Research paper on worried-well patients

Environment, Disaster

Worried-well patients

Introduction

‘ Worried-well’ patients are those are anxious about their physical wellbeing and would be in health centers seeking medical advices or treatments for ailments that cannot be diagnosed. These patients are said to be suffering from hypochondriasis, which is described as a psychological condition of excessive worry about having a serious illness (Reilly & Markenson, 2011). The unbearable condition is attributed by an incorrect acuity of the human body’s condition despite the deficiency of a genuine medical condition. Worried-well patients can thus be categorized as hypochondriacs. They are distressed about any somatic signs they detect no matter their minority. Their conviction is that it might be serious or death threatening. Many worried-well patients stress on a particular symptom as the facilitator of their anxiety, such as fatigue, shivers, or gastro-intestinal complications.

The DSM-IV-TR classifies hypochondriasis as a somatoform ailment with records proving that 3% of people entering primary care settings are hypochondriacs (Weck et al., 2011). Hypochondriacs are mainly identified by worries about minor bodily harm or symptoms, which may result in constant self-diagnosis and self-examination of a person. The patients do not believe physicians diagnosis and so are always unconvinced of their recommendations. Furthermore, in the presence of doctors other symptoms like stress, anxiety, and high blood pressure surfaces in a condition called ‘ white-coat syndrome’ (Weck et al., 2011). These patients require endless guarantees from family, friends, and physicians on their wellbeing. Some patients would frequent general practitioners; others never speak about their

fears, while others completely avoid reminders of their sickness.

Therefore, this research paper would analyze worried well patients during times of emergencies. This is greatly seen in hospitals near emergencies who record high numbers of patients experiencing ‘ white-coat syndrome’. The discussion would encompass effects of worried-well patients, reasons of seeking emergency services during emergency, preparation of health institutes for an influx of these patients, and management of these patients.

Effects of Worried well patients

It is known that worried-well patients suffer from health anxiety that is either psychologically related or medically originated. The theory of learning proposes that medical conditions of the patients are as a result of classical conditioning; they are signs occurring and result in anxiety. The classical conditioning is also maintained by operant conditioning and cognitive processing (Stone, 2007). Operant conditioning includes avoiding behavior and confirmations that result in negative occurrences, while cognitive processing includes upsetting thoughts and intensive attention. The assumption of illness is done to avoid difficulties that are not easy to deal with. Therefore, the effects from the condition are:

Higher rate of physical problem observation: Danger feelings cause amplified awareness of sensations caused by an inactive nervous system. For instance, if a patient senses unbearable and strange pains in the stomach, the first reaction might be cancer. Furthermore, if the pain continues on, the patient focuses on that feeling which would increase his discomfort. Prasko et al., (2010), posits that focusing on first instance symptoms leads to real changes on the physical body, such as difficulty in swallowing food, breathing

problems, and muscle problems.

Danger feelings: There is a stress reaction from danger feelings that is triggered by incorrect information, and delusion of non-threatening bodily signs appearing in the stressful period or bodily signals of a real disease.

Seeking and confirming reassurance: Worried-well patients start to systematically observe their symptoms. The frequent indicators measured are blood pressure, temperatures, and pulse rate. When searching for disease causes, a small deviation from the normal will result in anxiety. The patient seeks medical opinions from general practitioners. If the inference from medical experts is unclear, the interpretation might be catastrophic.

Avoidance Behavior: There are various inducements in the society that might increase anxiety towards certain symptoms. The inducements are: discussions of diseases in the waiting room of a hospital, media information about diseases, and queries on patient feelings (Prasko et al., 2010). These inducements can result in common avoidance behaviors that are similar to those experienced in phobias. Worried-well patients in similar fashion might also behave in a manner to prevent an oncoming catastrophe. Interestingly, the behaviors are all intended to make patients concentrate on their problems, hence negative personal experiences would be sustained or worsened. Other avoidance behaviors are accurately seen to openly influence symptoms. An example is that avoidance of physical activity causes continued muscle weakening, which might also cause fatigue and decreased performance in the future.

Amplified bodily activity: The feeling of danger is a condition that escalates activity of bodily functions in a system that contains a nervous system that is

vegetative (Prasko et al., 2010). The symptoms associated with enhanced bodily functionality are: acroparesthesia, hyperventilation, extreme sweating, itchy skin, heaviness in large muscle groups, and headache.
Cognitive Avoidance: Worried-well patients more often fail to define the specific consequences of their fictional diseases. As a result, their thoughts and ideas increase anxiety which makes them respond with blocking them. Hence, worried-well patients respond by not thinking about their feared diseases, and so control their thinking by diverting their attention (Prasko et al., 2010). This strategy is referred to as cognitive avoidance.

Reasons for seeking emergency services during disasters

There are many emergency disasters that can call for people seek for the help of primary health care facilities. Some of these emergencies are cases of earthquakes, nuclear accidents, floods, bomb threats, and other extreme weather conditions like hurricanes. Disasters categorized in the CBRN (Chemical Biological Radiological and Nuclear) category bring about fears on toxicity. This makes worried-well patients to seek emergency services whenever a slight symptom that is related to CBRN poisoning. Symptoms like persistent dry coughs in case of a nuclear leakage can make worried-well patients to develop anxieties which would make them hyperventilate, develop headaches, and sweat more (Hart & Björgvinsson, 2010). The symptoms would make them rush to primary health units in emergency centers for confirmation of their health status.
In cases of weather disasters like hurricanes, worried-well patients can be delusional from extreme danger feelings. This can make them visit emergency centers to ascertain whether what they feel is legitimate or they

are suffering from secondary symptoms of another illness. Some patients in this category would visit health centers just for counseling since the event might have caused trauma. An instance is during the event of hurricane Katrina, many worried-well patients requested services of general practitioners for the treatment of shock which many of them (20%) were diagnosed not to have the illness (Hart & Björgvinsson, 2010).

Need for confirmatory and monitoring of illnesses is also a reason why worried-well patients seek emergency services from primary health units in emergency services. This is common amongst hypochondriacs who are caught up in an emergency event. A slight minor symptom can make the patients relate it to the emergency event; hence the need to confirm if it is correct diagnosis will make them visit the primary health units. Furthermore, even if the diagnosis proves that they are okay, many do not believe it and so will just come back to monitor if an illness comes up. This reason is common in emergency events such as earthquakes, nuclear accidents, and even terror activities (Stone, 2007).

Preparation of health institutes for an influx of worried-well patients

In preparation of disasters, hospitals should be aware that worried-well patients would surface and as it is known that almost 3% of hospital visitors are these types (Stone, 2007). Hence, the first thing is for the hospitals to prepare a plan on how to prevent their influx. The strategy should be planned in two parts; before and after the emergency.

Before an emergency event, health institutes must involve the community, partner with the media, developing trust agents, and prepare alternative

communication channels. In community involvement, health institutes must facilitate the community take part in drills that help people in dealing with emergency cases. This involves, counseling, instant identification of symptoms that call for emergency treatment, and response to emergency events (Stone, 2007). This involvement will relieve hospitals of some of the burden of handling an influx of worried-well patients by giving some people in the community to play in treating and handling these patients.

Partnering with the media is also a very important step in pre-emergency cases. This is stipulated by Stone, (2007), who says that information is very crucial in decreasing worried-well influx to health institutes. In many instances, hospitals have no relationship with the media and so this type of illness is not known by many people in the community. Therefore, through educative documentaries and periodic advertisements of how worried-well patients should conduct themselves or diagnose their symptoms for actual illness, the influx rate would be vastly decreased. Alternatively, trust agents can be set up in strategic places who will deal with counseling, diagnosis, and education of these patients, which will in turn result in a decrease of these types of patient numbers. Alternative communication channels also act to decrease the influx of these patients. These include hot-numbers, or internet chats which act as avenues for confirmatory and monitoring the progress of patients. This would reduce the influx rate of worried-well patients since they have no reason to go to hospitals to confirm their status (Stone, 2007).

After an emergency, the main aim is to prevent worried-well patients from seeking treatment from emergency health institutes. Therefore, health

institutes can implement this strategy through introduction of a three level system. The first level aims at two tasks, which are to provide an effective message to the public and an alternative facility for these types of patients. The second level will entail stopping worried-well patients at the door since they must come to the emergency institutes. When they are stopped at the door, they must be directed to the alternative facility set apart for them. The third level is required for treating patients who actually require emergency medical services. Services administered in this level are hospitalization, wound care, and drug administration.

Management and treatment of worried-well patients

According to Reilly and Markenson, (2011), the basic management principles that can be applied in managing these patients include: launching a solid therapeutic relationship with patients; educating patients on the appearance of hypochondriasis symptoms; offering regular guarantees; strategizing on ways patients can handle signs as opposed to eliminating them; avoiding high-risk operations; and interaction amongst all general practitioners to avoid investigative duplications and treatments.

Other strategies advocate for a cognitive-educational system to understand the onset of anxiety linked with hypochondriasis and the dynamics maintaining the anxiety. Stone, (2007), asserts that CBT (Cognitive-Behavioral Therapy) is very effective and hence the recommended intervention. The treatment would focus on selective attention, association between stressful physical signals and healthiness, symptoms and fear explanation, and cycle of fear and autonomic overactivity (Hart & Björgvinsson, 2010). When it comes to medications, there is no FDA

approved treatment of hypochondriasis. There have been positive responses from drugs containing imipramine, fluoxetine, and clomipramine. Recently, paroxetine and fluvoxamine have also been discovered. Other treatments for the sickness can be involvement in physical exercises. Exercises have been proved to increase psychological well-being. This intervention has been thought to be hard to apply by the patients but with time as they continue with their exercise they become better.

Conclusion

Worried-well patients can be categorized as hypochondriacs—phobia for being ill. The condition has been seen to exist in 3% of all visitors of health institutes. Therefore, in cases of emergency disasters, there is a very high possibility that their influx can hamper operations in hospitals, even making patients in need of emergency services not get them. Effects of the condition are noted to be: higher physical observation rate, feelings of danger, avoidance behavior, cognitive avoidance, seeking and confirmatory behavior, and amplified bodily functions. However, hospitals can avoid their influx into emergency hospitals through proper prepared plans that factor before and after emergency occurrences. Treatment involves cognitive behavioral therapy combined with drugs such as imipramine, fluoxetine, and clomipramine, paroxetine, and fluvoxamine.

References

Hart, J., & Björgvinsson, T. (2010). Health anxiety and hypochondriasis: Description and treatment issues highlighted through a case illustration. Bulletin Of The Menninger Clinic, 74(2), 122-140.

Prasko, J., Divekey, T., Grambal, A., Kamaradova, D., & Latalova, K. (2010). Hypochondriasis, its Treatment, and Exposure to the Imaginative Illness and Death Experience. Journal of Psychology, 52(1): –76

Reilly, M. J., & Markenson, D. S. (2011). Health Care Emergency Management: Principles and Practice. Ontario: Jones & Bartlett Learning Pp. 387-401

Stone, F. P. (2007). The Worried-well response to CBRN response: Analysis and Solutions. Alabama; Maxwell Air University. Available at: http://www. dtic. mil/cgi-bin/GetTRDoc? Location= U2&doc= GetTRDoc. pdf&AD= ADA475818

Weck, F., Bleichhardt, G., Witthöft, M., & Hiller, W. (2011). Explicit and Implicit Anxiety: Differences Between Patients with Hypochondriasis, Patients with Anxiety Disorders, and Healthy Controls. Cognitive Therapy & Research, 35(4), 317-325. doi: 10. 1007/s10608-010-9303-5