Somatization and Illness Anxiety Presentation Crib Notes 10/2018

Theory:

Somatization cycle: Patient tends to recognize benign signs and symptoms, and then:

- ⇒ Worry about negative meaning
- ⇒ Catastrophic interpretations , e.g. "I feel alarmed, therefore this must be alarming"
- ⇒ Fear arousal promotes both vigilance and more symptoms
- ⇒ Seek care and feel better from external reassurance
- ⇒ Monitor for new signs and symptoms

Practitioner's Double-Bind: reassurance may be disbelieved, and unmollified Pt. will intensify care-seeking. But if reassurance is believed, then this may reinforce somatization cycle and clinic visits.

Avoidance is the engine of anxiety: by resisting exposure to that which we fear, fear is reinforced. Example: a spider provokes panic arousal. Distancing from the spider brings immediate comfort. That comfort reinforces the spider's being a cue for anxiety.

Somaticizing patients avoid acceptance of ambiguous or discomforting symptoms. Resolution requires willingness tolerate them (exposure), and desensitization. Pt's interactions with healthcare system may partially serve as avoidance.

Strategies:

Emphasize empathy. Reflect patient's emotional experience, trying for vocabulary which expands Pt's expression. You are helping to reduce *alexithymia*, a risk factor in somatic symptom disorder. Also reflect *impact* on that which patient specifically values.

Validation: State, "Your pain is absolutely real. Your worry is legitimate". Escalation in Pt's drama - or your own frustration - may indicate you are not validating Pt's experience sufficiently.

More validation: No matter how hard you work against it, Pt. may interpret "it's all in your head". Forcefully counter this, e.g. repeating: "I know these symptoms are real, and intense. Given that, your worry is legitimate."

Amplify dramatic verbiage by "trumping" it to get ahead of escalation. For example, "I'm completely exhausted" could be answered with, "Virtually impossible to get out of bed?"

Inquire about adherence to plan. Lack of follow-up inquiry about recommendations generates non-adherence.

Introduce words to explain concepts: Iatrogenic, idiopathic, anhedonia, interoception.

Confronting stable belief may backfire. Be careful in stating, "You don't have the condition you fear". One alternative: "Anxiety (or depression), is the biggest complicating factor, and the most treatable".

Schedule routine visits, so that contact is more structured, not contingent on symptoms or distress. You may later taper frequency, or at least guard against increase. Invite spouse/partner to join.

Nurture alliance by inquiring about it, e.g. “How are we doing through all this; you and I? Anything I’m not understanding or respecting?” Beware of chit-chat satisfying social need.

Identify and correct common myths: E.g. Pain is pathology. Symptoms indicate need for treatment and rest.

Try interoceptive exposure: Ask Pt. to hyperventilate until dizziness – *and* then benign outcome - is experienced.

Check on domestic turmoil or violence, fear for safety and security.

Inquire on activities, goals, health practices - and values: What do you want your life to stand for? Ask not, “How are you doing?” but rather, “*What* have you been doing?”

The Miracle Question: “If this resolved 100% while sleeping tonight, what would you find yourself doing differently tomorrow? What else? What will others see?”

Have Pt. describe manifest incremental improvement, “When this starts to get better, what will be the first indication? And what will others notice?”

Take Pt’s worry: “It is MY job to worry about disease. Your job is to delegate the worry, and go forward with your life. Can you trust me with this? How will you remember when the worry returns tomorrow?”

Avoid third repetition of explanation or reassurance. Instead, ask patient voice it.

Elicit confirmation of shared goal: Management of symptoms, not resolution, and maximizing quality of life.

Symptom log: “We all modify what we track, and you and I will make good use of the information you collect” Track symptoms, emotions, self-care; possibly other correlates, for 1-2 weeks.

Prescribing: “Start low, go slow”. Promise side-effects but remain vague about specifics. “Side effects show us the drug is doing its thing”.

Promote self-efficacy at first sign of improvement: “Nice work! What are you doing differently? It’s never just the medicine.”

EMR Text in tomlinde.com (formatted for Epic – alter to suit):

.HEALTHANXIETYBOOKS -Two recommendations, one very short and easy to read

.ANXIETY -On controlled breathing, the single best technique for anxiety IF practiced twice a day

.DEPRESSIONSELFCARE -Ten options for addressing depression with behavioral activation

.FEELINGSINVENTORY -To expand emotion vocabulary (patient’s *and* yours!)

.STRAIGHTNOCHASER – Alcohol

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