



Intrusive imagery in people with a specific phobia of vomiting

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ABSTRACT

Background: and objectives: Specific phobia of vomiting (SPOV) is a chronic, pervasive and debilitating disorder which is clinically regarded as difficult to treat. Research into its development, maintenance and treatment has been limited. This study explored the prevalence and characteristics of intrusive mental imagery in people with SPOV. It investigated the relationship between presence of imagery and severity of phobia.

Method: Thirty-six participants meeting DSM-IV criteria for SPOV were recruited from online support groups and outpatient clinics. A semi-structured quantitative interview was administered.

Results: Twenty-nine (81%) participants reported multi-sensory intrusive imagery of adult (52%) and childhood memories (31%) and worst case scenarios (“flashforwards”) of vomiting (17%). Extent of imagery was significantly related to severity of phobia. Participants primarily fearing others vomiting had less severe phobic symptoms.

Limitations: No control group was used and a heterogeneous sample of clinical and community participants was recruited. Correlational data comparing extent of imagery with severity of SPOV symptoms were derived from as yet unvalidated measures.

Conclusions: Intrusive mental imagery is a clinically important feature of SPOV and may contribute to its maintenance. Causality needs to be demonstrated.

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1. Introduction

A specific phobia of vomiting (SPOV) is classified under “Specific Phobia, other type” (DSM-IV-TR) (APA, 2000). It is defined as a marked, persistent fear and avoidance of vomiting or others vomiting which causes significant distress or impairment. Prevalence data for SPOV are limited. The Dresden Mental Health Study identified a point prevalence of 0.1% (Becker et al., 2007). Other studies, based on a fear of vomiting, have estimated prevalence at 1.7–3.1% for males and 6–7% for females (unpublished studies quoted in van Overveld, de Jong, Peters, van Hout, & Bouman, 2008; Philips, 1985). Veale and Lambrou (2006) found that the phobia commonly begins in middle childhood with a mean duration of 26 years. Extensive avoidance, such as food, travel or pregnancy, and safety behaviours, such as taking unnecessary medicine or excessively cleaning, often lead to a clinically significant impact on functioning (Lipsitz, Fyer, Paterniti, & Klein, 2001; Veale & Lambrou,

2006). Primary fear of others vomiting is thought to be more easily amenable to treatment (Veale, 2009).

Although classified as a specific phobia, SPOV has distinctive characteristics. People with SPOV have been found to have elevated disgust sensitivity (van Overveld et al., 2008) which may be less relevant in other phobias. Davidson, Boyle, and Laughlan (2008) identified an increased need for, and fear of losing, control in people with SPOV compared to phobic controls. Baeyens and Philippot (2006) and Boschen (2007) propose models emphasising the unique role of gastrointestinal (GI) sensations to SPOV. They highlight vulnerability to GI somatisation of anxiety and hypervigilance to, and catastrophic misinterpretation of, GI sensations.

Overlap has been identified between SPOV and non-phobic anxiety disorders. Veale and Lambrou (2006) highlighted similarities with panic disorder and health anxiety in the vigilance to, and catastrophic misinterpretation of, physical sensations. Avoidance of perceived risks may result in a misdiagnosis of agoraphobia (Pollard, Tait, Meldrum, Dubinski, & Gall, 1996) or anorexia nervosa (Manassis & Kalman, 1990). Safety behaviours, such as food checking or hand-washing and an inflated sense of responsibility for preventing vomiting, have similarities with obsessive compulsive disorder (OCD) (Veale, 2009).

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Veale (2009) has proposed a cognitive-behavioural maintenance model for a SPOV. He identifies a core cycle of imagery, nausea, catastrophic beliefs and anxiety. This is further maintained by self-focused attention, hypervigilance, worry and reassurance, avoidance and safety behaviours. With respect to imagery, Veale highlights the role of aversive memories in strengthening the belief that vomiting inevitably follows nausea through conditioned association. Images of imagined scenarios may strengthen beliefs about likelihood of vomiting. Although Veale suggests that imagery is central to its maintenance, it has not, to date, been empirically demonstrated in SPOV.

Images are defined as “contents of consciousness that possess sensory qualities as opposed to those that are purely verbal or abstract” (Hackmann, 1998). Imagery has been shown to have greater emotional potency than verbal processing alone (Holmes & Mathews, 2005; Holmes, Mathews, Dalglish, & Mackintosh, 2006). A review of the imagery literature (Brewin, Gregory, Lipton, & Burgess, 2010) conceptualises images on a spectrum from fully autobiographical memories to hypothetical situations. Images are defined as intrusive when they spontaneously come to mind without voluntary retrieval (Brewin et al., 2010). Brewin et al. (2010) highlight that intrusions of memories and of imagined scenarios share not only content and characteristics, but also the neural mechanisms involved in their generation. In this paper “imagery” encompasses both intrusive memories (defined as full autobiographical memories) and intrusive imagined scenarios.

Mental imagery has been explored in anxiety disorders such as social phobia (Hackmann, Clark, & McManus, 2000), agoraphobia (Day, Holmes, & Hackmann, 2004), health anxiety (Muse, McManus, Hackmann, Williams, & Williams, 2010) and body dysmorphic disorder (BDD) (Osman, Cooper, Hackmann, & Veale, 2004). Within specific phobias, mental imagery has been explored in snake (Hunt et al., 2006) and spider phobia (Pratt, Cooper, & Hackmann, 2004). Speckens, Hackmann, Ehlers, and Cuthbert (2007) found that presence of imagery was related to symptom severity in OCD. Intrusive images have been demonstrated in the maintenance of depression (Brewin, Reynolds, & Tata, 1999) and social phobia (Hirsch, Clark, Mathews, & Williams, 2003).

The unique nature of SPOV means that imagery may differ from that in other disorders. The role of GI symptoms (Baeyens & Philippot, 2006) and aversive experiences of vomiting (Veale, 2009) may mean that physical sensations are more likely to be present in imagery. The disgust sensitivity indicated in SPOV (van Overveld et al., 2008) may mean that taste and smell may play a more prominent role. Imagery about vomiting may also be linked to increased disgust. Perspective of imagery is less likely to be from an observer perspective than in disorders where social evaluation is the primary fear (Veale & Lambrou, 2006). Veale's (2009) prioritisation of aversive memories suggests that these may play a particularly key role in SPOV imagery. Veale's (2009) suggestion that those who primarily fear others vomiting may be more easily treated indicates that this group may differ in severity from those primarily fearing self vomiting.

This study sought to investigate the presence and characteristics of mental imagery in phobia of vomiting. It aimed to identify the proportion of people with phobia of vomiting that experienced intrusive mental imagery. We hypothesised that, in line with Veale's (2009) model, a significant majority of participants would experience intrusive imagery. Secondly, it aimed to explore the nature of the imagery experienced by people with SPOV. We hypothesised that physical sensations, taste and smell may be more prominent than in other disorders. Also, that aversive memories would be likely to predominate over imagined scenarios. In addition, we hypothesised that disgust would be likely to be a feature of

images. Thirdly, the study aimed to investigate whether the presence of intrusive imagery was related to severity of SPOV symptoms and to levels of disgust. Veale's (2009) model identifies imagery as a central maintaining factor. We therefore hypothesised that the presence of imagery would increase severity of symptoms and disgust. As a further aim, the study sought to investigate the hypothesis that SPOV symptoms and frequency of imagery would be greater in those primarily fearing self vomiting than those fearing others vomiting.

2. Methods

2.1. Study population

Participants needed to be aged 18 or over and experience specific phobia of vomiting as their main problem. Participants were excluded if they only feared vomiting in public. Exclusion criteria were: verbal ability not being sufficient to discuss their cognitive experiences; having undergone imagery rescripting; or being unable to discuss cognitive experiences due to anxiety. Participants were excluded if they could not meet for a face to face interview.

Clinical participants were recruited through the South London and Maudsley Trust and the Priory Hospital North London. Participants were also recruited by advertising with online anxiety and phobia support groups. Adverts did not mention that imagery was the focus of the study in order to avoid a response bias towards those with imagery. Recruitment took place between July 2009 and August 2010.

Twenty-eight (77.8%) were recruited through website adverts and eight (22.2%) from clinical sources. One person was excluded for being under 18, one for feeling too anxious to be interviewed and 28 because they lived too far away for an interview. Three people were booked in for interviews and then disengaged. Twenty-four people responded to the research advert but did not respond to the follow up email.

2.2. Procedure

Participants not previously assessed at one of the clinics were contacted by phone and administered the Structured Clinical Interview for DSM-IV Axis I (SCID-I; First, Spitzer, Gibbon, & Williams, 1996) for specific phobia, tailored for SPOV. All participants contacted met SPOV criteria.

Participants were first sent the participant information sheet and pre-interview questionnaires. Participants who scored above cut off on any Psychiatric Diagnostic Screening Questionnaire (PDSQ, Zimmerman & Mattia, 2001) category were administered the relevant sections of the SCID-I (First et al., 1996). If participants experienced comorbid symptoms better explained by their phobia of vomiting, a comorbid diagnosis was not made.

2.3. Measures

2.3.1. Psychiatric Diagnostic Screening Questionnaire (PDSQ) (Zimmerman & Mattia, 2001)

This 111-item self-report measure screens for 13 adult psychiatric disorders (depression, post-traumatic stress disorder, bulimia nervosa, obsessive compulsive disorder, panic disorder, psychosis, agoraphobia, social phobia, alcohol and drug misuse, generalised anxiety disorder (GAD), somatisation disorder and health anxiety). Participants exceeding cut-offs were administered relevant sections of the SCID-I.

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