ReAttach Affect Coach JOURNAL

Case Report

# Increasing Resilience in Somatic Symptom Disorder with ReAttach: A Single Case Study in Occupational Therapy

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## Abstract

In the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Somatic Symptom Disorder (SSD) is a presentation of physical symptoms that accompany excessive thoughts, emotions, or symptom-related behavior, causing significant dysfunction or distress (1, 2). A medical condition does not always explain the symptomatology. According to Kurlansik and Maffei (1), patients with Somatic Symptom Disorder first experience a heightened awareness of bodily sensations. Furthermore, these patients tend to interpret these bodily sensations as indicating that they must have a medical illness (2). Besides the fact that this causes much concern for patients, research shows that there is comorbidity with personality problems. Based on scientific research, the prognosis for patients with these complex complaints is unfavorable. According to Rief and Rojas (3), up to 90% of SSD patients have a disease course that lasts longer than 5 years. Previous studies only yielded small to moderate effect sizes in treatment outcomes for this patient group (4). The current study focused on a 28-year-old young woman as a case with an unspecified SSD and cluster C personality traits. In general, the authors of this study hope to shed a different light on SSD and the use of ReAttach to improve the resilience and self-reliance of this patient group. Authors also argue that the ReAttach intervention should be applied within Occupational Therapy (OT) as a supportive tool. Most importantly, they want to share the story of a young patient whose quality of life improved dramatically after ReAttach while on the waiting list for outpatient SSD treatment.

**Keywords**: ReAttach, Somatic Symptom Disorder (SSD), W.A.R.A., New Mind Creation, Occupational Therapy, Resilience

## Introduction

Somatic Symptom Disorder (SSD) is a mental illness marked by an overemphasis on physical symptoms, including fatigue or pain, which results in severe emotional discomfort and other functional issues. High levels of health-related anxiety or symptoms that medical issues cannot sufficiently explain are common among people with SSD (2). The daily functioning of the patients is affected by the illness, and patients often seek medical attention but receive little benefit from conventional methods of treatment, including medicine and psychotherapy.

In the classification delivered by the American Psychiatric Association (5), SSD is a mental health condition distinguished

by an intense obsession with biological symptoms, such as discomfort or exhaustion. These images can be linked to an underlying medical condition, but the individual's response to them is often excessive, causing significant distress and disrupting daily life. In addition, DSM-5-TR interprets SSD through the lens of somatic symptoms. These symptoms are one or more distressing physical manifestations that significantly disrupt daily life. Furthermore, there are excessive thoughts, feelings, or behaviors related to these symptoms, of which at least one of the following must be present: a. Disproportionate and persistent ideas concerning the seriousness of the symptoms. b. Persistently high anxiety regarding health or symptoms. c. Excessive duration and energy are dedicated to these symptoms or health situations. It is important to note that the symptomatic state persists for over six months (5).

As a transdiagnostic approach, ReAttach is a new therapeutic strategy that has drawn interest since it can be used to treat psychological diseases other than SSD (6). It consists of planned, therapist-led sessions in which patients perform a special mix of cognitive and sensory activities to enhance social functioning, emotional control, and information processing.

# ReAttach Targets Transdiagnostic Mechanisms in SSD

Sensory processing disruption is one of the fundamental processes of SSD targeted by ReAttach. Individuals with SSD frequently have increased sensitivity to physical feelings, which causes them to misinterpret body cues (7). This disruption of sensory processing is not unique to SSD; it is also seen in other illnesses, such as autism spectrum disorders, anxiety disorders, and PTSD (6,7). ReAttach addresses several important transdiagnostic mechanisms, such as:

- Enhancing cognitive flexibility is the goal of ReAttach treatment, which enables patients to reframe and reevaluate their feelings and ideas about their symptoms. This is especially important in SSD, where inflexible thinking and catastrophic symptom interpretations can worsen distress.
- Emotional Regulation: ReAttach assists patients in improving their ability to regulate their emotions through controlled multisensory input. This part of the therapy helps people deal with the strong feelings and anxieties that frequently accompany their physical issues.
- ReAttach also focuses on enhancing social processing skills and attachment styles, which are frequently impaired in people with long-term medical conditions. Improving these areas can result in improved social support and interpersonal relationships, which are essential for managing SSD.
- Integration of Sensory and Cognitive Data: By promoting the integration of sensory and cognitive data, the therapy aids patients in gaining a more comprehensive comprehension of their emotional and physical experiences. This combined approach can effectively address the erroneous perception of body signals typical in SSD (6,7,8,9).

ReAttach offers a brief and friendly training option for SSD by focusing on these transdiagnostic pathways (6). It offers a comprehensive strategy that tackles the intricate interactions between cognitive, emotional, and sensory processes contributing to the illness of SSD (7) . Thus, clients can implement meaningful activities concerning self-care, mobility, work, and leisure in their chosen surrounding

# Single Case-Study of SSD and ReAttach

## Anamnesis

The Psychiatric Department of a General Hospital referred patient S. and reported to the community Occupational Therapist (OT):

Patient S. concerns a 28-year-old woman who was under treatment until three years ago in a psychologist's practice for suspected avoidant personality disorder and anxiety disorder, as well as burn-out symptoms for four years. The patient was voluntarily admitted to the psychiatric department after being referred for the diagnosis of persistent physical symptoms, with her having, in addition to severe physical fatigue, moments of 'absences' with intact consciousness for two weeks.

During hospitalization, limited load capacity, excessive fatigue, and fear of unconsciousness were foregrounded. The consulted neurologist found no indications of an underlying neurological substrate. The clinical presentation mostly indicated an unspecified Somatic Symptom Disorder associated with anxiety and depression and underlying deficient coping mechanisms as in cluster C personality characteristics. The hospital discharged patient S. after four weeks. The patient was referred to a multidisciplinary outpatient mental health treatment center. Before she could join that waiting list, on average three to four months, she needed to work towards having enough stamina to travel to and participate in the initial interview. The objective was to increase stress resilience and work towards outpatient Somatic Symptom Disorder treatment.

## Disease progression

- 2019: First reported stress about choosing the right University Master and excessive worrying about the future led to burn-out symptoms.
- 2020: Burn-out symptoms and relational problems. S. subsequently lived with her brother and brother-in-law and later with her parents, with whom she came into conflict;

then, she moved in with her boyfriend, but the relationship ended.

- 2021 / 2021: First basic mental health care, psychological support. Subsequently, treatment for avoidant personality disorder and anxiety disorder.: EMDR, cognitive behavioral therapy, and schema therapy.
- 2023: Excessive worrying, anxiety, relational problems, loss of confidence in therapy. Symptoms: excessive thirst, fatigue, anxiety. S. tried an exercise for the vagus nerve, but then she felt different and developed new physical complaints: panic, difficulty falling asleep, and throat tension.
- 2024: Crisis admission at the Psychiatric Department of the General Hospital, discharged after four weeks, and referred to OT in registration and awaiting further treatment of the SSD. Medication at discharge: Ferrofumaraat 200 mg, twice a week and Lorazepam 1 mg for 10 days, Lorazepam 0,5 mg for 5 days.

## Social support

A difficult situation has arisen with her parents. S. has had no contact with her mother since four years ago, but she occasionally contacts her father. Due to her past problems, S. lost the informal care of her housemates and friends.

## Occupational Therapy - treatment options

The occupational therapist decided to integrate ReAttach (6), W.A.R.A. (Wiring Affect with ReAttach, 6,10) and the New Mind Creation (11) into her overall treatment plan. Besides ReAttach, she used care as usual for O.T., more specifically:

- Psychoeducation by the stress model of zebra and the lion (12).
- Psychoeducational elements from the Practice of Cognitive Rehabilitation Therapy: the Cognitive Hierarchy (13).
- Use of weights

Promoting self-care and recovery-promoting factors in a day- and week's schedule integrating moments of rest, physical activity, cognitive tasks and social interactions.

## Symptom Status before ReAttach

Since her hospital discharge two weeks ago, S. has been lying in the dark on a mattress on the floor; she has a microwave and cooler next to the improvised bed. The OT introduced herself. S. said she did not know the therapist was coming but knew the therapist was an OT. S. could only whisper and could not be seen in the dark. S. received home care for supervised showering twice a week. Going to the toilet evoked fear. Housemates and friends felt overloaded, and the family suggested a key box for home care because S. could not walk to the shared living room, kitchen, or front door.

## First session (week 1)

S. was invited to sit up straight on the therapist's return and receive a second W.A.R.A. She was then handed a T-shirt before the next break to sit up and dressed in bed for the next round. After the third W.A.R.A., she could wear pants and move to a chair. S. sat opposite the therapist on a chair before the fourth W.A.R.A. Finally, she could open the curtains herself to let the light in.

After a psychoeducational conversation, the therapist started with an introductory ReAttach session. S. could not speak enough to tell her story; she felt exhausted but ultimately said that her goal was to be able to comb and wash her hair and to be able to get herself dressed again. A week later, a proper intake interview was conducted with goal setting during the second visit. This time, the therapist used the Canadian Occupational Performance Measure (COPM), a standardized, patient-centered, and occupation-focused instrument consisting of semi-structured interviews (12). S. self-rated her performance and satisfaction using a 10-point scale (12).

The ReAttach session started with focusing on the area above the eyebrows during the fast drumming tempo and relaxing while activating the parasympathetic nervous system. The therapist used identification to change the threat perception from an external to an internal locus of control and trained adaptive identifications with resilience, self-knowledge, and an avatar: a big fluffy chick that can fall and rise.

Cognitive Bias Modification 1 (CBM1, 6) focused on examining the positive and negative aspects of the self and working on compassion and self-acceptance. At CBM2 (6), S. practiced walking as a chick through the hallway to the toilet and shower. This hilarious image evoked a relaxation response. The session ended with a W.A.R.A. to reduce negative affect and a body scan for relaxation.

They discussed how S. could get to the front door and came up with a heavy bag filled with extra weight that she could carry on her stomach to feel more grounded. S. cried with relief and accompanied the therapist almost to the front door when she left.

## Patiënt narrative:

*I thought, "Here comes another occupational therapist to tell me how to distribute my energy." I just thought that I could 'just end it all' as a solution. I didn't know what else I could do to recover other than sitting outside, doing yoga, and taking it easy. I remember the tapping in different rhythms and that I could try it myself. I remember the W.A.R.A. and feeling and releasing the tension between the eyebrows. Then I had to choose a Mascot (Avatar), and my brother-in-law was in the room; I was aware of it. That was the first time I could look at myself and see how bizarre it all was. It made me laugh. Then, I dared to stand upright again for the first time. After the sessions the first day, I felt that I could simply describe something again, for example, in an app to my*

*brother-in-law, instead of staccato putting my complaints in the app. It immediately felt like a little more air and distance.*

## Second session (week 2):

Occupational therapy intake with S. herself. S. felt much improved, was dressed, and spoke at normal volume. S. described her physical, emotional, and cognitive complaints from the past three months:

- - Ringing in my head (a beep)
- - When lying down, my orientation in bed was lost. The whole bed turned
- - I felt like I was falling over from dizziness
- - Tremors all over my body
- - Palpitations,
- - Sounds came in too loud
- - Tingling all over my body
- *- Temperature jumps from cold to warm and back again.*
- *- Panic*
- *- Flashbacks to past months with loss of control.*
- *- I was lying in bed and felt like I was completely disappearing*
- *- The world outside stood still*
- *- There were flashes in my head.*
- *- My throat was constricted*
- *- I could not eat*
- *- I could not walk, my muscles failed during admission, and I kept falling*
- *- The experience of time also seemed to distort.*
- *- I could not keep my attention anywhere.*
- *- I had doubts about my image of reality.*
- *- I was sad*

The goals of the COPM (11) were now named improved mood 2/6, being able to relax 1/1, being able to communicate with people without fear 6/8, less compulsive/ controlling behavior 1/ 3, and being able to do my sport and get about 1/ 3. The first number describes execution, and the second number measures satisfaction with that score. The mean score was 2,2 for execution and 4,2 for satisfaction.

During the social cognitive training perspective, the therapist used S. as Super Woman. The therapist chose identification and Cognitive Bias Modification, focusing on adaptive skills such as trust in the body and what to let go of to increase self-confidence. The avatar still was a great help. CBM3 (6) was used to retrain the optimism bias and create perspective.

With W.A.R.A., it was challenging to deal with adverse affect: S. had many urges to puke and had to burp. However, the body calmed down with coregulation and persistence from the therapist.

## Patiënt narrative:

*I had so much hope because the first session had done so much that I was happy that the second session also worked. The build-up schedule started with brushing my hair and teeth, and I was so happy that that was possible again. I had not done that for six weeks. I also had much tension around breathing, but after that session, it was gone. I walked outside with my brother and brother-in-law the next day. Walking outside for the first few times was safe because I felt so safe with the psychosomatic physio and occupational therapist; I decided I trusted them unquestioningly now, and then we will see. For the first time, I felt that it kept going forward instead of forward and a crash, forward and a crash. I am now doing something that gives me some stretch, and it doesn't matter if I have minor setbacks. For the first time, I can plan, frame, and make it feasable on that day. I can also do something the next day.*

# Evaluation occupational therapist:

S. responded well to the ReAttach treatment, which resulted in a cautious return to normalization in the first week. Every day, S. opens the curtains and walks in the hallway. Can open the front door herself. She met with her brother again last weekend (had not seen him for a long time) and connected with her housemates. S. carefully took a shower independently while someone of home care was present. Home care was subsequently stopped.

## Sesssion three, four and five (week 3, 4 and 6)

Between the second, third and fourth ReAttach sessions, there was coaching from the OT who talked with S. about her increased independence. S. downloaded a yoga app and started small conversations with her housemates while cooking in the shared kitchen. The weekly schedule was adjusted, and her active periods increased. Medication reduction started.

In the third and fourth sessions, the OT used the New Mind Creation to train secure attachment. The therapist used positive, funny metaphors to create positive affect and learn S. to let go of negative thought patterns. The W.A.R.A. was increasingly used as a trusted method to learn to downregulate negative affect.

The fifth ReAttach session took place during the seventh treatment contact with the OT, which was also the end of the treatment. For the last time, S. received a combination of ReAttach W.A.R.A. and New Mind Creation, focusing on self-awareness, self-acceptance, autonomy, and resilience.

### Patiënt narrative:

*Sometimes it feels like it's been a lot longer. It has only been five months since the hospital admission and intake. But it's as if you now think back to your high schooldays, like: I experienced it, but in a different life, a different time. I think it is still close in the memory for my brother and sister because they were so shocked and worried.*

*The previous cognitive behavioral therapists then said to me, you have experienced this, so you will always have a sensitivity to it, but I don't know if that is true. I feel like a different person, not anxious but liberated. Back to my core.*

*I was so worried about the future and having to shape my own life... Moreover, when I started searching I came across descriptions of personality disorders. We only talked about the future for one session in the ReAttach and now I have peace of mind that even though I don't know my future, I have confidence and peace. EMDR, which I have also experienced, is very specific. ReAttach is not that specific. ReAttach has many side effects that continue. For example, we did not talk about the job and the future, but focused on being free in my choices. I can now make choices without fear and panic. (And no blocking about which hobby to choose or which socks to buy…)*

### Evaluation by the occupational therapist:

# Results

The goals in the COPM (Canadian Occupational Performance Measure) were measured as: improved mood 7/8, being able to relax 5/6, communicating with people without fear 7/8, less compulsive/ controlling behavior 6/7, being able to do my sport 8/9. The first number describes execution, and the second measures satisfaction with that score. The mean score was 6,6 in execution and a mean score of 7,7 in satisfaction. This is a change in execution with 4,4 and a change in satisfaction with 3,4 whereby a changed score of 2 or more is seen as clinically relevant.

There was a brief 6-week, intensive process with ReAttach, with fast recovery of independence in sleep, self-care, home care, mobility, relaxation, and leisure activity. S. has started a daily schedule and can now cycle functional distances. She can start the planned intakes and is mobile by bicycle. She has visited her old work and will choose a new workplace to reintegrate. S. helps (week 12) at a repair shop once a week, does an allotment project, and feels equipped to build up her sports (running, cycling, swimming) with a physio schedule.

Advice**:** Keep the heart rate low for now and invest in more meditative techniques. Contact with parents experienced a disruption four years ago that could be repaired, but preferably from a position of mental stability. Since the first results were emerging, it seemed hopeful or likely that S. could recover by herself, after which she could have more say and control in reevaluating her relationships with her family. With the client's permission, the therapist spoke with the parents in general terms, after which the pressure of a reunion was lifted. Guidance in this regard may be provided from a follow-up setting (3-month waiting list).

# Discussion

Individuals with greater optimism, resilience, and general self-efficacy report lower somatic burden than persons with poorer optimism, resilience, and general self-efficacy (14). Therefore, enhancing these adaptive characteristics in patients with SSD might reduce their complaints and increase their mental and physical health. Especially for women with SSD since they tend to show poorer optimism in a wide range of life expectations and tend to show more significant somatic burden (14, 15, 16, 17). Training resilience is promising to reduce stress, anxiety, psychosomatic symptoms, traumatic stress (18), and negative affect (19). Resilience-promoting interventions can alleviate or eliminate psychosomatic symptoms and increase the resistance to somatic and psychological distress (14).

Considering ReAttach an OT intervention to support a vulnerable female SSD patient waiting for outdoor SSD treatment, the observed and measured changes are promising and clinically relevant. After ReAttach, vulnerability was replaced by resilience and increased autonomy. This patient gained personal well-being, relaxation, social functioning, executive functioning, sports, sleep, self-care, leisure activity, and occupational reintegration. The improvements in mental and physical health are significant, clinically relevant, and obtained quickly. The recorded mental and physical health improvements are significant, clinically relevant, and obtained quickly. As stated earlier, these adaptive skills and increased social and physical activities foster physical and mental health and general self-efficacy (14).

The OT used ReAttach to optimize sensory processing and learning conditions, develop a Growth Mindset, and train secure attachment. This case study beautifully illustrates the opportunities of the full ReAttach arsenal, including W.A.R.A. and New Mind Creation, in helping complex patients such as individuals with SSD.

# Conclusion

This case study illustrates how ReAttach Affect Coaches can use ReAttach, W.A.R.A., and the New Mind Creation for patients with complex problems, such as SSD, waiting for further treatment. Besides, it shows that an Occupational Therapist with ReAttach as supportive intervention can make a significant difference in treatment outcome. The results are promising!

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# Declaration of interest

Paula Zeestraten-Bartholomeus is the developer of ReAttach. Authors received no funding for this study.

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