Ménière's Disease: Managing the Psychological Aspects

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Living with Ménière's disease is aversive. Symptoms can be intrusive, episodes are unpredictable, can be disabling and most people have limited ability to control vertigo episodes.

The symptoms of Ménière's vary substantially between individuals, from mild to severe.

Because of the challenging aspects, people with Ménière's disease have an increased likelihood of experiencing psychological problems, most frequently anxiety and depression.

Experiments of Learned Helplessness, conducted with dogs in the 1970s, reported in Martin Seligman's book *Learned Optimism*, demonstrate the effect of repeated aversive experiences when one is helpless to control them.

Anxiety is our response to the perception of threat. Our limbic system (which controls the emotional parts of our brain) reacts by activating a "danger" response. It prepares our body for action.

Fear

When perceived threat is immediate, our amygdala sounds the alarm and our body goes into 'Fight or Flight' mode. Symptoms include elevated heart rate, blood pressure, breathing rate, muscle tension. It can last for anything from a few minutes, to several hours.

Anxiety

When perceived threat is in the future (not immediate), we experience anxiety.

Our body goes into a 'state of preparedness', with the most obvious physical changes being increased muscle tension and increased breathing rate. Other common physical symptoms include 'nervyness', inability to relax, high startle reflex, dizziness, tiredness, disturbed sleep, headaches, tremor, tooth grinding, twitches, neck pain, chest pain, heat surges, nausea, indigestion, irritable bowel, etc.

Anxiety also affects our cognitive function: the way that we think, and use our mind.

Behaviours: Attempts to reduce threat through avoidance or safety behaviours.

Ongoing anxiety impairs our concentration, memory, attention; reduces our level of functioning; diminishes quality of life; produces *somatic* (physical) symptoms; disturbs our sleep; increases likelihood of anxiety disorders.

Common Anxiety Disorders

Include panic disorder, agoraphobia, generalised anxiety disorder, specific phobias, social phobia, separation anxiety disorder.

People who are high on *Trait Anxiety* have an increased likelihood of developing anxiety and its disorders. Trait anxiety is determined by our genetic makeup as well as our history.

The role of Behaviours

Behavioural responses are motivated by desire to be safe. However, excessive safety behaviours is counter-productive, because they maintain high threat appraisals.

Types of Avoidance

Situational avoidance: e.g. avoid people, places, situations. Only going at certain times, leave early, escape.

Cognitive avoidance: e.g. distraction, constant busyness, don't talk about it

Somatic avoidance: e.g. alcohol, drugs.

Examples of Safety Behaviours:

sit near the door, take someone with you, phone "check-ins", vitamin pills, bottled water, excessive planning, frequent toilet stops, have an escape plan, checking online, reassurance seeking, worrying, over-analysing, perfectionism.

Strategies for Managing Anxiety

1. Mental Hygiene

Daily Physical Exercise**:** reduces arousal, increases stamina, increases endorphins and endocannabinoids, improves mood, feelings of wellbeing.

Healthy lifestyle habits**:** good nutrition, drink water, avoid excess alcohol, don't smoke, sleep hygiene

Cognitive Flexibility**:** Adapting to things beyond our control. For example:

"How can I optimise my quality of life, given that I have Ménière's?"
"If they can't cure it, I can learn to live with it".
"Ménière's is just one part of my life. What other things matter to me?"
From: "I need to be on high alert, just in case" to "I will deal with it if/when it happens"
Learning to *accept* things beyond your control.

Beware the Cognitive Bias

Anxiety creates cognitive bias towards threat. During an anxious state we have catastrophic thoughts and false alarms. In addition, our thoughts feel true.

When you are anxious, your thoughts are not reliable indicators of danger.

Beware: Overthinking/ Overanalysing.

Mindfulness

The present moment is not a bad place to be most of the time! Emotional distress is rarely caused by what is happening in the present moment. Our thoughts create most of our suffering.

Mindfulness - Attitude is important:

Non-judging, non-striving, dropping resistance to unpleasant experience. Becoming a curious observer of current experience.

"Surf" the symptoms.

Surfing: don't struggle against unpleasant sensations, whether it be panic attack or dizziness. Let your body do what it needs to do.

Metaphor: "Surfing with the wave rather than trying to swim against the tide"

Wave of panic peaks and subsides.

Monitor your avoidance and safety behaviours

Behavioural experiments – drop the safety behaviours e.g. standing in queue, café, etc.

Address ongoing fears through repeated exposure.

Exposure, in the absence of catastrophic consequences leads to habituation**.** If it makes you uncomfortable, do it often! Create a 'stepladder', from least difficult to more difficult, in order to build your confidence

Medications

Benzodiazepines (e.g. 'Valium', 'Rivotril', 'Ativan')

Helpful for brief, acute anxiety (including during a vertigo episode).

Anti-depressant medications

These need to be taken daily for several months. They have been found to reduce anxiety and dizziness in two thirds of people who take them.

Persistent Postural Perceptual Dizziness - PPPD

Previously called Psychophysiological Dizziness, Chronic Subjective Dizziness, Phobic Postural Vertigo.

Typical Symptom Cluster of PPPD

- Episodic dizziness, light-headedness or rocking
- Feelings of imbalance, unsteadiness or veering
- Ground feels unstable
- Dizziness with head or body movements
- "Fullness", "heaviness" or "cloudiness" of the head
- Hypersensitivity to motional stimuli e.g. shopping centres; supermarket
- Visual disturbances
- Neurological/ neuro-otological tests are NORMAL or do not account for the symptoms.

Initial Trigger:

Most often, PPPD is triggered by episodes of rotational vertigo. Can also be triggered by an acute medical event, panic attacks or a reaction to reaction to medication.

Underlying physiological processes causing these symptoms are unknown, although there are various theories. Brain becomes 'sensitised'? Anxiety clearly plays a key role.

Note: Dizzy patients frequently have anxiety, and anxious people frequently suffer from dizziness.

MANY PEOPLE WITH MÉNIÈRE'S ALSO HAVE PPPD. They are two separate conditions.

What helps?

1. Anti-depressant Medication

Dizziness and unsteadiness reduced or resolved in two thirds of cases. One third don't respond or drop out.

2. Vestibular Rehabilitation

Exercises aiming to speed up CNS compensation for organic vestibular deficits (e.g. inner ear trauma). Studies show some improvements following 6-12 sessions.

3. Cognitive Behaviour Therapy (see reference book at end of this flyer)

Need to reduce threat perceptions. Treatment includes: psycho-education to reduce threat and hypervigilance. Build cognitive flexibility. Behavioural experiments and exposure to feared situations and sensations. Mindful attitude – drop the resistance. Increase self-efficacy re tolerating symptoms.

Exposure Exercises

For example:

- Daily walk / physical exercise
- Supermarket
- Social activity
- Busy public places e.g. public transport, shopping mall cinema.

Urge to keep monitoring

Monitoring symptoms is a safety behaviour. It feels like we are keeping the symptoms in check, by keeping an eye on them. Most people feel compelled to keep monitoring or checking their symptoms, even when they know that doing so is counter-productive.

Common (unconscious) beliefs that maintain the urge to keep monitoring the symptoms:

- "Focusing on my symptoms helps me to stay safe"
- "It is dangerous to relax or ignore the symptoms"
- "If I accept the symptoms, I will suffer them forever.

DON'T TRY TO STOP THE SYMPTOMS. They will come and go. Your job is to 'surf' the symptoms when they arise, and learn that you can tolerate them.

Suffering =

Physical symptoms + Emotional distress

Your response to the symptoms is key. Common unhelpful responses include:

- **Cognitive**: monitoring, preoccupation, analysing, worry
- **Emotional**: anxiety, frustration, despair, depression
- **Behavioural**: checking, avoiding, hiding, etc.

Reflect: If you were able to **eliminate anxiety**, what would be left? Would you feel different?

Aggregate Suffering:

For some, aggregate physical symptoms are brief, but they suffer 100% of the time.

The Resistance Paradox: The harder we fight it, the greater the threat $\rightarrow$ the bigger the problem grows. Trying to eliminate symptoms maintains their threat associations

What would it be like if you gave up trying to eliminate the symptoms and just accepted them?

PRACTICE **ACCEPTANCE:** From trying to **STOP** the symptoms to **ACCEPT** the symptoms

Engage with Life NOW

Don't wait for the symptoms to resolve before you can get on with your life. Change your goal from trying to make the symptoms go away, to leading as normal and healthy life that you can, in spite of the presence of symptoms.

<u>Reading on Cognitive Behaviour Therapy</u>:

Edelman S. Change Your Thinking, HarperCollins publishers.

To be published end of June 2019:

Edelman S. No Worries: A guide to managing anxiety and worry using CBT. HarperCollins.