What triggers chronic dizziness?

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A report in one of the last issue of *Psychotherapy and Psychosomatics* addresses the physical and psychological triggers for attacks in Meniere's disease. Ménière's disease (MD) is a debilitating disease of the inner ear for which the main symptoms comprise vertigo, hearing loss, tinnitus and a sense of fullness or pressure in the ear. Residual and movement-provoked dizziness may also occur between major attacks.

High levels of psychiatric comorbidity, disability and reduced quality of life are often reported among people who experience such symptoms. Attacks cannot be prevented, and a great deal of uncertainty and distress exists in relation to when symptoms might occur and what might trigger them.

The aim of this study was to carry out an in-depth qualitative exploration of views and beliefs about triggers of symptoms of MD and to relate these to the different types of reported symptoms. Semistructured telephone interviews employing open-ended questions were carried out with 20 members of the Ménière's Society (a UK-based self-help group for people with dizziness and balance disorders) who had completed screening questionnaires and fulfilled inclusion criteria.

A total of 11 main themes were discussed by participants, which were grouped into four overarching categories (physiological, environmental, psychological and patterns of association with triggers). Participants described different triggers for different types of symptoms. Severe vertigo was most commonly perceived to be associated with stress, followed by tiredness, meal times and specific times of the day

(primarily mornings), and then by making quick head movements and reading.

Severe vertigo was also associated with exposure to triggers of greater severity/intensity, exposure to multiple triggers at once, and exposure to triggers for a prolonged period of time. Many factors were reported to trigger milder symptoms. Several of the physiological and environmental types of triggers discussed by participants are consistent with known aetiologies.

For example visual environments are a trigger of visual vertigo, and postural factors are a trigger of positional vertigo Symptoms occurring in the morning, after standing too quickly, or after meals are reported in orthostatic hypotension, a condition common among people being treated for hypertension. Elevated levels of hypertension have recently been described among people with dizziness and MD. Interestingly, people with orthostatic hypotension are advised to increase their salt consumption and drink coffee with meals.

Therefore, it could be hypothesised that for some people with MD, some symptoms may possibly occur as a consequence of following dietary restrictions. Although dietary restriction is a low-risk management strategy that is medically easy to implement, this study did not identify any clear patterns among participants of dietary items triggering symptoms of dizziness or vertigo. The restriction of salt in particular appeared to be an onerous task. Although some were glad to have found something that helped or tied the restriction in with other goals such as losing weight, the findings of this study suggest that such strict regulation was particularly intrusive to people's lifestyles. and fuelled frustration and anxiety, adding to the psychological burden imposed by the disease.

This may also worsen symptoms, as stress and anxiety are known to contribute to the presence of residual and provoked dizziness. The

majority of participants in this study had strong beliefs and discussed examples where stress was perceived to be a definite trigger of symptoms. Interestingly, virtually all participants referred to patterns associated with level of exposure and irregularities in the triggering of symptoms.

Many participants described symptoms associated with being exposed to multiple triggers and/or being exposed to triggers for a prolonged period of time. Participants also reported symptoms following exposure to triggers that were more intense or severe than their normal experience (e.g. stress due to the death of a close family member or travelling in a car going fast).

Despite some limitations, this study does offer insight into the subjective experiences and perceptions of triggers for symptoms that people with symptoms of MD considered to be an 'attack'. By providing an in-depth exploration and understanding of the patient's perspective on triggers for symptoms, this study could form the basis on which further work could be carried out, and raises further questions to be considered in the management of MD.

More information: Kirby, S. and Yardley, L. Physical and Psychological Triggers for Attacks in Ménière's Disease: The Patient Perspective. *Psychother Psychosom* 2012;81:396–398

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