

TA Treatment of Emetophobia – A Systematic Case Study – ‘Peter’

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Abstract

This study reports on the application of elements of Hermeneutic Single Case Efficacy Design (HSCED) (Elliott 2002) to a 39 session TA-based psychotherapy intervention with a 19 year old white male student in the UK who was suffering from emetophobia. The author, who was also the researcher, provides literature reviews on emetophobia clinical characteristics, contrasts it with other phobias, and reviews prior research including TA-based approaches to phobias generally. HSCED Methodology is briefly described; quantitative outcome measures are obtained and analysed using GAD-7 (Spritzer et al 2006) and SPQ (Elliott et al 1999), and qualitative measures via a rich case record, session recordings/transcripts, and a 4-month follow-up interview. Bohart et al's (2011) 56 criteria for evidence adjudication were used alongside HSCED criteria. There was strong evidence of significant client changes, and that these changes were the result of the therapy.

Key Words

Emetophobia, Hermeneutic Single Case Efficacy, Case Study Research, Transactional Analysis Psychotherapy

Introduction

Phobic disorders are organised into three main categories under Anxiety Disorders in the Diagnostic and Statistical Manual (DSM-IV TR), namely Social Phobia, Specific Phobia and Agoraphobia (APA 2000). Emetophobia is classified under Specific Phobia (Other Type). Specific phobias are found across cultures although the prevalence, phobic objects/situations and gender differences vary (Lewis-Fernandez et al 2009). Within the UK, there is currently no specific NICE (National Institute for Health & Clinical Excellence) guideline for the treatment of Specific Phobia (NCCMH 2011).

Looking at the available research on emetophobia, successful treatment is poor and dropout rates from treatment high (Veale and Lambrou 2006). In addition, a number of the studies reviewed suggest that emetophobia be considered in a separate category from specific phobia (Boschen 2007, Vandereycken 2011) in a similar way that social phobia and agoraphobia are. With early onset, chronic course, few if any periods of remission, and associated with significant distress and restriction in daily life as well as being considered more difficult to treat, I believe that emetophobia is a condition in urgent need of research (Lipsitz et al 2001, Hunter and Antony 2009).

There are a variety of theories as to the acquisition and maintenance of phobias (Davey 2008, Hersen and Bellack 1999, Gelder et al 2001) that inform a variety of treatment approaches. In the case of emetophobia, I could find no documented transactional analysis approach and mixed success with pharmaceutical and cognitive behavioural approaches (Lipsitz et al 2001).

Case study research has been used in the TA literature by Widdowson (2012a, b, c, 2013) and McLeod (2012) and these have demonstrated TA to be effective for the treatment of depression and for working with people with long-term health conditions. This article presents a research case study exploring the effectiveness of a TA approach for the treatment of emetophobia in adults.

Literature Review

Emetophobia – Clinical Picture

In a study comparing 100 individuals with vomit phobia to a group suffering with panic disorder and a control group, Veale and Lambrou (2006) add to an earlier survey of 56 emetophobics carried out by Lipsitz et al (2001) to provide a clinical picture of emetophobia which is summarised in Table 1.

Table 1 – Clinical Picture of Emetophobia (Constructed from Lipsitz et al 2001 and Veale and Lambrou 2006)

Variable	Value
Mean age of onset	9.8 years
Described as first becoming a problem	11.6 years
Mean duration of vomit phobia	25.9 years
Equal fear of vomiting alone and in public	77%
Fear of self-vomiting mainly	41%
Fear self and others vomiting equally	47%
More concerned about vomiting alone or in the presence of others	In the presence of others
Frequency of vomiting	no different from normal population
Sensations of nausea	almost every day or every other day
Anxiety inventory	significantly higher compared to those with panic disorder
Interpretation of feeling sick	“I am going to vomit” “I will be paralysed with fear”
Associated symptomology	Panic attacks
Feared consequences of vomiting	Losing control, becoming ill, choking, dying, fainting, others not wanting to know me, others finding me repulsive
Safety seeking behaviours	“looking for an escape route” “trying to keep a tight control on their behaviour” “taking medication” “reading” “sucking antacids/mints” “moving very slowly”
Avoidance behaviours	a wide range including illegal substances, being around drunks, fairground rides, people who are ill, boats, holidays abroad, aeroplane travel, drinking alcohol, crowded places, public transport, eating from salad bars or buffets, visiting others in hospital, pubs, eating at restaurants, public toilets, specific foods, pregnancy, surgery
Need to differentiate presenting features from other disorders	Obsessive- Compulsive Disorder, Panic Disorder, Social Anxiety
Gender bias	Majority female

Approaches to Phobias Generally

Choy et al (2007) suggests that “most (specific) phobias respond robustly to in vivo exposure” (p 226), but goes on to highlight that this approach, although apparently successful for those who complete the treatment, “is associated with high dropout rates and low treatment acceptance” (p.266) highlighting that the research “should be interpreted with some caution” (p.282). This is echoed in a meta-analysis of RCTs by Wolitzky-Taylor et al (2008).

Holmes (1982) describes formal research carried out demonstrating the validity of a psychodynamic-attachment based understanding of agoraphobia. Ruitter and van Ijzendoorn (1992) also carried out research

confirming the relationship between attachment issues and agoraphobia. In terms of social phobia, there are a number of recent studies that confirm the association of insecure attachment with the development of social phobia (Knappe et al 2012). Bowlby (1973) demonstrated the impact of poor attachment with school phobia and agoraphobia; Klein (1964) reported on a sample of female adult patients with panic and agoraphobia having a history of separation anxiety or school phobia.

Approaches to treatment of emetophobia

In line with the treatment for other specific phobias, exposure-based therapy is the most common approach mentioned in the literature for emetophobia (McFadyen

and Wyness 1983, Phillips 1985, Hunter and Antony 2009). In the Veale and Lambrou (2006) study, 70% of the vomit phobics had approached their GPs and been referred: 20.3% received behaviour therapy (which was the least effective), 17.9% received cognitive behaviour therapy (moderately effective), 41.3% received medication (mildly effective).

In an outcome study with 7 patients using exposure treatment based on film of people vomiting, Phillips (1985) reported initial success with all seven subjects, although the phobia returned to some following treatment. Wijesinghe (1974) successfully used flooding and hypnotherapy on a 24 year old woman. McFadyen and Wyness (1983) present a successful single case study with a young woman using graduated exposure. There appear to be no single case studies with male subjects.

Whereas earlier behavioural approaches focused on the external – for example the smell of vomit - Lipsitz et al (2001), Veale and Lambrou (2006) and Boschen (2007) highlighted that internal sensations (e.g. of nausea) were key to understanding emetophobia. However, van Overveld et al (2008) demonstrated that individuals suffering from emetophobia have significantly elevated levels of both disgust propensity and disgust sensitivity. This may partly explain the high levels of avoidance of situations where a disgust stimulus is likely, such as public toilets, food smells, etc.

Although exposure-based approaches seem to have been successful in the treatment of some phobias, the relative lack of success with emetophobia leads me to agree with Boschen (2007), Hunter and Antony (2009) and Vandereycken (2011) about the need for a separate classification for emetophobia, reflecting a greater difference to other specific phobias and more in common with panic disorder and agoraphobia. Interestingly, van Overveld et al (2008), referring to social phobia, agoraphobia and panic disorder, comments that “the appearance of comorbid disorders starts only after the onset of emetophobia” (p.525).

Hunter and Antony (2009) present the successful treatment of a young woman using exposure and psychoeducation where the client remembered a specific incident where she vomited in public and the negative reaction of her parents to this; however, as with some cases of agoraphobia (Thomson 1986) it is possible that there may be a more complex etiology and need for a more integrated approach.

Studies carried out to date seem to omit three potentially important factors: family dynamics, underlying psychological factors and the therapeutic relationship. These omissions may provide a clue to the mixed outcome success. Lambert and Barley (2002) showed the primacy of the therapeutic relationship in the

successful outcome of psychotherapy in general. The mixed success with emetophobia reported in the literature may be due in part to the quality of the relationship between client and therapist.

Transactional analysis approaches to phobias

Transactional Analysis understands phobia to be located in the Child ego-state (Berne 1966) and potentially comprising contamination (Berne 1961) and destructive script decisions (Goulding and Goulding 1978); suggestions in the TA literature as to how such contaminations and script decisions arise (English 1977, Goulding & Goulding 1978, 1979, Kottwitz 1984, Thomson 1986, English 1996, Janoff 1997, Ohlson 2005) can be summarised as:

- early primary caregiver abuse, neglect, inconsistent attention or overprotection
- family dynamics – modelling, attribution, associated or observational learning
- an attempt at defence against an intolerable fear which the individual cannot control

Goulding & Goulding (1978) identify the phobic defence as arising from specific parental injunctions: “phobias are Child decisions made to protect oneself” (p 228). Phobias associated with a “Don’t Exist” injunction include any activity or situation where there is a danger of dying, such as high places, water, underground, flying, lifts etc. They suggest that a child receiving a “Don’t exist” injunction can develop a phobia as one of three responses to the injunction:

1. Initially decide to kill themselves so that their parent(s) will be sorry, but then become fearful at the decision and develop a phobia for self-protection.
2. Be so fearful that they “displace the fear onto something more controllable” (p.229).
3. Develop a phobic fear of the medium, possibly through magic thinking e.g. after having a near death experience by drowning, develop a phobia of water

English (1977, 1996) highlights that although phobias are dysfunctional, they function to protect the individual from the original parental injunctions. She gives the example of a phobia of fire protecting an individual believing, “I must get hurt to be loved” (p.296).

In the case of family dynamics, ways that a phobia might be established in an individual include modelling by a parent or parents (Stewart and Joines 1987), attributions from parents (Holtby 1973) and/or transgenerational hot potato or episcrpt (English 1996), where a parents’ fear can be transmitted to a child.

There appear to be no formal case studies on the TA treatment of phobias although journal articles and book

chapters do describe working with a variety of phobias including heights, water, insects (Goulding and Goulding 1978, Kottwitz 1984), panic disorder and agoraphobia (Thomson 1986, Janoff 1997) and flying (Ohlson 2005), all reporting positive outcomes.

Although there is no single common approach, the above studies all mention employing decontamination techniques (psychoeducation, desensitisation and exploring catastrophic beliefs). The Redecision approaches also include working with the past scene, addressing the original injunction (where this can be found) through rededication work, self-reparenting and therapist affirmation. Janoff (1997) and Thomson (1986) also mention the use of empathic transactions and the importance of reparenting.

Research Question

My motivation for carrying out this research was largely to determine whether TA is effective for working with phobia, particularly emetophobia, in order to inform my own choices about working with phobia in the future.

Ethical Considerations

Care was taken to discuss the nature of the research with the client who agreed to be involved in the research. This included a discussion of, and agreement on, who would see the raw data and how the data would be anonymised for wider publication.

In all this, the priority of the client work was emphasised whatever decision the client arrived at, and it was also emphasised that the client could withdraw from the research element at any time.

Research Methodology

Introduction

This study used a combination of quantitative and qualitative measures as part of a rich case study based on the original HSCED design by Elliott (2002) and incorporating adjudication based on the pragmatic case evaluation method described by Bohart et al (2011). This approach was chosen in order to minimise any intrusion into the therapists' normal way of working but at the same time provide a rich case to consider and tools to interpret the data.

The research evaluation was initially conducted using a critical-reflective practitioner-researcher model (McLeod, 1999). In line with guidelines for conducting case study research developed by McLeod (2010) relating to credibility and trustworthiness. The research process, data and findings were supervised and audited by Mark Widdowson, Teaching and Supervising Transactional Analyst (Psychotherapy). This research supervisor/auditor was selected due to his expertise in case study research methods. Although Elliott et al (2009) state that the analysis of the data can be carried out by the

individual practitioner-researcher, having the findings audited by a third party goes further in addressing issues of researcher bias.

Quantitative Outcome Measures

GAD-7 (Spitzer et al 2006) was used at the assessment session, regularly throughout therapy and at separate follow-up sessions. The GAD-7 is a self-completed questionnaire based on ICD-10 diagnostic criteria for anxiety and is widely used in therapy research.

An individualised Simplified Personal Questionnaire (SPQ) (Elliott et al 1999) tailored to the specific presenting issues of the client was collaboratively constructed at the first therapy session and completed regularly throughout therapy and at the follow-up sessions. This type of questionnaire has been found to be particularly effective for measuring therapeutic change (Greenberg and Watson 1998) and fits well with the TA concept of an agreed therapeutic contract (Berne 1966).

Qualitative Outcome Measures

All sessions were recorded with therapist notes on each session written up following the session and kept with the case file.

An open-ended qualitative interview was carried out at the end of therapy to explore the client's progress and experience of therapy. A similar interview was carried out 4 months later. Both interviews were transcribed and used as the basis for the qualitative evaluation.

Data Analysis

Data from the GAD-7 and SPQ questionnaires were plotted to show any change between first signing up for therapy, during therapy and in the 4 months following completion of therapy.

In order to assist in a critical evaluation of change and the plausible causes of change, use was made of the 56 criteria proposed by Bohart et al (2011) for a jury adjudication of the evidence. The rich case record was carefully examined for evidence in order to answer the two basic questions: (a) did the client change, and (b) if so, is there evidence that psychotherapy caused or contributed to the change (p.145).

The first 39 criteria were used to provide an evaluation, based on a preponderance of the evidence, as to whether the client changed. The remaining 17 questions were similarly used to evaluate whether it was the therapy that helped bring about this change.

In order to examine in more detail whether something outside the therapy could have brought about any change, the criteria from HSCED (Elliott 2002) for evaluating non-therapy explanations for change was also used. Again, the transcripts of the change interviews

were examined for "... descriptions of changes experienced over the course of therapy" and "... client descriptions of their attributions for these changes..." (Elliott 2002, p4).

Data from the therapist notes and individual recorded sessions were reviewed where there was a need to look in more detail at specific events.

Participation

Client

Inclusion criteria for the study was any client over 18 years of age and fulfilling the criteria for emetophobia. Exclusion criteria included any client with a history of mental illness (as self reported) or personality disorders as indicated by DSM IV (APA 2000). The client, Peter, was chosen from the therapists' normal client workload, being the first client to present with emetophobia.

Peter had been on anti-anxiety medication for eight months when I first saw him in weekly individual therapy. His GP initially suggested he may have an eating disorder and subsequently that he had a vomit phobia.

Peter is a 19 year old white male student, just completed his first year of university, living at home with his parents. In the first session, I found that he engaged with me easily and seemed generally relaxed, although he did say that he hadn't eaten all day so he wouldn't be worried about vomiting.

Peter said that his phobia relating to vomit gradually developed over time. He stopped going out anywhere because he felt sick and if he had to go out he became very anxious. His anxiety was around anything to do with vomit – being sick, feeling sick, talking about sick or disgusting things, food smells, parties (where someone might be sick), and his own vomit. If he had to go somewhere outside, he would not eat that day and would try to make himself sick before he left the house so there was nothing in his stomach to vomit. He did this every morning before university. He also expressed concern when asked about what the future might hold for him; whether he would be able to keep attending university or ever get a job.

I noted that his experience and behaviours were typical of the clinical picture presented earlier of emetophobia (Lipsitz et al 2001, Veale and Lambrou 2006).

TA Diagnosis, Contract, Treatment Plan and Intervention

While there were a number of possible causes and contributing factors, I decided on a working diagnosis of a Child and Parent contamination along with attachment issues (Bowlby 1973, Thomson 1986) that, along with a traumatic incident at school, resulted in a split-off or partially excluded Child ego-state (Berne 1961, Hargaden

and Sills 2002). I found it most convenient to think about the client as living out this script presentation as a 'Phobic Anxiety' Racket System (Erskine and Zalzman 1979) where a phobic response is one of his main script displays and ensures proximity to his primary attachment figure and secure base.

We negotiated an outcome-focused behavioural contract (Berne 1966, Stewart 2006) to be able to live a normal life like other young men his age with some specific measures relating to taking part in and enjoying a number of activities he currently avoided.

I followed a treatment plan based on Woollams and Brown (1978): Motivation, Establish a Working Alliance, Decontamination, Deconfusion, Redecision, Relearning, and Termination. Whilst having its own fully informed model of the personality, TA has a psychodynamic underpinning, relational emphasis and incorporates cognitive-behavioural techniques (Berne 1961, Hargaden and Sills 2002, Stuart 2007, Widdowson 2010, Novellino 2012).

The study imposed no narrow focus on specific TA interventions. This approach was chosen to ensure that the therapist was not constrained in his normal way of working. Key TA concepts and tools, including contracting, use of the ego-state model, developing and use of a therapeutic relationship, therapeutic operations, psycho-education, empathic transactions, strokes, decontamination, racket analysis, and deconfusion were all used (Berne 1961, Clark 1991, Erskine and Zalzman 1979, Hargaden and Sills 2002, Novellino 2012, Stewart 2007, Widdowson 2010).

Therapist/Researcher

I have been practicing as a psychotherapeutic counsellor in a voluntary capacity at a Community Health Project for five years. I see adult clients presenting with a variety of symptoms including depression, anxiety, developmental trauma and relationship issues.

I have a core, four year training in Transaction Analysis psychotherapy, a Diploma and MSc in TA Counselling and am a Practitioner Member with the Confederation of Scottish Counselling Agencies (COSCA). As well as having a similar philosophical outlook to my own, TA provides me with a comprehensive theory of personality and development, a theory of psychopathology and change, and a rich set of diagnostic tools and techniques to work with a client to achieve symptomatic relief and personal change.

I draw from all schools of TA as well as from other traditions and inform my practice with research. As well as adhering to the COSCA (2007) and ITA (2008) Code of Ethics and Practice, I have TA Supervision twice a month.

Results

Quantitative Outcome Data

The results from the SPQ and GAD-7 are summarised in Table 2 and Figures 1 and 2.

SPQ

Peter's scores varied considerably during the earlier stages of therapy, as during the holidays from university he tended to stay in the house and avoid any phobic provoking stimuli (e.g. sessions 2, 6, 12). As therapy proceeded, he engaged more in making choices to eat more and go out socially. The large peak at session 33 and 34 was where he started a part time job. At session 37 he reported that "going back to uni has been a walk in the park" and "my anxiety is definitely subsiding because I've not been noticing it recently".

The scores show that Peter achieved clinically significant change which remained stable at the follow-up sessions.

GAD-7

The GAD-7 scores highlight the nature of phobia with Peter generally only experiencing higher levels of anxiety when fearful of encountering or actually encountering phobic stimuli, the most frequent of which was around travelling to and from university and being at university.

After session 36 he did not experience any anxiety travelling and being at university and remarked that his anxiety over exams had a different quality which he considered 'normal' anxiety and which he did not see as a problem.

What this shows I believe is that Peter did not suffer from general anxiety and that his periods of anxiety were short-lived, amounting to single episodes.

The higher scores at the beginning of therapy may have indicated an anxiety related to starting therapy. The scores for the remainder of therapy are fairly stable. Ignoring the initial high scores, there does appear to be a reduction in his general anxiety over the last seven sessions and follow-up which are in agreement with Peter's self-report.

Qualitative Outcome Data

The full analysis using the 56 criteria proposed by Bohart et al (2011) for a jury adjudication of the evidence and criteria from HSCED (Elliott 2002) for evaluating non-therapy explanations for change are available from the author. The following section provides a flavour of the evidence from the follow-up interviews.

Evidence that the Client Changed

Peter himself verbalised that he had made considerable progress. He firstly mentioned noticing that he is no longer anxious all the time: travelling and being at university is no longer an issue for him at all, as reported above for Session 37 SPQ score. He noted that he was

also now going to university when he doesn't need to in order to use the equipment.

He also noted that he no longer seemed to be afraid of certain foods, food smells or eating (both larger quantities, before going out, eating out, and eating a wider variety of foods).

When asked, he agreed that it was at least six months since he last made himself gag to check that he wouldn't be sick when he went out.

Peter recalled his fear at the beginning of therapy that he might not be able to get a job because of his phobic anxiety and that he might end up housebound. He noted that he is now more positive about getting and having a job in the future, although he doesn't know yet what he might want to do if he doesn't get a good degree.

I asked him what else he noticed was different. He mentioned that previously his mind was often blank and had a tendency to go blank – especially if there was something potentially anxiety-provoking on the horizon. Now he is aware of thinking. He believes that previously it was because he was too afraid of what to do or what needed to be done, whereas now he believes that he can tolerate anxiety and so can think about what he needs to do.

He also noted that there were "some things I'm no longer thinking about – I'm not avoiding thinking about them because it would be anxious, I'm not thinking about them because I *know* I'm not anxious."

At the 4 month follow-up session, Peter mentioned that he had been physically sick a few weeks earlier and just said to himself, "Oh well, get on with the rest of the day" adding that "it didn't bother me at all".

Peter also mentioned that he had been continuing to go out for meals, had been at a party and out with a female friend a couple of times – "I phoned xxxxx and we went out for the day...I really enjoyed it...wasn't anxious at all."

I asked him about vomit. He said it's still something he finds disgusting, but he no longer feels sick or anxious thinking about it.

I asked him how his parents are with him. He said "Mum and dad are really pleased. I'm eating more, put on weight and I've eaten everything when we went out – and had dessert!"

I asked him if there was anything else. He said he had been more irritable and went on to say, "I don't feel so limited. I can go out and do other things. I don't need to stay in the house".

Based on a more detailed analysis using 39 criteria to facilitate determining whether a client has changed (Bohart

Table 2: SPQ and GAD-7 Results

	SPQ (mean)	GAD-7
Clinical cut off	3	5
Pre-Therapy	5.14	9
Session 9	3.85	3
Session 19	2.28	3
Session 29	2.28	2
Session 39	1.85	2
6 Week follow-up	1.57	1
4 Month follow-up	1.28	2
9 Month follow-up	1.28	1

Figure 1: SPQ Mean Score across Sessions and Follow-ups

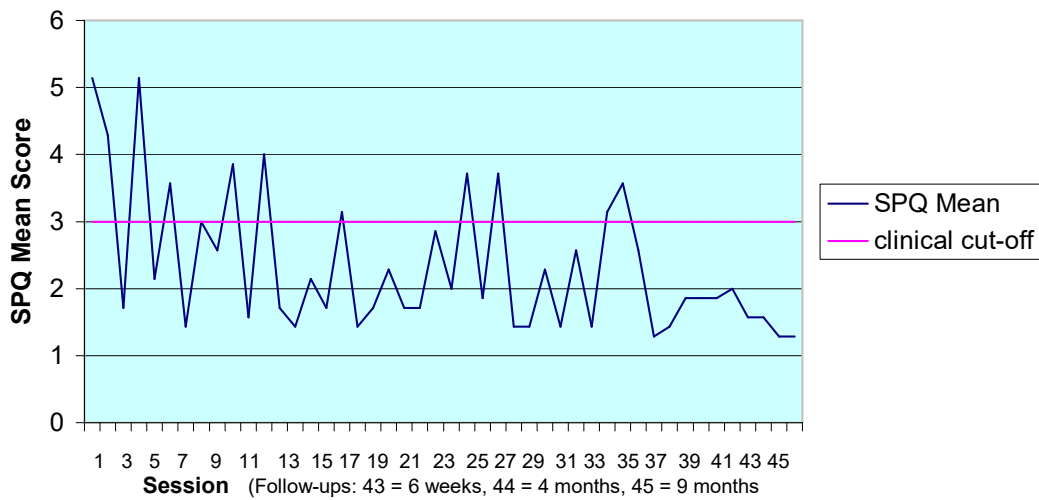
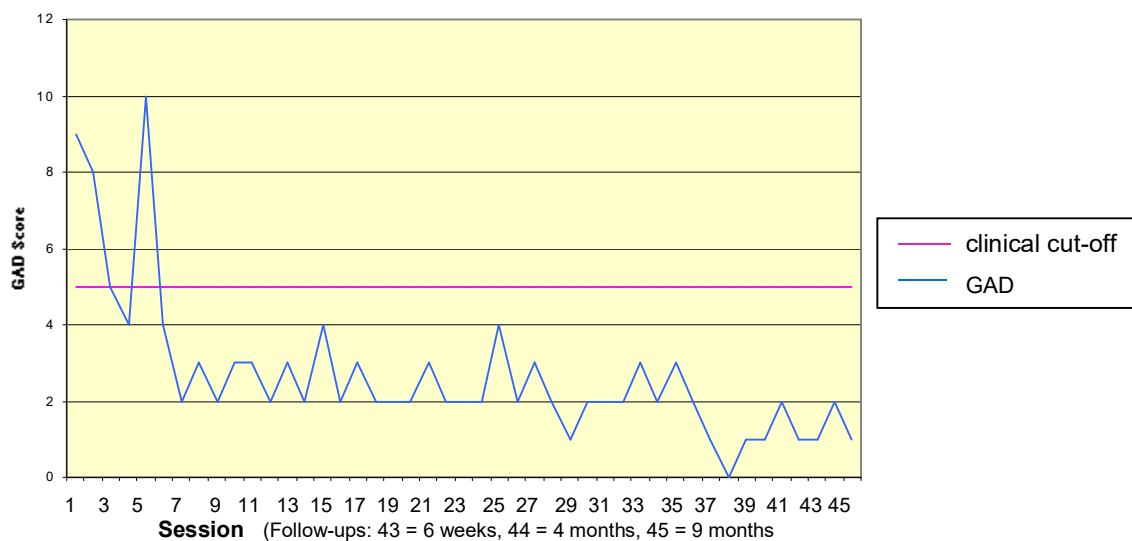


Figure 2: GAD Scores across Sessions and Follow-Ups



et al 2011), there is clear evidence in 18 of the criteria, some evidence for a further 13 criteria and no evidence in 6 of the criteria. Two criteria were considered not applicable for this client. Based on this analysis, there is sufficient evidence to argue that the client changed.

Evidence that it was the therapy that helped

In response to my asking to what he attributed the changes, Peter replied, "The therapy and doing stuff". He went on to say that it was gradual since the holidays. I asked him if it was related in any way to the part time job. He said he didn't know, but it was after that that he started to do more things. He said, "When I started (therapy) I didn't really think that anything would change, but I also didn't want to end up ...housebound".

I asked him what specifically about the therapy had helped him change. He hesitated and then said, "I don't know. To talk about stuff as it happened; to talk about stuff before it happened. It's been good to have someone to talk to that's not involved but interested." He also mentioned the structure of coming to therapy regularly as being helpful: he tried things and gained confidence to try more things. He noted that there was no light bulb moment but that over time he gradually got better.

I asked him if there was anything specific that he felt helped. He mentioned the various diagrams we did, "I found these interesting. I learnt and it helped being able to understand about (my) stuff".

I asked him if there was anything else outside therapy that could have had an impact on him changing. Again he hesitated and then said, "No, I didn't do anything."

I asked him if there could have been anything else, like for example, him just deciding to be different. Again he said "I don't know" and then added, "A different attitude. I would say that I'm thinking more positively." He went on to talk about his re-sits and the fact he is thinking about them and what he needs to do, quite a change for him. I asked him if he was anxious about them. He said "No, well just like most people would be – I've got to do better this time, but I'm not overwhelmed".

When asked if there was anything that he found wasn't helpful he replied "the guided fantasies".

When asked him if he had any ideas what his phobia had been about, he responded "No, I still don't know. I don't think I'll ever know".

Based on a more detailed analysis using 17 criteria to facilitate determining whether therapy aided change (Bohart et al 2011), there is clear evidence in 9 of the criteria and some evidence for a further 8 criteria. Further analysis to specifically evaluate the presence of non-therapy explanations for change (Elliott 2002) showed clear evidence that the client's self activation outside

therapy contributed to significant change, but equally clear evidence that this activation was brought about by the therapy itself.

There is, in conclusion, sufficient evidence against a non-therapy explanation for change and sufficient evidence to show that the therapy positively contributed to change.

Discussion

The evidence from the quantitative and qualitative data demonstrates convincingly that the client changed considerably over the course of therapy.

Measurement against the 17 criteria evaluating whether therapy helped (Bohart et al 2011), suggests this to be the case. Further evidence from an evaluation of non-therapy explanations for change based on the HSCED model (Elliott 2002) adds support by showing that change did not appear to be attributable to extra-therapy events. It could be suggested that the changes would have happened over time with or without therapy; however research on emetophobia highlights no cases where change or recovery took place without therapeutic intervention or in less than an average 25 years (Veale and Lambrou 2006).

Peter's onset of emetophobia was gradual, becoming serious enough to seek advice in the months before I first saw him, and during therapy he did not have relapses to health. Lipsitz et al (2001) noted that emetophobia is persistent with no periods of remission. In Peter's case change has been persistent through the follow-up sessions.

The case presented used a number of TA concepts and interventions which paralleled aspects of the behavioural and cognitive-behavioural treatments carried out for emetophobia. So, for example, during decontamination there was a significant element of education around the physiology of panic and techniques to reduce escalating panic, and around the meaning of gastrointestinal sensations (Boschen 2007, Lipsitz 2001). There was also an element of graded exposure in the form of guided fantasies, leading up to the clients' experience of a job interview and a part time job (Phillips 1985).

The literature mentioned a high fall-out rate from treatment approaches (Veale and Lambrou 2006), which I believe may in some cases have been related to clients being unable to manage the anxiety associated with treatment (e.g. exposure interventions). I believe that development of the therapeutic relationship and a specific attachment to me as his therapist enabled Peter, gradually over time, to reappraise his phobia anxieties. Getting and enjoying a part-time job towards the end of therapy marked a significant and important turning point for him. This event, I believe, along with the development of a new Nurturing Parent and decontaminated Adult,

allowed Peter to make (re)decisions and experience a greater level of autonomy.

The client in this case aligned with the majority of the presenting features of emetophobia presented in the literature (Lipsitz et al 2001, Veale and Lambrou 2006) with the notable exception that the client was male: the majority of cases presented and the general reported prevalence of emetophobia is in females. This may reflect a social frame of reference (Schiff et al 1975) where males are more embarrassed to seek help for such a condition.

Validity and Limitations

The presenting symptoms and inclusion criteria for the study is representative of a large proportion of clients experiencing emetophobia (Lipsitz et al 2001, Veale and Lambrou 2006) and therefore potentially replicable.

The study makes use of a number of proven instruments to capture and analyse data along with triangulation of the results from the objective outcome data (questionnaires), client story (interviews) and the therapist (notes).

Internal validity is further enhanced by having a six week period following the initial assessment, to confirm the stability of symptoms and client experience prior to starting therapy.

External factors potentially influencing the clients' improvement (or deterioration) are captured through notes from the session reviews and the final interviews and reviewed against the HCSED criteria for non-therapy explanations for change (Elliott 2002).

Although operationally the practice of TA can be described from key publications and papers, there remains a wide latitude in the choices, application and way of being of individual TA therapists, which would make a close replication difficult.

This was work with a single individual and although his presentation and reported experience of emetophobia aligned with published research, and although the study shows that TA has been effective in the case of this client and therefore **can** be effective for emetophobia, it cannot yet be said to be an effective treatment for emetophobia in general.

Conclusion

Peter improved significantly and achieved symptomatic relief and social control. He went from living an extremely restricted life at the beginning of therapy to exercising autonomy and starting to explore the wider world around him. The evidence strongly suggests his use of therapy was the main vehicle Peter used to enable him to make these significant changes in his life. The study has shown

that a TA approach has been effective in the case of this client and therefore can be effective for emetophobia.

I might infer from what I observe that as well as addressing the contaminations, he has also readdressed the imbalance in his attachment-exploration system (Berne 1961, Goulding and Goulding 1979, Mikulincer and Shaver 2007). However, the research process did not directly measure the attachment aspect of emetophobia and this requires further study.

Colin Kerr can be contacted on colin.kerr@lycos.com

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