

Psychological distress and disability in patients with vertigo

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Abstract

Objective: Vertigo is an extremely debilitating experience for the patient, especially during attacks; it is neither easy to identify nor control. The importance of psychosomatic factors has already been widely studied and discussed. In particular, it has been shown that stress factors are relevant in setting off episodes of dizziness, but there is no agreement if the presence of distress might influence the vestibular disability. **Methods:** This study is concerned with evaluating the quality of life (QOL) in a group of 206 patients suffering from vertigo and 86 control patients, using the UCLA-Dizziness Questionnaire (UCLA-DQ) scale. The results were correlated with those achieved using the Hospital Anxiety and Depression Scale (HADS) psychometric test. **Results:** What is

clear is that, in patients suffering from vertigo as regards those who are not, there is a significant amount of anxiety and depression distress, especially in female subjects. There appears to be no relationship between psychological change and the various forms of clinical vertigo. In terms of the QOL parameter, what emerges is that, from a statistical point of view, fear of becoming dizzy is most closely correlated with the perception of disability. **Conclusions:** There is also a need for psycho-education here in collaboration with the E.N.T. specialist so that the patient can learn to recognise his/her medical condition and be aware of the factors that primarily contribute to the deterioration of their QOL. © 2001 Elsevier Science Inc. All rights reserved.

Keywords: Anxiety; Depression; Dizziness; Vestibular disability; Vertigo

Introduction

Vertigo is a psychologically disabling symptom for at least three reasons. Firstly, it is hard to identify and/or to see physically, and therefore, patients easily fail to locate its source [1] and thus become potentially prone to somatization. Secondly, since vertigo arousal is often unforeseeable, the fear of a new episode is probably the most common complaint among patients with vestibular disorders [2], and their tendency to anxiety and panic is well established [3,4]. Thirdly, it induces a profound involvement of both body and mental sensations [5]. There is no generally accepted clinical test that measures vestibular sensation or any aspects of subjective vestibular disability resulting from an altered vestibular sensory function or, more generally, orientation [6]. Further, it is also suspected that comorbidity of psychopathological

factors and vestibular disorders is involved in the experience of vertigo [7–13] even though research to assess these factors in controlled studies has been limited [14,15]. In particular, Menière's disease has been studied [16–20], but the results have been contradictory [21]. Some experiments [22,23] confirm that anxiety and agoraphobia are respectively associated with enhanced nystagmic responses to caloric testing and with impaired upright balance in response to critical proprioceptive cues. This data may support the hypothesis that patients with psychological distress could perceive a stronger rotational vertigo and unsteadiness than patients in a normal mood should, if a vestibular dysfunction occurs. Therefore, vestibular disability seems to arise primarily from psychological distress rather than from clinical conditions [24–26].

In the present study, the first aim was to study whether anxiety and depression distress are prevalent in a group of patients with vestibular dysfunction compared to subjects with normal vestibular function, and whether gender plays a particular role. A second objective was to establish whether anxiety and depressive symptoms are differently raised in

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the major categories of the vestibular diseases. The third aim was to conclusively verify if patients with raised anxiety and depression scores show higher values on a specific disability scale for vertigo.

Methods

Sample

In 1998, 206 consecutive, unselected neurotologic patients were studied in the Modena Hospital Centre for Vestibular Testing, University of Modena and Reggio Emilia. They included 59 men (28.6%, 23–72 years, mean age = 52.8 years) and 147 women (71.4%, 20–74 years, mean age = 55.6 years) of similar age. All patients suffered from recurrent vertigo, and the presence of a well-documented vestibular disorder was the only prerequisite for participation in the study. Patient data were compared with that obtained from 86 healthy control volunteers well matched according to sex (24 men, 27.9% and 62 women, 72.1%) and age (men: 24–70 years, mean age = 50.3 years; women: 22–78 years, mean age = 53.8 years), who were selected among the residents and the staff of the Modena and Reggio Emilia University Hospital. Healthy subjects were recruited on the basis of normal vestibular examination. The experimental protocol followed the Declaration of Helsinki for Human Experimentation, and informed consent was obtained from each participant before they were examined.

Measures

Each patient and control underwent a complete examination of their history and physical and neurological states. A computerised electrooculography examination was performed in all cases to explore oculomotor and optokinetic functions. The EOG battery included test for spontaneous, positional and gaze nystagmus, three cycles of sinusoidal rotation testing with a maximum speed of 60°/s for vestibular-oculomotor reflex and bithermal irrigation of both ear canals for labyrinthine activity. A 40% right/left excitability difference on caloric testing was the necessary requirement for a significant labyrinthine hypofunction, and the presence of a typical provoked-positional and torsional nystagmus was referred to as paroxysmal posi-

Table 2

Average values of self-rated anxiety, depression and total HADS (Mann–Whitney test)

	Anxiety		Depression		Total	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
Patients (<i>n</i> = 206)	12.61	4.80	6.71	3.94	19.34	6.88
Controls (<i>n</i> = 86)	3.86	2.99	1.68	1.51	5.30	2.92
<i>P</i>	<.0005		<.0005		<.0005	

tional vertigo. The neurotological examination was completed by cerebral magnetic resonance in all cases to confirm the diagnosis.

Patients were divided into four major diagnostic categories: (1) peripheral disorders (vestibular neuronitis, vestibular hypofunction induced by ototoxic drugs, neurotomy for removal of acoustic neuroma, traumatic involvement of the labyrinth, perilymphatic fistula), (2) Menière's disease, (3) central vestibular pathology and (4) benign paroxysmal positional vertigo (BPPV; Table 1).

The total course of the disease from onset until the time of examination varied from 91 to 9190 days (mean = 740.37).

Patients and controls were given a self-report, forced-choice, five-item list, the UCLA-Dizziness Questionnaire (UCLA-DQ), which has been previously considered to be a promising instrument for the subjective evaluation of the vertigo patient's disability [27,28]. The items specifically investigate physical, functional and emotional attributes of vestibular dysfunction. The first two items rank the magnitude of dizziness in terms of frequency and severity, the third and the fourth feature the impact of dizziness on daily activities and on quality of life (QOL) and the last item rates the fear of a new episode of dizziness. For each of the questions, patients were asked to choose the answer from a list of five, presented in ascending order of gravity ranging from one to five (that best corresponded to their feelings).

Patients and controls were also given a second list of 14 items, the Hospital Anxiety and Depression Scale (HADS), which is a self-rating questionnaire used to measure anxiety and depression on two separate scales. The HADS, given in the Italian version [31], is a reliable and validated psychometric instrument [29,30] also used in a controlled trial in vertigo population [32]. There are four possible answers for each item (score: 0–3) that express an increasing level of severity. It is considered a measure of psychological distress rather than psychiatric diagnosis [33–36]: Therefore, values

Table 1

Number, gender and diagnostic categories of the pathological sample

Gender	Vestibular dysfunction				Total
	Peripheral	Menière	Central	BPPV	
Males	23 (11.2%)	7 (3.4%)	15 (7.2%)	14 (6.8%)	59 (28.6%)
Females	64 (31.1%)	32 (15.5%)	23 (11.2%)	28 (13.6%)	147 (71.4%)
Total	87 (42.3%)	39 (18.9%)	38 (18.4%)	42 (20.4%)	206 (100.0%)

BPPV, benign paroxysmal positional vertigo.

Table 3

Average values of self-rated anxiety, depression and total HADS according to gender (Mann–Whitney test)

	Anxiety		Depression		Total	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
Males (<i>n</i> = 59)	5.86	4.47	3.71	3.13	9.57	6.69
Females (<i>n</i> = 147)	10.92	5.86	5.38	4.32	16.30	8.97
<i>P</i>	<.0005		NS		<.0005	

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