2) the suggested protocols are by no means exhaustive and are provided for indicative purposes only:

Left / Right-Brain Balance

Left brain negative logical dominance (invalid / limiting logical thoughts / beliefs & self-talk, often without associated kinaesthetic reactions)	Right brain emotional reactions (with or without supporting beliefs, logical beliefs may contradict the emotional reaction)
Hypno Desensitisation / Education / Systemic Desensitisation (McKenzie, 1994; Andrews, Crino, Hunt, Lampe and Page, Kroger, 1977) / …	NLP Fast Phobia Technique (Bodenhamer and Hall, 2000) / Hypno Desensitisation (Waxman, 1989, Andrews, Crino, Hunt, Lampe and Page, ????; Cambridge University Press, 1999) / …

Limbic Encoding V Belief Encoding

Incident memory in the amygdala / limbic system / brain stem	Belief systems (logical cognition + reinforcing emotional reaction / +ve kinaesthetics)
EMDR (Shapiro and Forrest, 1997) / Metaphor (Hammond, 1990)/ …	EMDR / REBT (Ellis, 1988; Ellis, 1993) / NLP (Bodenhamer and Hall, 2000) / …

Other Factors

<u>Other factors applicable to all types</u> Learnt responses (e.g. parental conditioning), sensitivity to disgust / ease with which the nausea response is generated, underlying levels of stress / anxiety, past experience of vomiting (seeding event(s)), motivation, willingness to change
Hypnotherapy / NLP / Regression to seeding event {Symptom Manipulation via Regression} / Analytical Techniques / etc …

Suggested Generalised Treatment Protocol

The primary targets for the suggested therapeutic approach could therefore be (in no particular order as such) and using whatever therapeutic approaches you are qualified to practice:

- Strengthen ego / boost self esteem (Waxman, 1989)
- Targeting key limiting beliefs (Ellis, 1988, 1993)
- Externalise locus of focus
- Boosting logical reasoning by education / targeting ways of thinking / thought patterns
- Direct desensitisation to triggers (Dobson, 2001; Kroger, 1977) - Presentation of stimuli without expression of unwanted reactions (similar to, but not the same as systemic desensitisation – the net result is the same – gradual exposure to the stimuli that is being avoided – either approach may be effective)
- Improving ability / willingness to communicate feelings / thoughts by talking / drawing (to boost internal positive dialog to interrupt cycles)
- Increasing motivation
- Provide in-situ coping mechanisms

Identify and challenge self limiting beliefs

This should include the beliefs of all parties – provide the family unit with educational material and ask them to notice what seems not to fit with their understanding of the world. Directly counter any misconceptions by providing detailed explanations.

“I’m afraid of being sick” =>

- “What would happen if you did vomit? I have vomited many times and I’m fine. When I vomited I experienced <detailed step by step from before to well afterwards – safe to safe – unknown to known>”
- “For what purpose are you choosing to be afraid of vomiting? How is choosing to think that way beneficial to you?” Strong approach – directly implies choice. (Should be reworded for kids)

An interesting common belief is that “Everyone vomits at some stage or another”. Who says? Emetophobes often report that they have not vomited for many decades. Is vomiting therefore inevitable during a lifetime? When did you last vomit? (If you really had to think about that question perhaps this is because most of us tend to forget periods of nausea / vomiting soon after the event – or at least lose strong kinaesthetic associations with the vomiting itself). One should also note that some people are naturally more prone to the sensation of nausea that others and some people are more prone to vomiting / illness than others.

Externalise locus of focus

Emetophobes will often feel little or no empathy for other people being ill / vomiting as such. Their primary concern may often be to protect their personal safety and to avoid the situation in order to reduce the threat to them personally. Using perceptual positions can be helpful when seeking to externalise the locus of focus. It may also be helpful to reframe any nausea as a natural empathetic response.

Boost logical reasoning capabilities

This can be achieved by a combination of education about the nature of illness and vomiting as well as challenging ways of thinking (internal self talk or verbalisations) that result in negative self-fulfilling prophecies. Teaching the patient to challenge self-talk questions can be very beneficial, however beware of situations where infinite loops / incongruities exist between a number of different contradictory beliefs.

Desensitisation to triggers

In reality – in vivo: Presentation of stimuli in the form of audio samples / cartoons / video clips / photos without expression of unwanted reactions. This is similar to but not the same as systemic desensitisation (Dobson, 2001; Kroger, 1977) – the emphasis is on no reaction (ambivalence) or appropriate empathy rather than pairing with relaxation which can be rejected as an implausible / inappropriate response. NLP Note: It is possible to anchor “null” i.e. feeling nothing / thinking nothing. (Bodenhamer and Hall, 2000)

Directly encouraging direct, physical confrontation by literally inducing vomiting should be avoided for moral, ethical and legal reasons. Additionally the patient may have avoided vomiting for so long that they may find it impossible to vomit at all. The trauma of their body attempting to vomit may result in further sensitisation.

In the imagination – in vitro: When EMDR is employed the processing may naturally track to associated beliefs hence some flexibility is required when using the EMDR phobia protocol. Hypo desensitisation (McKenzie, 1994; Waxman, 1989) and / or the NLP Fast Phobia Technique (Bodenhamer and Hall, 2000) can also be effective after some of the self-limiting beliefs have been weakened / removed. Confusional linguistic approaches can be useful in this respect to “loosen the concrete”. (Chomsky, 1957; Diltz, Grinder, Bandler and DeLozier, 1980)

Improving ability / willingness to communicate feelings / thoughts by talking / drawing

Emetophobia patients will often avoid communicating about their fears and thoughts in relation to vomiting and this tendency can sometimes generalise to include many other inner feelings and thoughts. One approach is to literally “draw” the fear or feared situation - this can reveal further hidden negative / limiting beliefs. It can also be helpful to encourage open and frank communication within the family unit about feelings and thoughts generally.

When dealing with children and there are significant issues with tormenting brothers / sisters, perhaps consider encouraging the parents to negotiate a truce. This provides a safe environment for the child to explore their feelings and implement change. A threat / penalty based approach may be necessary.

Increase motivation

Motivation may also be a key issue with many emetophobia cases. When patients are suitably motivated to confront the fear and reconsider their self-limiting beliefs progress can be rapid. If motivation is limited the patients avoidant behaviours will remain dominant and the issue will remain.

There are three mains methods of motivation: Move away (the stick approach - aversion), Move towards (carrot approach – solution / goal focus), Propulsion (Some move away + lots of move towards). To achieve rapid / substantial change more or less mandates a propulsion approach with effort distributed as follows: 20% move away 80% move toward. (Bodenhamer and Hall, 2000)

To amplify and focus the move away motivation find out what the cost of their behaviour is in terms of things they would like to do but can’t – then make the avoidance less pleasant. If the patient stays home make the concept of staying home even more tedious – e.g. no DVDs / videos / TV etc unless there is positive progress in terms of undoing the avoidant behaviour.

To amplify and focus the move toward motivation project them into a future in which they are doing those positive things and living their life in a positive manner. For kids a points based system can be beneficial with rewards for good behaviour and deductions for less positive behaviour.

When motivation is poor the therapeutic outcome may also be poor. If the timing is not right for the patient it may be beneficial to delay treatment until the motivation to change increases or until the life-cost of the situation remaining the same increases. In some ways it can sometimes be better to wait until things get worse – which can of course be used as a therapeutic intervention in its own right.

Provide in-situ coping mechanisms

All of the following resources can be beneficial this ensures that they are in control and that they can boost that sense of control when something unexpected happens:

- Quieting reflex / breathing relaxation techniques
- Positive self talk / belief challenges generally e.g. “I can deal with this, this feeling will soon pass” (Ellis, 1988)
- NLP anchoring / Swish / sub-modality shift techniques e.g. move sensations out of the body (Bodenhamer and Hall, 2000)
- Singing (silently) to neutralise self-talk / thought stopping techniques (Bodenhamer and Hall, 2000)

Reduce overall anxiety levels:

- Self-hypnosis to internalise locus of control (Alman and Lambrough, 1992)
- Relaxation CDs / hypnotherapy CDs that include of ego strengthening / seek to internalise locus of control

Conclusions

Emetophobia need not be a lifelong behaviour pattern – but often is. Therapy can be effective – but is often not. As therapists it is important for us to remain flexible in terms of our approach and to keep in mind the overall game plan of the mind that we are seeking to assist. By understanding and modelling how we “do” problems we can find appropriate methods to enable us as therapists to find appropriate solutions. In the case of emetophobia (and other phobic responses perhaps) this means targeting the issue using a wide variety of approaches to effect change at a number of interconnected levels.

Finally, consider how you relate to the concept of vomiting? I personally can recall only one episode of significant vomiting when I picked up a campylobacter (food poisoning) infection on day 11 of a 15-day hiking holiday in the Atlas mountains of Morocco in 1994. I am now very wary of Moroccan tagines now but remain unconcerned by vomiting. (The person that I vomited onto the head of from some height may however feel very differently about vomiting!)

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Internet Based Resources

http://www.gut-reaction.freeserve.co.uk/
http://emetophobia.bravepages.com/vomiting.html
http://www.vh.org/navigation/vh/topics/adult_patient_nausea_and_vomiting.html
http://abdellab.sunderland.ac.uk/Lectures/Gastro/vomit01.html
http://www.emetonline.co.uk/
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