Emetophobia: Help for Kids Afraid of Throwing Up or Getting Sick

Disclaimer: This is an article about getting sick, particularly nausea and vomiting. If you are squeamish or anxious about this, reading this article may cause distress.

In 2004 the Elementary School my daughter attended had an outbreak of the flu. She saw several kids vomit. She became afraid of getting sick. I have since discovered she was not alone. Over the years it has been my professional experience and personal opinion that the fear of getting sick (nausea & vomiting) is far more common than reported in the professional literature and media. It is often missed as the core fear with anxious children. If we get calls from families who have used **Turnaround** yet still need some extra help it is almost always about this particular fear. It tends to impact school attendance, eating behavior and social interaction in such a way it cannot be ignored or accommodated.

This fear is called emetophobia. *Emesis* is the Greek word for the act of vomiting. Phobia, from the Greek *phobos*, is an intense inflated fear. This phobia is a problem for adults and kids. I see both frequently. Over the course of several blog posts I hope to layout key elements in understand and treating it. Dr. McCarthy and I hope to add a supplemental CD to the Turnaround program for this and similar problems in the near future. In fact, these posts are from the process of developing that script. Your feedback and comments will help us in its development.

Importance of Understanding HOW a Phobia Develops and Continues

It is necessary to understand "how" the fear works. If the "how" makes sense, the treatment makes sense. Most of the time people want to know "why" there is the fear but that isn't nearly as helpful as understanding "how". Let's begin with a general explanation that would fit most sorts of anxiety but focused on emetophobia. I am going to use a series of diagrams to explain the reinforcing cycle of this phobia**.

Step 1: A Trigger

First there is something that "triggers" or signals a threat to a person. It can be external as in seeing someone throw up or internal as in imagining someone throwing up. It could be external like a disgusting smell or internal as a gagging feeling. Any of the senses; sight, smell, taste, hearing and touch, could be involved in triggering the fear.

A trigger isn't inherently something bad. It is just information. Two people can experience the exact

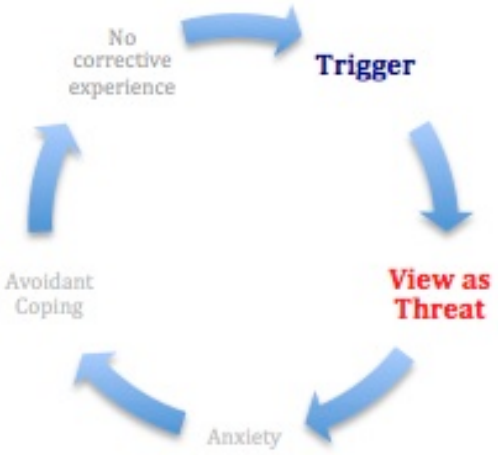
same trigger but one person is fine and the other gets alarmed. It is the next steps that give meaning to the trigger that make it part of an anxiety cycle.

Step 2: Misinterpretation

In the case of a phobia the trigger is misinterpreted as far more threatening than it really is. For example, throwing up is viewed not as unpleasant but as catastrophic. This threat seems so real or possible to the person because of how they mentally construct it.

There is an important point to be made here. Fear of actual danger is not a problem needing treatment. No one gets therapy because they ran in the house after lightning stuck nearby. They get treatment because they get extremely anxious when there are just dark clouds so much so that it interferes with their lives.

Human beings are designed to learn fear FAST and to extend the sense of threat to anything similar or related. I only have to step on a nail once to forever be careful walking through construction debris. This is a good thing. There is a solid logic to being scared by a nearby lightning bolt and then be on the lookout for future lightning bolts.

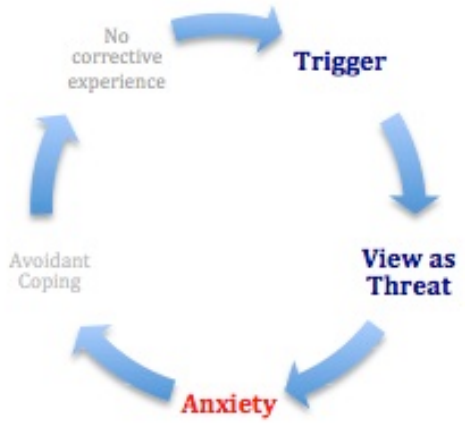


However, a problem is beginning when the fear spreads to things associated to the specific threat that are imagined as far more dangerous than they are in reality. They key word is imagined. It is a mental movie about something that might happen. For example, lightening is obviously dangerous but storm clouds are not that dangerous. When someone is phobic the dark clouds become a mental movie of lightening striking and killing, therefore the dark clouds = lethal danger. In the case of emetophobia vomiting is misinterpreted as a threat. (Sometimes, embarrassment of vomiting in public is more of the imagined threat.) Then the mind spreads it to anything that might lead to vomiting like an uncomfortable feeling in the tummy or the “contaminated” desk of someone who got sick.

This is still all normal. We misinterpret things all the time. Everyone imagines distressing things like this but it only occasionally leads to a phobia. There are more steps involved before it becomes a phobia.

Step 3: Anxiety, Fear or Worry

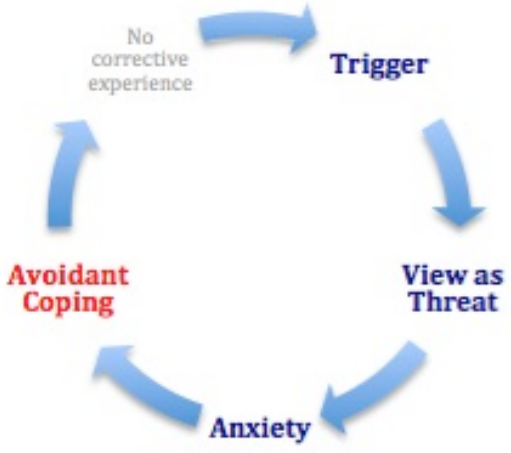
So there is a trigger, then misinterpretation, and then intense anxiety. Although the imagined danger is not real, the experience of anxiety is real. That makes the misinterpretation seem much more plausible. When a threat is perceived the body prepares – dramatically.



This process is often called the fight or flight response. Without going into too much detail, it is the body's way of responding to danger – real or imagined. In the right circumstances this process instantly optimizes your body to survive. In the wrong circumstances it can become part of an anxiety disorder. Panic while running from a charging rhinoceros is good. Panic while sitting in a classroom, not so much. It is basically the same physiology but interpreted differently.

Anxiety disorders are fundamentally incongruence between what a person is thinking and feeling compared to the actual situation. Using our previous example, the anxiety for an actual lightening strike is evoked by dark clouds. The physical reaction is just as strong for the imagined problem as for the actual danger. For emetophobia there is extreme distress at the possibility of vomiting. The anxiety leaps to anything that might lead to vomiting. (In one of life's great ironies, anxiety causes stomach distress and then that evokes more anxiety.) The belief that it is a serious threat leads to the next step. This is the tipping point of something becoming a phobia.

Step 4: Avoidant Coping



This step may be the key element in why someone develops an anxiety disorder. Everyone experiences the first 3 things but not everyone develops an anxiety disorder. The tipping point is when someone acts consistently with the misinterpretation. In other words, they behave as if the imagined fear is truly a threat. The main thing people do is avoid or escape the "danger" in a desperate attempt to get relief. When you are terrified, relief is AWESOME. People come back for awesome over and over. Then it becomes a powerful habit and even a compulsion. Because it does give relief it is very hard NOT to do it. Unfortunately, these kinds of behaviors interfere with living a normal life. At first it might not be that disruptive. But it gets bigger. For example, if you are afraid of getting sick first you may want to avoid a classroom but then you will want to avoid school. Getting to stay home gives relief. We all know how big a problem that becomes. Less dramatically, if the fear is contamination causing illness there could be extreme hand washing and cleaning. The urge to escape, avoid or fix can become ferocious. If you have tried to stop a terrified child from doing something to avoid the fear you know what I mean.

Let me state again that avoiding authentic, genuine, and certified danger is NOT a problem. (Well, okay it is big problem but not regarding anxiety disorders.) Anxiety problems only happen when

there is not an actual threat. Because the anxiety "feels" real and the avoiding "feels" better this becomes enormously influential. Because this becomes the norm, the next step seals the deal.

Step 5: No Correction

When you avoid, escape or fix you don't experience the things necessary to disprove the threat. Your misinterpretation doesn't get corrected. In fact, over time you add more and more "proof" that it is really perilous. Not concrete or accurate evidence just more imagined proof. For example, if a child is afraid of vomiting she might begin to hyper-focus on how her stomach is feeling. What is going on in your stomach changes continually. At any given point in a day a person will likely feel some discomfort in his or her stomach. This normal discomfort is misinterpreted as increased likelihood of vomiting and is avoided if possible. She might change her eating habits if she thinks the feeling is connected to a certain food. That food is now additional "proof" of how likely she is to vomit. Stressful things cause stomach distress at times and so stressful things are avoided. Each additional association becomes more false evidence of threat.

Because she is now worried most of the time, she will scan for evidence of threat and gradually "discovers" more and more potential dangers and the cycle continues. The triggers remain triggers because they are never challenged and repetition strengthens the cycle. More triggers are added and they become part of the cycle.

An Example of the Cycle

Okay, let's drop a simple example into this cycle. Here is something that seems quite ironic to me. Lot's of kids are scared of clowns. They are supposed to be funny and likeable right? Anyway, imagine a young boy, Ben, at a circus. He is captivated by all the sights and sounds and doesn't notice that a clown comes up behind the audience and does something noisy (which is what clowns do). (1. Trigger) The clown startles Ben with the loud noise, he turns and sees this wildly dressed "thing" (2. View as Threat) and he starts to cry (3. Anxiety). Ben turns away, buries his head in father's chest and is so upset the family leaves (4. Avoidant Coping & 5. No Correction). After a few days, no one thinks much about it but a clown comes on TV. Ben, to everyone's surprise, gets anxious and cries (1, 2, and 3). What happens next? The channel gets changed or Ben leaves the room (4 & 5 again). Clown triggers are pretty easy to avoid so to keep the peace the family makes sure no clowns are around (4 & 5 again). No one else in

the family thinks clowns are scary but they don't want to freak out Ben so they inadvertently add proof that clowns are dangerous by helping him avoid them. But then he goes to a friend's house and there is a clown doll. It is close enough to the real clown so now clown dolls are scary and another trigger is added. The clown doll is avoided or removed. (1, 2, 3, 4, & 5). The cycle is reinforced and becomes more elaborate. Sometimes it jumps to any costumed characters – more triggers. It just has to be similar to the existing fear to become part of the cycle.

The Cycle for Emetophobia

So how does it work with emetophobia? No one likes to feel nauseated and sick. Vomiting is awful. Vomiting is NOT dangerous or threatening however. I'll use the example of my daughter. One of my pet names for her is Lelu. Lelu is at school and sees several students get miserably sick and vomit. She sees, hears and smells it. (Step 1). Lots of kids are getting sick. She naturally thinks she could get sick. But she thinks it would be terrible physically and humiliating. She interprets it as far worse than it is (Step 2). She begins to fear getting sick (Step 3). She wants to stay home while the flu is going through the school (Step 4). I think we may have let her do that (can't remember for sure) at first (we reinforced Step 4). She avoids anyone who might be sick. She avoids anything that might be contaminated with flu virus (Step 4 & 5). She starts to ask us if she is sick. She wants us to check her temperature. She wants reassurance she isn't sick. We do that(Step 5). She washes her hands. We tell her she is fine but start to make accommodations so she won't freak out (Step 4 & 5). The reason reassurance doesn't fully work is because kids know you can't promise they won't get sick. No one knows. But it helps a little so they keep asking. We stop saying vomit or synonyms, we change the channel (there is a surprising amount of vomiting on TV, even kids shows), she scans her body to see how she is feeling, especially her stomach. Well, anxiety causes digestive distress. (Step 1, 2, 3, 4 & 5).

Explaining It to Your Child

So, one of the first things to do in treatment is to explain how this works to a child. Someone afraid of this is seriously worried about vomiting. Explaining how anxiety works makes it less scary. Understanding gives a bit of control. It will also make the treatment make sense. First we suggest you use the cycle to explain something unrelated. Think of a time your child was a bit scared to do something new like ride a bike, swim in the deep end of the pool, go to camp, etc. Make sure it is something they are no longer afraid of and show how they went through the process.

Here is an example. Annie, remember when you learned to ride your bike? We took off the training wheels(step 1) and you were nervous you might fall (step 2). You were really upset and worried (Step 3). You went into the house and refused to get on the bike at first (on the edge of step 4). But you let your dad hold you in the seat. He held you at first as you started to ride until all of a sudden you said, "Dad, let go," and off you went. The cycle stopped because you didn't do step 4. You faced the fear and realized it wasn't that dangerous to ride a bike and so Step 5 didn't happen because you had evidence it was safe enough.

In the next several posts I will go through the treatment process step-by-step. Please let me know if this description was clear and helped you understand how a phobia starts and maintains itself. Do you have any questions that were not answered?

**Functional analysis based on lecture notes from Pollard, A. C. (2012) Cognitive Behavioral Treatment of OCD. Behavior Therapy Training Institute. Massachusetts General Hospital, Boston, MA

Part 2 Treatment – Exposure

The effective way to help kids afraid of throwing up is two-fold. First, face the fear. That part of the treatment is called exposure. (Just so you know, contact with actual vomit or the act of vomiting is not a necessary part of exposure.) Second, don't play it safe. That is called response prevention (preventing the usual response). Kids come up with all kinds of ways to stay "safe." These are steps 4 & 5 in my previous post. In this post I will only cover exposure. In my next post I will cover response prevention. For kids with anxiety both of these are incredibly difficult so it is important to understand how this works.

What is Exposure?

Exposure is doing something deliberately that will evoke the distress normally avoided. Don't miss this.Exposure is being anxious on purpose. You are not doing exposure if you are trying to not be anxious or if you are not anxious at all. This is hard to get because it is so counter-intuitive. For example, let's say the exposure is looking at a picture of person who appears sick. Most kids will try to come up with a story about the person in their mind so it is not so scary. They might think the person may be sick but not in a way that would lead to vomiting. This might seem good, right? Wrong, that is NOT the way to do the exposure. The goal is to feel the fear and think the scary thoughts and do it for an extended amount of time. (**Please keep reading, this can be done with only moderate discomfort so don't dismiss this because you think your child will NOT do it.)

I will address why exposure works in later posts but if you are interested, here is an article about it. It is quite academic so unless this is your field you may need a dictionary. (Don't tell anyone but I have to use a dictionary sometimes myself.) Briefly, here are some of the reasons. 1) If you stay in something long enough your body gets used to it. Think about a concert. The sound hurts at first but you get used to it. 2) If you do it on purpose you are choosing it and that gives you some control back. 3) The feeling makes you think something bad will happen. If you do it enough your brain realizes the feeling doesn't lead to the feared outcome and reduces the feeling. 4) Anxiety problems are a result of mistaken ideas. Exposure leads to disproving these mistaken beliefs.

The fact is that kids are already thinking about it all the time. I am not asking anyone to do anything they are not ALREADY doing. We are just going to do what their brain is doing with a plan to make it less scary. Their nervous system is already forcing exposure in an attempt to overcome the fear. I tell kids we are just going to help their brain finish what it is trying to do and stop the things that are keeping that from working.

Exposures can be all sorts of things. You can imagine, observe, watch through media or actually experience whatever triggers your distress. In this series of posts I will lay out the steps I typically use with kids but I will also try to layout the principles so you can apply it to all sorts of fears. Following are the steps necessary for successful exposures.

Exposure should be organized and planned

When I explain exposure to adult clients they tend to give it a try without a plan. They are in the moment and so they try to do some exposure on the fly. Sometimes they can see the benefit but often they don't make much headway because they bite off more than they can chew or don't do it enough. It is important to layout a "map" and follow it step-by-step, especially with kids. This is, of course, easy for some people and hard for others. I am personally not very structured. If there were a way to wing I would have found it. So when I say follow the map, I mean follow the map. So here are the steps to make the map.

1) Make a list

You will make out a list of things that would evoke anxiety or distress. Then order them from easy to hard. You will probably change it a bit as you go but make your best guess. I have done that for you for this particular phobia and will cover it later in detail. For other phobias you will have to create your own list. Here is a brief preview:

1. Individual words, easy to hard
2. Short sentences with the trigger words
3. Short sentences that are personalized to particular aspects of fear
4. Paragraphs that describe situations and feelings that will evoke distress
5. Simple cartoon illustrations of sick characters and characters that are vomiting
6. Sick people photos but no vomit
7. Photos of vomit but no people
8. Photos of people vomiting
9. Animated videos of vomiting
10. Videos of people vomiting
11. Fake vomit and vomit smell (purchased on eBay. Yes, believe it or not you can purchase vomit smell.)
12. Exposure to places and situations that evoke distress

2) Track the distress

It is tempting to skip tracking the level of anxiety during an exposure. Please don't do this. I think I get close to annoying with this because I ask about it over and over during exposure. This procedure is called a SUD score (Subjective Units of Distress score). With older kids I use a scale of 1 – 10. You can use 1 – 100 also. If numbers don't work there are plenty of visual examples online like thermometers you can use. I print a card to use and here is what it looks like. You can

change the words to best fit your child's descriptions of the distress if you want.

For younger kids I have a white board and have them draw a line. The top of the line is "freaked out" and the bottom is "doesn't bother me at all." Here is a picture of the board after a session. We were doing exposures on words. You can see the distress wasn't too bad. Particularly at the beginning I try to keep the exposure mild to moderate. This is important to clearly show the effect of the exposure. Kids memories of this are not very good. It is biased toward the distressed feelings so an "objective" measurement is extremely important. It is very motivating to see progress. I have them mark or give me a score at the initial exposure, during the exposure and then at the end of the exposure. Periodically, I will go back to previous exposures and most of the time it will have dropped even further. Once you do the harder exposures the first ones seem very easy.

3) Do Exposure gradually

When you do this you will run into resistance. Who wants to feel anxious? If an exposure is too hard don't force it but don't give up. Just break it into a smaller step. Finding a beginning point is often a surprise. A client and I will come up with an exposure plan and sitting in my office they are sure they they can do it. However, they are frequently surprised that it is WAY more difficult than they imagined. Therefore, start slow and easy. Better it is too easy rather than too hard. Here is an example of what I might do. I will introduce the idea of just saying one word that might make them uncomfortable. I then ask permission. If that is too hard, I ask if I can write one letter. If you look at the prior whiteboard illustration you can see lines under the word GAG. First it looked like _A_. Then it looked like _AG. Finally the whole word GAG. Take it nice and easy until you find an acceptable starting point. Do NOT worry about what your child WON'T do, help him or her figure out what they CAN do. Here are a few variables you can use to make an exposure easier or harder. Don't guess, just ask if they think it would be easier, they will know. This also has the effect of giving some control to the child. Make them part of the process as much as possible.

- Quiet or loud. Example: You can whisper something first for example or turn the sound off on a video.
- Close or far/big or little. You can show the video very small on the other side of the room.
- Break into parts. Read part of the sentence and leave out the hardest part and then add in a word at a time.
- Who does it first. One child needed to touch a toilet seat for an exposure and I did it first.
- With words and paragraphs it usually is easier if someone else says it first
- Read silently or out loud
- Silly voice or scary voice

Parent's, remember while helping your child that what they fear is not actually dangerous or threatening. You will hate to see them scared and will want to comfort them. Encourage but don't rescue. The purpose of exposure is for your child to eventually see that it is not dangerous. Then the anxiety will go down. Don't try to remove the anxiety first and then face it. That is backwards. You can adjust the difficulty but don't remove it.

4) Prepare your child that it WILL be difficult

Make sure your child is prepared to feel anxious. I emphasize this over and over. However, I tell kids it is my job to figure out how to make an exposure kind of hard but not too much. I want them to tell me if it is too much. More than likely your child will feel comfortable telling you it is too hard so, if possible, don't get into a power struggle. I will tell kids they are the experts of their anxiety. The more information they can give the more I can help them. Tell your child it is normal to feel uncomfortable when doing exposures. I tell kids, everyone and I mean everyone, feels uncomfortable. I change the words to less distressing words in describing their reaction, for example instead of saying "anxiety" I say "uncomfortable," or whatever is age appropriate. You will know their use of words. It is a fact that exposure tasks must evoke discomfort to be successful. In other words, you are doing it right if it is distressing. This discomfort is temporary and it will subside as you remain in the task and as you repeat the task. You can probably think of a time your child did something or learned something that was hard at first but is now pretty easy. Remind them of this.

I tell kids to try to not fight the anxiety or fear. They will not benefit from exposure if they fight the anxiety. Instead, they need to just let themselves feel the discomfort. Don't do anything about it, just let it be there. You may have to encourage them that it is something they already feel and it will just be uncomfortable, not dangerous. Throughout this process, ask your child what they think about what you are saying. They may have concerns and being able to address those are really important.

I have few responses to help with this. I may ask or say some of these. 1) Do you think you could do an exposure if we keep it really easy? Sort of like a hungry feeling? 2) Do you think you could hear me say or just look at a word about this? 3) If you think it might be too much let me know and we will stop right then. This gives a sense of control. 4) You are probably going to feel bad anyway, wouldn't be better to get be in charge of it? 5) You have been really good at not throwing up, right? You can probably handle a small worry, right? Just do what you normally do when it is not too hard. Ask them if they have ideas that might help them face it.

5) How long should an exposure last?

I so wish I had known the answer to this when my daughter was struggling. I tried an exposure with her and when she got anxious we all freaked out and quit. That may be worse than not trying an exposure. It just makes you more afraid. Here is the key: You must stay in the anxiety until it starts to subside on its own. It needs to come down from the peak before you stop the exposure (based on their SUD score). It doesn't have to be gone completely just lower. For example, let's say the exposure is with the word "barf." I usually ask, "Would you like to see it, hear me say it or you say it first?" Start with what they suggest and get a distress score or mark. Say looking at the word is a 5. I then ask them to look at the word for an amount of time. I have a timer on my cell phone I use.

Typically I start with 30 seconds. Then I ask, “Where is it now on the scale?” If it is the same or higher I ask them to continue to look at the word until it comes down. Then I suggest we do the next hardest thing like I say the word. Same process. I will say, “Barf” or even spell it first. Maybe I say, “Bark” playfully first. This usually ends up with me saying barf, barf, barf to some simple tune.

Keep doing the exposure until it comes down. This is important because this will be the experience to support that exposure works. Believe me, they will want proof. I usually make note of the time. I can then say, “Okay, now we have some kind of idea about how long an exposure will take.” I always qualify this by expressing some uncertainty but it helps kids know it is uncomfortable but it will pass and about how long. Then I can say, “Do you think you can stand being uncomfortable for about X amount of time?” This really helps with some of the initial fears kids have about the process. Just as a rule of thumb, in my experience, it takes 15 to 30 minutes when you are first starting. You just have to accept it takes as long as it takes. Nothing is wrong if it takes a while or even goes up at first.

I have found that specific questions about the distress can be helpful. I will ask, “Can you tell in your body where you feel the worry?” Usually it is the tummy or throat. With one young client, I don’t remember how we got to this analogy but we started to describe the uncomfortable feeling in her tummy as a potato. I would ask her, ”How big is the potato?” It disarmed the feeling by calling it something silly but also became another way to measure the exposure. I could use the metaphor to ask her if she would be willing to feel the potato for a bit while we did the exposure.

A counseling session is usually around an hour. That seems about the right amount of time for the initial exposures. I wouldn’t go longer than that at home. I check in a lot to see if they are okay to keep going or if it is time to end. If it is clear a child is worn out or feeling a bit overwhelmed then I don’t mind ending sooner. You will have to figure out that with your child. Also, counseling is usually once a week. So I send a child home with homework to practice the same exposure we did in session as many days as they can before next appointment. (I have varying degrees of compliance with that but don’t make a big fuss if not much happened at home. I just tell them it will take longer to get through this and they can decide.) I won’t move to the next exposure in the hierarchy until the current exposure is pretty low like a 3 on the SUDs.

So the rhythm is do the exposure during the session. Homework is to repeat it as many days as they can. Then the next session we take the next step up the hierarchy, then home to practice, and so on. You will have to find the right speed for the process at your home. Remove all the distractions you can during the exposures and plan enough time. In the next post I will address response prevention. This whole process may seem a bit overwhelming at first. I am describing it in some detail so you will be prepared if you decide to do this. Keep in mind that Dr. McCarthy and I will be creating a supplemental product for this to go with the Turnaround program in the future that will help you with this.

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Much of this article was adapted from this superb book and his steps for successful exposures: Abramowitz, Jonathan S. (2012-06-25). Obsessive Compulsive Disorder (Advances in Psychotherapy; Evidence-Based Practice) (Kindle Locations 2630-2652). Hogrefe Publishing (com). Kindle Edition.

There is a marvelous website devoted to emetophobia (http://www.emetophobiaresource.org/) that I have used but then adapted for use with children. The site is for adults but you can see the principles and examples of the hierarchy clearly laid out. It is outstanding. Here is the link.

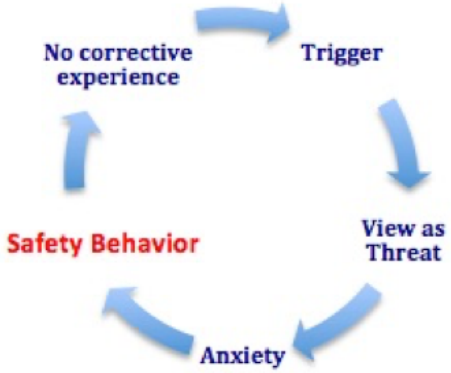
Part 3 Treatment – Safety Behaviors

In the previous blog, I mentioned treating this fear (emetophobia) was two-fold. First, face the fear. This is called exposure. Second, don't play it safe. This is called response prevention. This is third in the series on helping kids afraid of throwing up or getting sick and will make more sense if you read part 1 and part 2before you read this. In this post I will do my best to describe response prevention and what to do about it.

Response Prevention is the academic phrase for NOT doing something. When anyone gets anxious they try to fix the problem. This is the response. Ironically, sometimes those attempts to fix the problem become part of the problem and make it worse. Response prevention simply means to stop any problematic behavior that is part of the cycle.

Safety Behaviors

I am going to introduce a new term here: safety behavior. Playing it safe is the response that is important to stop. I like this term because it is so descriptive. It means the same thing as avoidant coping that I discussed in part 1 of the series. Avoidant Coping is more descriptive of the principle, while safety behavior suggests an action. It can also be generally interchanged with the word "compulsion". A compulsion is likewise an attempt to solve the anxiety problem by making things safer or less distressing. I don't mean to be confusing but these terms are nearly interchangeable to some extent: compulsion, safety behavior, and avoidant coping. These are the behaviors that are important to stop, hence the phrase, response prevention.



As a quick reminder, remember the anxiety cycle from the first post? Here is the diagram again with safety behavior included. It follows mistaking a trigger for a threat, feeling anxious and then attempting to fix the problem with an action based on a mistaken interpretation.

Stopping safety behaviors is generally as important as exposure. Think of it this way: Why would you do something to be safe unless there was a possible danger? A safety behavior assumes danger, threat, or intense distress. So each time you do something "safe" you are reinforcing the belief that something is dangerous. The treatment for this phobia is to prove that vomiting is not dangerous or threatening. Granted it is annoying, but in and of itself, it is NOT dangerous. Playing it safe is supporting the belief there is danger. Make sense?

Examples of Safety Behaviors

Safety behaviors can be very subtle. Once I was working with a young girl with emetophobia. I was doing it via videoconferencing. I noticed that the exposures were taking longer than expected. That is usually a sign of a safety behavior. I checked back in on this and discovered she would flick her fingers during an exposure out of view of the camera. (It was a way to support "mentally flicking away" the scary image. I am always amazed how clever kids are in figuring ways to cope. Whatever they do only has to help a little bit to become part of the cycle. It can be more symbolic or metaphorical than practical so don't get alarmed if it seems completely unfounded.) We then worked on doing the exposures as well as reducing and gradually ending the flicking.

That was working great but then something else jumped into its place. This often happens. As the flicking behavior tapered off she began to do a very subtle spitting behavior. You have to watch to make sure a safety behavior doesn't evolve into something else. We did the same thing with the spitting behavior. While doing exposures we worked on stopping any spitting. (By the way, the spitting was to make sure there wasn't a contaminant in her mouth.)

As I mentioned previously kids will also find other ways of mentally reducing the danger. In part of the exposure process I use pictures. Here is one of the pictures that I used that I eventually pulled out of the rotation because several kids transformed this to "spilled stew" in their mind rather than vomit. (Actually, I think they were probably right.) I will ask periodically, "Are you doing anything that makes it less disgusting like changing the picture in your mind or trying to blank it out?" For example, there is a variation of an anxiety disorder where intrusive violent thoughts come to mind. A common safety behavior for that is to think a "good" thoughts to counter the bad thoughts.

One of my adult clients figured out that chewing gum would reduce his nausea. It is so subtle that I didn't even notice he had it in his mouth until he told me about it. As long as he had gum, he wasn't fully facing the fear. Again, it hard to not think of this as a good coping behavior since it works. That is the sneaky thing about anxiety. It does help some but it reinforces the idea something is dangerous and so you win a battle but still lose the war.

By the way, with emetophobia the physical feelings tend to be either in the stomach area or throat. Watch for spitting, swallowing or changes in posture as attempts to make it safer or feel better.

Another subtle safety behavior is the location of the exposures. Being in my office is often a safety. They think, "He wouldn't do something to make me throw up." It will likely be the same at home.

Reducing Safety Behaviors during Treatment

I will often let safety behaviors continue as we begin the exposure process. It may be needed for a kid to even try the initial exposures. However, I talk about reducing them and bring them up as we discover them. I tend to go back and forth; exposure and then stop the accompanying safety behavior, next exposure, stop any safeties, etc. They also fit in the hierarchy from easier to harder just like the exposures.

For example, if my office is "safe" I have them do the exposure at home. If the exposure is saying words like puke and barf, I would ask him or her to start with the safest place at home and work toward the hardest place at home (assuming we determine some places are harder than others). As you could imagine saying, "Puke," at the kitchen table would probably be harder than in mom and dad's room. School is often the scariest place to get sick so eventually I will want them to do exposures on the way to school or at school if realistically possible.

If cleaning, washing, or disinfecting are safety behaviors then you would want to reduce those as well. I recently went through the main part of the hierarchy with a young boy before we directly addressed some of his safety behaviors. Stopping them would be really hard so they were farther up the hierarchy. So in his case, certain items in his bathroom were "contaminated." So after he goes to the bathroom and washes his hands he has to touch the contaminated places. We started with the light switch. In his case it was a jack-and-jill bathroom so there was a "clean" switch and a "dirty" switch. He would touch the dirty one and not wash his hands. Next he would do that right before he ate and so on.

I am frequently surprised to discover a new safety behavior with a patient. The reason it is hard to discover them is that people don't think of them as problems but as coping behaviors. It seems so reasonable. Before I really understood how to treat anxiety, I would help patients come up with ways to cope. I fell right into anxiety's trap. Much of what I read on the internet is full of these coping skills.

I was working with a young man who was avoiding school because he was afraid of getting sick. We went through the whole hierarchy with great success. He is back at school and doing great. There were just a couple things left to tackle. Then it comes out he was scrubbing his desk, chair, pens, pencils every morning with hand sanitizer. Probably the only reason it ever came up is because people were asking him what he was doing. The excessiveness that caused people to comment was a clue that it wasn't just a preference but a safety behavior.

Not Taking it too Far

Just to be clear, I don't ask kids to be unsanitary, at least not permanently. It is perfectly okay to use reasonable care with hygiene. Here is the thing; all that cleaning and washing don't really provide complete protection anyway. It is more an illusion of safety than actual security. This stuff is microscopic so there is no way to know you get it all when you clean. Nevertheless, kids should wash after going to the bathroom or before meals. My goal is to make the behavior reasonable or normal. If I kid is washing hands 20 times a day or for protracted periods the goal is not to stop it entirely but bring it back to a more normal practice. If you want to gage what is normal do a survey of friends and family and get an average. I will ask the purpose of the behavior. Is the behavior for the purpose of being safe due to the fear or just a good habit? If it is for safety then I will want to modify it at least during the exposure process until the fear is disconnected from the action. A safety behavior will ALWAYS have the purpose of reducing the anxiety. If the behavior isn't reducing the anxiety then it isn't a safety behavior and you don't need to address it.

List of Possibilities

I have been doing this a long time and I still miss safety behaviors so don't expect to catch everything. The research is not as certain that safety behaviors always interfere with treatment as long as there is consistent exposure so if you miss something the process should still work fine. Because it is subtle, here are some things you might look for:

1. Avoiding contact. This can be hard to catch if there are plenty of other options available to your child. For example, if a certain chair is contaminated there may be plenty of other places to sit so no one notices. Pay attention to resistance or avoidance that doesn't make sense like avoiding the nearest bathroom. Are clothing items or previously favorite toys avoided for no good reason? Watch for eye movement that is clearly avoiding looking at something. If child suddenly avoids contact with family member see if someone mentioned being in contact with sick person recently. Avoidance is the most frequent safety behavior so this is most likely to show up.
2. Physical behaviors like swallowing frequently, peculiar movements especially repetitive ones, messing with or organizing food, checking details on food items. Lots of my clients hold their hands or arms slightly funny. If you watch you will see they are keeping their hands from contacting their own body or something else. For example, if they think they sat on something contaminated they won't touch their pants. Anxiety usually cranks up kids so watch for agitation or hyper-activity when triggered.
3. Long periods in the bathroom. Evidence of excessive cleaning like soap being used at extraordinary rate. Rolls of toilet paper being used rapidly, using towels faster than usual, etc.
4. Frequent or strong disgust responses. This can be bad smells, hearing about things, images on TV, etc. You will be able to see the disgust response, that one isn't subtle.
5. Refusing to eat or change in what child will eat.
6. Mentally neutralizing or changing triggers to be less fearful. Hard to catch this, you will probably have to ask.
7. Insistence of being around a safe person
8. Asking for reassurance

There are certainly any number of these but this is what I could think of as I wrote. Maybe some more will come to mind later and I will add them to the post. I would love for you to add comments about this or what you may have noticed in your own children. I hope this was clear.

Part 4 Treatment – Hierarchy

Warning: there are graphic pictures of vomit and people vomiting in this post.

In the first three posts in this series, I provided an explanation of the fear called emetophobia and described the two elements of treatment: exposure and response prevention. Please read them carefully before starting the process below with your child. In this post I will detail the hierarchy I use in my office to treat this phobia. (We call hierarchies "stair-stepping" in Turnaround.) This is a general template and I modify it to fit my patient. Once again I want to credit the excellent site by Anna Christie who laid out the general pattern that I used as a resource in developing this for kids.

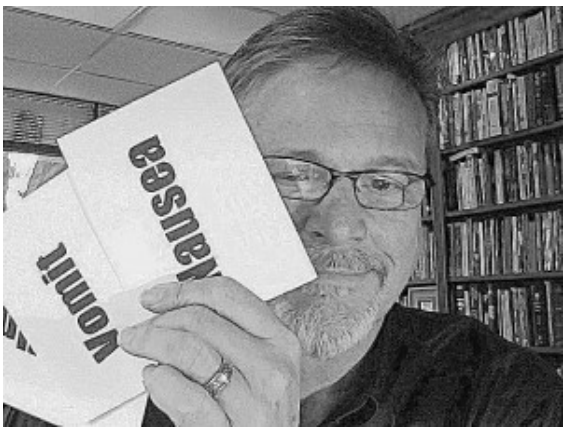
If you are squeamish at all about this subject, I would recommend you go through these steps yourself before doing them with your child. You need to make sure you don't get triggered by any of this while trying to help him or her. You could also recruit another family member or friend to help do this if your child needs help right away and you don't have time to go through the exposure process. We are going to create a supplement disk that will detail this for kids in the near future. However, I can't guarantee the timeline for that. It is quite an elaborate production.

Sometimes this process is pretty straightforward but there can be surprises. If you have access to a clinician who is trained in this or willing to take your child through the process I am describing that is something you should strongly consider. However, that is not always an option and that is why we are developing this.

Treating anxiety causes anxiety. Don't be surprised if your child is generally more anxious at the start of this and periodically during the process. That is common. What I am providing is just educational so please recognize I cannot guarantee how this will go.

First Step: Single Trigger Words

As I described in Part 2, I start with individual words, easy to hard. If I am working with a kid who is clearly very anxious about words, I'll show a word one letter at a time. They will probably guess it but it seems to work to ease into it. If it is too hard, don't push, step down to what they can do. I really want to encourage you to keep every exposure 5/6 or less if possible all the way through the entire hierarchy. (By the way, I will try to describe this in a way a parent can do it but I can't help but think of it as I do it in my office. Please forgive me if I fall back on thinking of it from my clinical point of view.)



I printed out the words on separate cards to make it easier to do the exposures

First, I either show the word or say it depending on what a child says they would prefer. Always, always, always, **get a SUDs rating**. It means subjective units of distress. Use either numbers or a line as I described in the previous **post**. Keep track of SUDS before, during and after. The next step is to ask if they can say it or write it. I use this sequence with all the verbal steps: 1) See the word, 2) I say it, 3) Child says it. Don't move to something harder until the step you are on has come down on the SUDs.

If I ask a child to say it and they can't yet, I ask if I can say it more. Or I see if they can stare at the word for a longer time. Keep doing the same step over and over until the anxiety drops. For example, if I show a kid the word "Puke" and they tell me that is a 5 or 6, I keep them looking until it drops. I like for it to drop by 2 or 3 at a minimum. Remember the principle is don't push something he or she **can't** do, find out what they**can** do and begin there.

At the first session, I may only do a few words. I warn them it might be harder than they expect. Anxiety may go up a bit during the exposure, just keep it going until it begins to drop. Use lots of encouragement and praise because this is hard. Let them know they got through it and they are okay. Sometimes it may kick back up later out of the blue, or when they practice the words later so don't promise it is always smooth and easy, it can be bumpy. Distraction is a **safety behavior** but I might use it at first to take the edge off of something. For example, if I see that anxiety is picking up steam, I may distract or use humor for a few minutes and then come back to the exposure. I try to use this less as we work our way up the hierarchy and it isn't as necessary as confidence grows.

Here is the general order of words. I have organized them in 3 categories of Easier, Medium and Harder based on my experience but you may have to guess which words will be hardest for your child. If you get it wrong say, "Do you think you can keep going on this word? If not, let's come back to it later." :

Easier: Spit up, sick, upset stomach, gag and hurl

Medium: Nausea, upchuck, throw up, barf

Harder: Puke, blow chunks, vomit, projectile vomit

Obviously, the slang for vomit will vary by country, region and certainly age so just substitute relevant words. I rarely get though all the words in one session. It takes at least 2 if not 3 hour long sessions separated by a week each in my office, so take your time. I go especially slow at the beginning. Better to not push too hard or future exposures will be resisted more than they are already. If you find you can go faster than go ahead. That happens sometimes as well, especially will older kids. When this problem involves school refusal the pressure to get through this fast can be huge. You will just have to use your best judgment on this but truly, try to NOT overshoot. Try to use humor if you can. (I can do silly. Might have something to do with a failure to mature properly. Anyway, try to add some playfulness.)

I just finished taking a young client through this and it took 13 sessions. Don't take that as a gold standard, I mention it only to give you some general notion of what to expect. I would be surprised if it took less than 10 sessions. I would NOT be surprised if it took 20 but I would start looking carefully for subtle safety behaviors when it you get in the high teens.

**Keys for every step

1. So here are the basics that will apply with each new category of exposure.
2. Find a starting point that is 5 or less on the SUD scale.
3. Start with easy and gradually get harder
4. Stay on the same word/step until the level of distress or discomfort drops on its own.
5. You can write it, you can say it, and your child can write it, say it and stare at it. Repeat, repeat, repeat! I'll put it in silly songs or poems. (Unfortunately, my patients have to go through exposure from my terrible singing.)
6. Periodically check back on earlier exposures and get a SUDs. Make sure they are the same or less. If they have gone up consider more exposure. If you just introduced something new, everything will get harder briefly.
7. Watch for any safety behaviors and eventually do the exposures without the safety behavior. Make sure that doesn't throw it too high. If it does, put it off until later.
8. Keep track of the exposure as well as beginning and ending SUDs. This becomes solid evidence of progress when you hit those moments of doubt. I have tried various forms but I usually just end up scribbling them down. Below is an illustration of one of my forms just to give you an idea of how you might track the SUD scores and progress.
9. Practice the exposures for several days before you go up a major step. Don't take the next step until you get consistently low SUDs on the existing exposures.

		Length of Time			SUDS 1-10		
Exposure	Date	Start	Stop	Total	Start	End	Comments

Example of form to track SUD scores

Second Step: Short sentences with the trigger words

The next major step up the hierarchy is to use the words in short sentences. With kids it is usually easier to use animals at first. If there is a family pet I will incorporate the pet into the sentences. (Unless it is a fish. Do fish even vomit?) Cats and dogs are great and usually kids don't get as freaked out when a critter vomits. Use the same pattern as with words. Start easy and get harder. If the sentence evokes too much anxiety build it one word at a time. Since they are already used to the trigger words it shouldn't be too big of a step. However, sentences may make it more likely to make the "movie" of it in their head. The word/sentence isn't the problem, it is the imagination triggered by the word. So here is a typical first sentence I will use:

The dog _____ in the grass. (Then carpet, then shoe, then bed.) I usually write out the sentence on my whiteboard with a blank where the trigger word goes and then write it in and have them look at it first, then we go through saying it.

Insert the easiest trigger words and work up from there. I will even ask what word my client would like to start with first. You usually can get to the harder words pretty quick if you have done a good job helping your child to habituate to the words in step one. Habituating is psych-speak for getting used to something. You can change animals to increase the difficulty. I might ask if an animal gets sick in the sentence would you prefer it to be a cat, dog or ferret? (I just now thought of the ferret as a silly option and will definitely throw it in with my next patient.) Then work up to larger animals with possibly ickier characteristics like a smelly buffalo, etc. I only do a few of these to keep things moving and may only have to repeat a few times.

Now the next step is a bit harder typically. If your child is a girl you may want this sentence to be a boy or vice-versa. It is a bit more objective than a same sex example. Then follow it with a same sex example.

The boy felt _____ after eating. Use the words like sick, upset stomach, etc. You can change the person, the action or the place as needed.

The girl raced to the bathroom/lav/loo and _____ into the sink/toilet/bath. Again, I am listing some variations for you to adapt to your child. When it comes to slang I realize I am very provincial so please translate to your country and region.

The next step is to personalize the sentences to include triggers. If there is a particular food that triggers the fear I might introduce it here in one of these sentences.

What if I _____ after eating lunch (or in school or wherever is a trigger)

I am going to _____

I feel like I am going to _____ now

I will _____ all over the place

I feel my throat gagging

I feel sick and sweaty and nauseous after seeing/smelling _____ (insert trigger food).

Keep the sentences short and don't move to a harder sentence until the current sentence has come down in SUDs. Refer again to the **keys used for every exposure.

Third Step: Paragraphs

I use a few templates but customize on gender and if something is more suited. This is much like the second step sentences except you add more detail and put it in a context. I typically do exposure on 3 or 4 of these. I have them printed out so I ask, "Do you want to read it silently first or hear me read it?" Your child needs to read it over and over until the SUDs drop. Sometimes, I will have them read just the hardest sentences over and over after going through the whole thing several times. That speeds up the drop in SUDs. Here are four examples.

I was at school and my friends were talking about some kids getting sick. Everyone was laughing about it but I was nervous. They said I need to chill out but I was worried I would get sick. Suddenly a kid at the table next to us leaned over and vomited on the floor. Everyone was grossed out but the teacher helped him go the nurse's office. Someone came and cleaned it up.

I was at a restaurant (you can personalize this to a place you go) with my family. We were having a good time when I excused myself to go to the bathroom. I was washing my hands when a man/woman/girl/boy (pick what works) burst into the bathroom. He/She looked sick. I started to leave but before I could escape he/she pushed open the door to the toilet, bent over and vomited loudly. It was gross. Before I could get out the door he/she puked again. I could hear him/her coughing and gagging.

The flu is going around. I stayed home today because of how many people were sick. I just knew someone passed the virus to me. No matter how hard I try I feel like someone will get me sick. I feel worried. I don't eat much just in case. Suddenly I hear my mom (or other family member) in the bathroom. She is vomiting violently into the toilet. I plug my ears with my fingers and get as far away as I can. But she is so loud! I can still hear her. I am feeling nauseous. I probably should go check on her but I don't know if I can. I am afraid I will get sick next.

All day I have felt sick to my stomach. I should not have eaten _____. It didn't look/smell/taste right but I was so hungry. I start pacing back and

forth but my stomach feels worse. I am afraid I am going to vomit. It is going to happen. I get hot and feel shaky. I can feel sweat on my forehead and my heart is pounding. I have tried everything that might help that we have. The nausea is terrible now and I can barely breathe. I can't help it; I give in to it and go into the bathroom. I kneel before the toilet. Bile rises in my throat but I try to hold it. Suddenly everything comes up and I vomit into the toilet. I vomit several times. Then it is over and it sticks. I gag and cough a bit. I have a terrible taste in my mouth.

With every step have your child practice the exposures for several days before moving up to the next major step. I tell a client that being bored with the exposure is a great outcome.

Fourth Step: Simple cartoon illustrations

This is usually a scary step to move from words to pictures so I may describe the image first. It is important to track the SUDs throughout the process. Have your child keep looking at the picture until the SUDs drop. I often ask for details so they will focus intently. For example, on picture 1 I might ask, "How old do you think he is?" Or I might point out, "Look how with a couple lines they make his eyes show feeling." I will pull out my phone app timer and have a child stare for X amount of time. Usually 30 seconds and up. We keep going until the SUDs go down. I'll do the same with the next picture and periodically come back to the previous pictures.

I have to throw in a disclaimer here. Since I just use these in my office I don't worry about copyright issues. However, I am about to publish a few of these. I just found them online. Because I don't want to violate any copyright laws, you will have to find images online yourself. Just go to Google images and search "vomit cartoon" and you will have every image you could ever want. I start with black and white line drawings of characters who just look sick and then move to vomiting and then color images. Here is an example of the sequence I would use. I typically find 6 or 8 illustrations.

Fifth Step: Sick people pictures but no vomit

In this step I move from illustrations to photographs. These are only people who look sick. Same process as before, look, look, look until the anxiety drops on it's own. As you search for images ("photo people nauseated") you will notice that there are not that many photos of kids. This is for obvious reasons because the use of minors on the Internet is appropriately protected. In my experience using adult images has not interfered at all with successful exposure so don't worry about finding kids the same age as your child. If you are feeling a bit ambitious you could recruit family and friends to

pretend to be sick and photograph them. The only thing that might be an issue is that if your child knows they were pretending he or she might mentally make the pictures "safe". Images are the point that I start to really notice a lot more safety behaviors because kids find ways to interpret the pictures to be safer. The simple remedy is to ask them to imagine that the person is really sick. Most kids will do that as soon as you say it. Again I will find 6 to 8 images like the ones in the example.

Sixth Step: Pictures of vomit

Next step in the hierarchy are photos of vomit. Again start with easy and work toward more difficult although if you see one vomit you have seen most vomit. The color and the amount of undigested food seems to be what makes one worse than the other. And then the kicker is the one with the bird. I save that for last. You can find plenty of these online if you search "vomit photo."

Seventh Step: Pictures of people vomiting

This can be a pretty big step. The cool thing is that these images would have completely freaked out your child if you started here but the SUD score should be 5 or below. If it is too high still then I would drop back and continue with previous exposures. You can make pictures small or hold them far away to make it easier at the beginning. Again I may ask questions about details to keep the focus on the pictures. For example in 3 I might ask, "What kind of car does that look like?" Or in 2 I might ask, "What kind of room do you think that is?"

I will point out all the progress as I go along, use lots of encouragement. Again, don't move up a step until the previous step is low on the SUDs. I start with an image of someone over a toilet but no visible vomit and get more graphic as I go. As usual about 6 to 8 images. I have noticed a high representation of what appear to be university students in these photos. Wonder why??

Eighth Step: Animated videos of vomiting

Kids generally express some concern at this point because we are starting with videos. I let them know the first ones are just animations and not as hard as they might think. With videos I usually start them with the sound turned off. Showing the video from a distance can also make it easier at first. I have a tablet I use in my office but you can use a computer just as well. I found all the ones I use on YouTube. I may have used a couple from the website I referenced earlier, I can't remember. Just be careful with those because some contain some adult language. I do this enough that I have edited

the videos so I can play them over and over with only the exposures sections showing. It saves a little time which may not be a big deal unless you are paying an hourly fee. I am not going to post the videos, instead I will list the links. These links worked at the time I posted this but I can't promise they will still work when you read this. These are just samples, I have a total of 5 cartoon videos and 12 people videos that I use as a standard protocol. You can find about anything if you need to customize the steps. For example, one of my clients is afraid he will accidentally ingest a bug while eating so I found videos of people eating bugs.

I typically start with this Claymation video. You may want to turn down the sound at first on all of these.

http://www.youtube.com/watch?v=fSdqFiRUCvk

This is a cartoon about emetophobia. There is no vomit but the character gets nauseated. I used a screenshot from this as my photo header for this post.

http://www.youtube.com/watch?v=OpTivUFpZTo

This is a video of a bird that vomits and has diarrhea.

http://www.youtube.com/watch?v=8NTrCkHvwkA

This is the animated video that I use at the top of the hierarchy before I move to people videos. It is a clip from Family Guy.

http://www.youtube.com/watch?v=4eYSpIz2FjU

I have another cartoon that involved Minecraft animations but I couldn't find the link when I wrote this. There are plenty of things if you search on "vomit cartoons."

Ninth Step: Videos of people vomiting

The next step is videos of people vomiting. I start with a video of a baby vomiting, then toddlers, then kids and adults. The amount of vomiting and apparent distress of the person are what makes one harder than another. In the first videos it is clear that the person is not very distressed. Again this is just a sample of some of the videos I use.

This is a baby vomiting milk. Milk doesn't usually freak kids out as much as food.

http://www.youtube.com/watch?v=3aKHoJy3VXI

This is a kid throwing up while singing a Christmas Carol in a choir.

http://www.youtube.com/watch?v=wChGAdjVHaY

This is Swedish woman on TV who vomits and laughs it off.

http://www.youtube.com/watch?v=_tXzKpmRrFs

Here is a kid vomiting and has several gag reflexes first.

http://www.youtube.com/watch?v=kjl1ZDVZ6JA

This is a girl throwing up in a small plane and it gets everywhere.

http://www.youtube.com/watch?v=gzZ_gYlXENI

Anyway, you get the idea. There are even compilations of people throwing up. I save this Monty Python skit for last. You'll see why.

http://www.youtube.com/watch?v=aczPDGC3f8U

I have had kids make their own videos of pretending to be sick but I am not sure that is necessary. It is an option if it turns out there are specific details not addressed in the exposures so far.

Tenth Step: Real Life Exposures

I have fake vomit I pull out at this point. I recommend leaving it out while practicing the other exposures. I also have vomit smell (you can buy anything on eBay) that I add to exposures. If there are certain locations that tend to trigger anxiety then the next step is going to those places as an exposure. One of my young clients needed to go to the nurse's office and touch things that sick people probably touched. Another client needed to touch things in the bathroom. These need to be done without resorting to safety behaviors.

Usually, once I get a kid this far they are pretty much over the fear. Periodically, I recommend going back through the videos just to make sure everything is still okay.

Dr. McCarthy and I plan to turn these steps into a supplemental CD to go with the Turnaround program next. Although I included a lot of detail we will add a lot more to this as well as translate this for kids just like we did in Turnaround. I would so appreciate your comments and feedback. If you are trying this and running into some problems and would like some feedback please include as much detail as you can. I can't promise I will get to every email but will do my best.