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# Relationships between emetophobia symptomatology, fear of food, and body mass index

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**Abstract**

Emetophobia refers to a specific fear of vomiting. Some persons with emetophobia restrict their food intake (i.e., the amount of food eaten in a meal and/or avoidance of certain foods) because of their fear of vomiting, which can result in a low body weight. However, only a handful of studies has yet examined relationships between emetophobia and body mass index (BMI). We analyzed data from a convenience sample of 233 persons (76% female) who completed the Specific Phobia of Vomiting Inventory (SPOVI) as well as the Fear of Food Questionnaire (FFQ) and indicated their current height as well as their current and highest past body weight. Scores on the SPOVI and FFQ did neither separately nor interactively relate to current BMI (with or without controlling for highest past BMI or age and sex). Although previous studies reported that persons with emetophobia who seek treatment tend to have a lower BMI than persons with other mental disorders (including other specific phobias), the current study does not indicate that emetophobia symptomatology is related to a lower BMI in general. Future studies are necessary to further examine why and under which circumstances fear of vomiting results in restricted food intake and low body weight.

**Keywords** Emetophobia, Fear of food, Anxiety, Body weight, Weight suppression

## 1 Introduction

Emetophobia refers to a specific phobia of vomiting [3]. While it is a relatively rare condition compared to other specific phobias, it appears that it is actually the most common specific phobia that requires treatment [18, 29]. People with emetophobia show a wide range of avoidance and safety behaviors such as checking expiry dates of food, hand washing, checking own and others' health status, overcooking food, or avoiding sick or drunk people and traveling/public transportation [10].

Some people with emetophobia restrict their food intake (i.e., the amount of food eaten in a meal and/or avoidance of certain foods) because of their fear of vomiting, which can result in a low body weight [30]. Because of this, emetophobia can potentially be misdiagnosed as an eating disorder such as anorexia nervosa [27]. In contrast to

anorexia nervosa, however, food restriction in people with emetophobia is not driven by weight and shape concerns and a distorted body image but by fear of vomiting.

If food intake is restricted due to fear of vomiting, there is also a strong overlap between emetophobia and avoidant/restrictive food intake disorder (ARFID, [35]). A key difference is that fear of vomiting is also present in situations that are unrelated to food intake—as described above—in people with emetophobia [10]. However, the current Diagnostic and Statistical Manual of Mental Disorders suggests that "although avoidance or restriction of food intake secondary to a pronounced fear of choking or vomiting can be conceptualized as specific phobia, in situations when the eating problem becomes the primary focus of clinical attention, ARFID becomes the appropriate diagnosis" ([1], p. 337). Thus, differentiating between emetophobia and ARFID related to fear of vomiting is not clear-cut but may be more precise in potentially revised diagnostic criteria in the future [19, 33].

Only few studies have explored the relationship between emetophobia and body weight. Two studies examined subgroups within samples of persons with emetophobia and found that those reporting food restriction [30] and those reporting often being nauseous [8] had a lower body mass index (BMI) than those not reporting food restriction or often being nauseous, suggesting that these variables moderate the link between emetophobia symptomatology and BMI. One study investigated a sample of inpatients and found that those with emetophobia had a lower BMI than those with other specific phobias [21]. Finally, self-reported emetophobia symptomatology did not correlate with BMI ($r$ = .07) in a convenience sample but weakly, negatively correlated with BMI ($r$ = −.14) in a sample of outpatients with mental disorders [6].

In this preregistered study (https://doi.org/10.17605/OSF.IO/HKE37), we examined relationships between emetophobia symptomatology and BMI in greater detail in a convenience sample. Based on the findings reported by Hennemann et al. [6], we hypothesized that scores on the Specific Phobia of Vomiting Inventory (SPOVI) would be uncorrelated or at most weakly, negatively correlated with BMI. The study also included the Fear of Food Questionnaire (FFQ), which assesses avoidance of certain foods due to fear of gastrointestinal symptoms [20, 34]. No study has yet reported if scores on the FFQ are correlated with BMI but, similar to the SPOVI, we expected that FFQ scores would be uncorrelated or at most weakly, negatively correlated with BMI. Based on the finding by Veale et al. [30] who demonstrated that there is a subgroup of persons with emetophobia who restrict food intake because of their fear of vomiting and who have a lower BMI than those who do not restrict food intake, we hypothesized that there would be an interactive effect between SPOVI and FFQ scores on BMI such that higher SPOVI scores would only or particularly relate to lower BMI in persons with high FFQ scores. We further expected that this interactive effect would still be found when controlling for age and sex.

While these analyses represent cross-sectional relationships between SPOVI scores, FFQ scores, and current BMI, we also examined relationships with current BMI while controlling for highest past BMI. Thus, a significant, negative coefficient when using SPOVI or FFQ scores as independent variable would indicate that those with higher scores have lost more weight sometime in their life. Here, we again hypothesized that there would be an interactive effect between SPOVI and FFQ scores such that higher scores on the SPOVI would only or particularly relate to larger weight loss in persons

with high FFQ scores. We further expected that this interactive effect would still be found when controlling for age and sex.

## 2 Methods

### 2.1 Participants and procedure

The study was approved the ethics committee at the University of Regensburg (reference number 24-3989-101). Participants were recruited in January and February 2025 through SurveyCircle (https://www.surveycircle.com), Psychology Today (https://www.psychologie-heute.de), pollpool (https://www.poll-pool.com), social media, and among psychology students at the University of Regensburg using the university's Sona System (https://www.sona-systems.com). Inclusion criteria were an age of at least 15 years and speaking German fluently. Informed consent was obtained from all individual participants included in the study. The study was advertised as a study about different aspects of human eating behavior and hosted by REDCap (https://project-redcap.org). Participa nts who completed the first part of the study and entered their e-mail address received an invitation to participate in a second part (which only included the FFQ) after two weeks. Results on the psychometric properties of the FFQ (which include other questionnaires used in the first part of the study and test–retest reliability based on the second part of the study) are reported elsewhere [20]. Among all participants who completed both parts of the study, 5 × €50 were raffled and psychology students at the University of Regensburg were credited with 0.5 participant hours.

Three-hundred and fifty-eight persons visited the website but 58 did not start the survey and 53 did not finish the first part of the study. Fourteen participants did not pass the attention checks (two instructed response items, cf. [22]. Thus, the final sample size was $N$ = 233. Most participants were female ($n$ = 178, 76.4%), had German citizenship ($n$ = 220, 94.4%), had attained at least higher secondary education ($n$ = 200, 85.8%), and did not report having a chronic gastrointestinal disease ($n$ = 216, 92.7%). Mean age was 28.9 years ($SD$ = 12.9, Range: 16–73).

### 2.2 Measures

#### *2.2.1 Sociodemographic and other information*

Participants were asked to indicate their biological sex (male, female), age (in years), nationality (German, Swiss, Austrian, other), highest educational degree (still in school, lower secondary education, middle secondary education, higher secondary education, bachelor's degree, master's degree, completed vocational training), body height, current body weight, highest body weight at their current height, and whether they have ever been diagnosed with a chronic gastrointestinal disease (e.g., irritable bowel syndrome, Crohn's disease, ulcerative colitis).

#### *2.2.2 SPOVI*

The SPOVI [31] measures emetophobia symptomatology in the past week with 14 items and its German version [6] was used in the current study. Responses are recorded on a five-point scale from 0 = *not at all* to 4 = *all the time*. Therefore, mean total scores can range between 0 and 4 with higher scores indicating higher emetophobia symptomatology. Descriptive statistics and internal consistency are reported in Table 1.

**Table 1** Descriptive statistics of and correlations between variables

| *N* = 233 | *M* | *SD* | Range | ω | 1. | 2. | 3. | 4. |
|---|---|---|---|---|---|---|---|---|
| 1. Specific Phobia of Vomiting Inventory | 0.49 | 0.55 | 0.00–2.71 | 0.92 | — | 0.33* | 0.002 | −0.01 |
| 2. Fear of Food Questionnaire | 1.06 | 0.86 | 0.00–3.61 | 0.94 | 0.33* | — | −0.04 | −0.002 |
| 3. Current body mass index (kg/m$^2$) | 23.6 | 4.52 | 15.4–43.9 | — | 0.002 | −0.04 | — | 0.93* |
| 4. Highest body mass index (kg/m$^2$) | 25.3 | 5.45 | 17.0–51.8 | — | −0.01 | −0.002 | 0.93* | — |

*$p < .001$

#### *2.2.3 FFQ*

The FFQ [34] measures fear and avoidance of foods in general with 18 items and its German version [20] was used in the current study. Responses are recorded on a six-point scale from 0 = *not at all* to 5 = *absolutely*. Therefore, mean total scores can range between 0 and 5 with higher scores indicating higher fear and avoidance of foods. Descriptive statistics and internal consistency are reported in Table 1.

### 2.3 Data analyses

All analyses were conducted with R version 4.5.0 in RStudio version 2025.05.0. Descriptive statistics were computed with the *summarytools* package version 1.1.4. Internal consistencies of all questionnaires were examined with McDonald's ω [15] obtained with the *psych* package version 2.5.3 (cf. [16]). Zero-order relationships between SPOVI scores, FFQ scores, current BMI, and highest BMI were examined with percentage bend correlation coefficients $r_{rb}$ [32] obtained with the WRS2 package version 1.1-6 (cf. [14]). Relationships of SPOVI scores and FFQ scores with current BMI while controlling for highest BMI were tested with robust regression models [11] using the *robustbase* package version 0.99-4-1. Such regression models were also used for testing interactive effects between SPOVI and FFQ scores on current BMI (with and without controlling for highest past BMI). All robust regression models were additionally run after adding age and sex as covariates, as outlined in the preregistration (https://doi.org/10.17605/OSF.IO/HKE37). Because of the large sample size and numerous statistical tests, we considered effects as significant when $p < .005$, as has been recommended [2]. The data and code with which all results can be reproduced can be accessed at https://doi.org/10.17605/OSF.IO/NWDH7.

## 3 Results

Neither SPOVI nor FFQ scores correlated with current BMI (Table 1; Fig. 1). There was no interaction effect of SPOVI scores × FFQ scores on current BMI ($b = -0.42$, $SE = 0.61$, $p = .497$), which was also not significant when controlling for age and sex ($b = -0.52$, $SE = 0.72$, $p = .474$). There was no effect of SPOVI scores on current BMI when controlling for highest BMI ($b = -0.02$, $SE = 0.13$, $p = .880$), which was also not significant when controlling for age and sex ($b = -0.0003$, $SE = 0.14$, $p = .998$). There was no effect of FFQ scores on current BMI when controlling for highest BMI ($b = -0.14$, $SE = 0.10$, $p = .147$), which was also not significant when controlling for age and sex ($b = -0.11$, $SE = 0.10$, $p = .302$). There was no interaction effect of SPOVI scores × FFQ scores on current BMI when controlling for highest BMI ($b = -0.13$, $SE = 0.24$, $p = .594$), which was also not significant when controlling for age and sex ($b = -0.13$, $SE = 0.24$, $p = .582$).

One of the reviewers suggested using the SPOVI cut-off value proposed by Veale et al. [31] and comparing groups as sensitivity analysis. After converting mean SPOVI scores

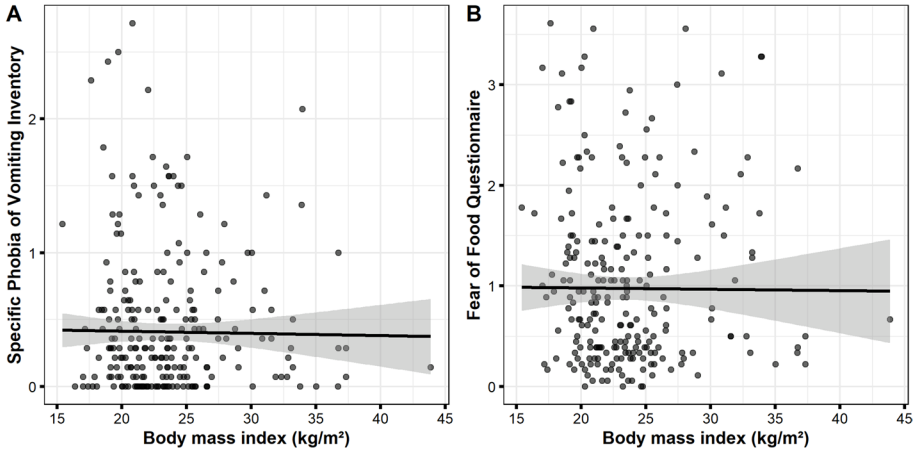


**Fig. 1** Scatterplots with robust linear trend lines visualizing the non-significant relationships between body mass index and **A** mean total scores of the Specific Phobia of Vomiting Inventory and **B** mean total scores of the Fear of Food Questionnaire. The grey shaded areas represent the 95% confidence interval

into sum scores, 52 participants (22.3%) scored above 10 and 181 participants (77.7%) scored ≤ 10. However, groups did not differ in BMI ($p$ = .915) based on a Brunner–Munzel test (cf. [9]) and all effects of interest were non-significant (all $p$s > 0.074) when re-running the robust regression models using the binary grouping variable, thus replicating results based on continuous SPOVI scores. These additional analyses can also be reproduced with the code available at https://doi.org/10.17605/OSF.IO/NWDH7.

## 4 Discussion

The current study examined relationships between emetophobia symptomatology, fear and avoidance of certain foods, and BMI. Contrary to hypotheses, higher emetophobia symptomatology and fear of food did not relate to BMI, neither separately nor interactively. While these results are in line with the finding by Hennemann et al. [6] who also reported that SPOVI scores did not correlate with BMI in a convenience sample, they are in contrast to studies reporting lower BMI in persons with emetophobia compared to persons with other specific phobias [21] and lower BMI in a subgroup within samples of persons with emetophobia [8, 30].

We are grateful to one of the reviewers for pointing out that fearful avoidance or restriction of certain foods does not necessarily mean consuming fewer calories but can also mean avoiding certain unprocessed, low-calorie foods in favor of processed, high-calorie foods, which could contribute to weight gain. This would be one explanation why there is no clear negative association between emetophobia symptoms and body weight as a function of fear of food. In line with this, research on ARFID has also not found a clear relationship with body weight. Specifically, most people diagnosed with ARFID related to fear of aversive consequences are not underweight despite this subtype being more associated with low weight than other ARFID presentations [7, 17, 26, 28].

The symptom overlaps between emetophobia and eating disorders such as anorexia nervosa and ARFID can be striking as this does not only cover fear and avoidance of certain foods but also underlying mechanisms such as disgust or interoceptive sensitivity [5, 19, 25]. An important future avenue would be to conduct longitudinal studies to examine potential transitions between disorders and to better understand the factors contributing to changes in body weight.

A methodological explanation for why hypotheses were not corroborated may be the samples' characteristics. Specifically, we did not recruit a sample of persons with emetophobia and, indeed, there was no participant who reached the maximum values of the questionnaires' scales (Table 1). As can be seen in Table 1 and Fig. 1, however, there was indeed a large variation in the questionnaires' scores as well as in BMI (ranging from persons being underweight to persons having obesity). Furthermore, 52 participants (22%) scored above the SPOVI cut-off value proposed by Veale et al. [31], indicating that a substantial number of persons had emetophobia symptoms in the current sample. Thus, the large sample size as well as the range and variance of the key variables in the current study were well-suited to detect the hypothesized effects.

Another aspect that may limit interpretation of results is that the current study relied on self-reports, which may be influenced by factors such as social desirability, recall bias, or demand effects. Yet, previous findings on the questionnaires used in the current study supported their reliability and validity [6, 13, 31, 34]. Moreover, while self-reported body height tends to be overestimated and self-reported body weight tends to be underestimated, there is a plethora of studies indicating that there is still a high agreement with objectively measured anthropometric data and, thus, that self-reported body height and weight is sufficiently accurate (e.g., [4, 12, 23, 24]).

The current and previous findings [6, 21] suggest that emetophobia symptomatology is not related to a lower BMI in general but persons with emetophobia who seek treatment do indeed tend to have a lower BMI than persons with other mental disorders, including other specific phobias. That is, it may be that having a low body weight is one reason why persons with emetophobia seek treatment or are encouraged by others to seek treatment, which is why persons with a low BMI may be overrepresented in clinical samples. Yet, future studies are necessary to further examine why and under which circumstances fear of vomiting results in restricted food intake and low body weight.

**Author contributions**
AM: Conceptualization, Formal analysis, Writing – original draft, Writing – review and editing; PAS: Conceptualization, Data curation, Investigation, Writing – review and editing; DRK: Conceptualization, Resources, Supervision, Writing – review and editing.

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**Data availability**
The preregistration as well as the data and code with which all results can be reproduced can be accessed at [https://doi.org/10.17605/OSF.IO/NWDH7](https:/doi.org/10.17605/OSF.IO/NWDH7) .

## Declarations

**Ethics approval and consent to participate**
The study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki and was approved by the ethics committee at the University of Regensburg (reference number 24-3989-101). Informed consent was obtained from all individual participants included in the study.

**Consent for publication**
Not applicable.

**Competing interests**
The authors declare no competing interests.

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## Publisher's Note