Common psychiatric problems

Depressive disorders

Definition :

Depressive disorders are characterised by persistent low mood, loss of interest and enjoyment, neurovegetative disturbance, and reduced energy, causing varying levels of social and occupational dysfunction. Depressive symptoms include depressed mood, anhedonia, weight changes, libido changes, sleep disturbance, psychomotor problems, low energy, excessive guilt, poor concentration, and suicidal ideation.

Epidemiology :

- Lifetime risk is in the range of 10-15%
- Lifetime prevalence is in the range of 15 – 25 %

Etiology of depression :

- The causes of depression are not fully understood however, Some studies have found a link between depression and other factors

    1. imbalance of certain neurotransmitters in the brain
    2. if an individual is abused and neglected throughout childhood and adolescence
    3. Relationship between smoking and depression
    4. Relationship between obesity and depression
    5. Susceptibility to a depressive disorder is 2 to 4 times greater among first degree relatives of patients with a mood disorder than among other people
    6. Genetics

Differential Diagnosis :

1- Hypthyrodism

2- cushing syndrome

3- drugs side effects :

A- B blocker B- Hormonal therapy

C- Chemotherapy

Classification of depression :

- DSM classification:

  1)major depressive disorder

  2)dysthymic disorder(chronic depression)

  3)postpartum depressive disorder

  4)seasonal depressive disorder

  5)depressive disorder

DSM-IV-TR Criteria for Major Depressive Disorder :

- Presence of a single or more major depressive episode (each
- separated by at least 2 months) for at least 2 week.
- The major depressive episode is not better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
- There has never been a manic episode, a mixed episode, or a hypomanic episode.

Major Depressive Episode :

5 of the mentioned clinical features & at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

D. The symptoms are not better accounted for by grief

DSM-IV-TR Criteria for Dysthymia Depressive Disorder :

A. 2 of the mentioned clinical features for at least 2 years.

B. During the 2 years there has to be no major depressive episode.

C. There has never been a manic episode, a mixed episode, or a hypomanic episode.

D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by grief

postpartum depression :

- a diagnosis of postpartum depression must meet the criteria for both major depressive episode and the criteria for the postpartum onset specifier.

Criteria for Postpartum Onset Specifier:
Onset of major depressive episode must be within 4 weeks after delivery.

Management :

- The aim is always treat the underlying cause of the problem and control the symptoms

1- Pharmacological Therapy :
   - Selective Serotonin Reuptake Inhibitors (SSRI).
   - Selective Serotonin – Norepinephrine Reuptake Inhibitors
   - Tricyclic Antidepressants

2- Psychosocial :
   - supportive therapy
   - family therapy
   - Cognitive-behavior therapy
   - Supportive

3- Electroconvulsive Therapy (ECT):
   - Indicated if patient is unresponsive to pharmacotherapy , if patient cannot tolerate pharmacotherapy , or if rapid reduction of symptoms is desired (suicide risk, etc)

- ECT is safe and may be used alone or in combination with pharmacotherapy.
- In pregnant depressed patient ECT is safer than antidepressants

Hospitalization:

- Indicated for patients at risk for: Suicidal or homicidal patient
- Patient with sever psychomotor retardation who is not eating or drinking
- Diagnostic purpose (observation , investigation)
- Drug resistant cases
- Sever depression with psychotic features

When to referral to specialist psychiatry:

- High suicide risk
- Psychotic major depression
- History of bipolar disorders
- Atypical symptoms
- Failure or partial response following >= 2 attempts to treat
- Recurrent depression

Anxiety

Definitions:

Anxiety is a normal feelings of apprehension in certain threatening situation
Anxiety disorders : are abnormal states in which the most striking features are worry , dread and physical symptoms of anxiety that indicate a hyperactive autonomic nervous system and not caused by organic brain disease , medical illness nor Psychiatric disorder

Etiology:

1- presence of physical or emotional trauma.

2- genetic factors(their first-degree relatives (odds ratio 6.1) developing the disorder)

Differential Diagnosis :

Hyper thyrodism

Primary anxiety disorders:

- Generalized anxiety disorder.
- Agoraphobia without history of panic disorder.
- Panic disorder without or with agoraphobia.
- Specific phobias and social phobia (social anxiety disorder).
- Obsessive-compulsive disorder.
- Acute stress disorder.

DSM-IV Diagnostic Criteria

PRIMARY ANXIETY-SPECTRUM DISORDERS :

The following primary anxiety disorders are described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*:

Generalized anxiety disorder. Patients who have generalized anxiety disorder experience chronic excessive nervousness, exaggerated worry, tension, and irritability that appear to have no cause or are more intense than the situation warrants.11 Their worries are often related to their perceived inability to perform with punctuality and competence in various settings and circumstances. Over the course of the disorder, physical signs—such as restlessness, difficulty in falling or remaining asleep, headaches, trembling, twitching, muscle tension, or sweating— often develop, which lead to further worries. Patients with generalized anxiety disorder may also have other anxiety and mood disorders.

Agoraphobia. The term "agoraphobia," which originally came from the Greek language to describe "fear of the marketplace," became generalized to describe fear of any open or public space. The condition can be quite disabling. Patients with agoraphobia fear being in a situation in which they experience anxiety or panic and from which escape might be difficult or embarrassing. As a result, they avoid those situations that cause anxiety or panic. It is the fear of the anxiety that leads to agoraphobia. Agoraphobia can be accompanied by panic disorder and panic attacks, or it can occur alone without a history of panic attacks.

Panic disorder. Patients with panic disorder usually describe periods of intense fear or discomfort that they call panic attacks. Very often, they seek medical treatment because they fear that their physical symptoms—which may include chest pain, dizziness, nausea, chills, trembling, and palpitations—are caused by a heart attack.

Patients may worry about recurrent and often unexpected panic attacks. The anticipatory anxiety and intense fear of future attacks may lead to the development of phobic avoidance. The combination of panic symptoms and the phobic avoidance can impair the patient's professional, social, and familial functioning

Specific phobias. Phobias are manifested by irrational fears when a person is exposed to or is in close physical contact with specific objects or situations that trigger intense anxiety. The intense anxiety can also be triggered when the person sees or hears the name of the object, or sees pictures of the object. Phobic avoidance develops, and the patient will altogether avoid all the specific things or situations that trigger the intense anxiety. The avoidance leads to an ongoing impairment in the patient's ability to function in settings where exposure to the specific object occurs.

Social phobia (social anxiety disorder). Social phobia is manifested by excessive, persistent fear of social and performance situations that is so severe that it disrupts daily life and relationships.11,15Persons with social anxiety have a persistent, intense, and ongoing fear of being extremely embarrassed or being watched, judged by others, or humiliated by their own actions. The most common social phobia is fear of public speaking.

Obsessive-compulsive disorder. Patients with obsessive-compulsive disorder experience repetitive ideas (obsessions) that are distressing and provoke intense symptoms of anxiety. To counteract the anxiety, patients use certain sets of actions, or rituals, and repetitive behaviors (compulsions). The repetitive behaviors diminish the anxiety temporarily, only to have it return within a relatively short period of time. As a result, patients often continue the compulsive behaviors, which consume most of their time, or they avoid situations with which the obsessions are associated, thus constricting their activities and range of behaviors.

Patients with obsessive-compulsive disorder may have only obsessions or only compulsions or both obsessions and compulsions. They most often experience obsessions that they must avoid contamination, that actions or items need to be checked for completion, or that they must engage in certain detailed and elaborate activities to prevent future harm to oneself or others. Repetitive, intrusive thoughts or images about violence or sexual actions, or urges to engage in violence or sexual actions are also common.

Despite patients' awareness of the irrational nature of their condition, they feel unable to control their obsessions or to prevent their compulsions. The disorder hinders mental, social, and academic performance; if untreated, it may lead to permanent disability because of the loss of meaningful interpersonal relations and employment.

Acute stress disorder. Patients with acute stress disorder experienced a traumatic event in which they were threatened or seriously injured, or they witnessed a traumatic event in which other persons were seriously injured or died. During the traumatic event, they responded with intense fear and helplessness.

The condition is usually associated with dissociative symptoms, such as numbing, detachment, a reduction in awareness of the surroundings, derealization, or depersonalization; re-experiencing of the trauma; avoidance of associated stimuli; and significant anxiety, including irritability, poor concentration, difficulty in sleeping, and restlessness. The diagnosis of acute stress disorder is made when the symptoms occur within 4 weeks of the traumatic event and are present for a minimum of 2 days and a maximum of 4 weeks. The disorder may resolve with prompt intervention or with the passage of time; however, in some patients, acute stress disorder may progress into a more severe psychiatric condition, such as posttraumatic stress disorder.

Posttraumatic stress disorder This disorder develops after a person experiences, witnesses, or confronts a physically and/or psychologically distressing event. The event may involve actual or threatened death or serious injury or a threat to the physical integrity of oneself or others.Symptoms of posttraumatic stress disorder include re-experiencing the traumatic event, a consistent pattern of avoidance of themes associated with the traumatic event, and hyperarousal and autonomic hyperactivities that may be manifested by difficulties with sleep or concentration, exaggerated startle reactions and, at times, anger outbursts. The diagnosis is made if the symptoms have been present for at least 1 month and cause clinically significant distress or impairment in functioning.

Management:

Always remember to rule out physical causes.

Two important points should be considered before starting treatment:

- The physician should discuss the different options of treatment with the patient, and come up with a shared decision about the method of treatment.

- The physician should provide information on the nature, course and treatment of the disease, including information on the use and likely side-effects of the medication.

1- Social:

a. EXPLANATION: nature, cycle and symptoms production.

b. REASSURANCE & SUPPORT: For patient and family.

2- Psychotherapy:

a. Counseling.

b.CBT.

c. Behavior therapy e.g. Anxiety Management Training, Relaxation Exercise and Specific Behavioral techniques.

d.Meditation

e. Psychodynamic Psychotherapy.

3- Medical treatment:

Benzodiazepines are usually started initially, and used for a short period of time (not usually used beyond 2–3 weeks) then is switched to antidepressants – mainly SSRI (Paroxetine or venlafaxine) - which is used for the long term treatment

When to refer to a psychiatrist:

When the patient still has significant symptoms after two interventions using a combination of methods (any combination of psychological or medical treatment) then the patient should be referred to a psychiatrist for further assessment.

Somatoform Disorders

Somatoform Disorders :

The somatoform disorders are a group of psychiatric disorders that cause unexplained physical symptoms. Patients with somatoform disorders present with enduring physical symptoms without an identifiable organic cause which causes significant distress or impairment in social, occupational or other area of functioning.

Somatoform Disorders include

1. somatization disorder (involving multisystem physical symptoms),
2. conversion disorder (patents convert psychiatric problems to a neurological problem and then spontaneously convert back to normal)
3. pain disorder (pain with strong psychological involvement),
4. hypochondriasis (fear of having a life-threatening illness or condition),
5. body dysmorphic disorder (preoccupation with a real or imagined physical defect),

These disorders should be considered early in the evaluation of patients with unexplained symptoms to prevent unnecessary interventions and testing.

Somatization disorder :

Patients with somatization disorder present with multiple vague complaints involving many organ systems. They have a long-standing history of numerous visits to doctors. Their symptoms cannot be explained by a medical disorder.

Etiology :

- Genetic factor
- Neuroscience : faulty perception and assessment of somtosensory inputs due to characteristic attention impairment .
- Psychological :

1- -displacement of unpleasant emotion into physical symptoms
2- -alleviation of guilt through suffering to obtain attention or sympathy

Epidemiology:

- Incidence in females 5 to 20 times that of males
- Greater prevalence in low socioeconomic groups
- Fifty percent have comorbid mental disorder.
- somatization is more prevalent in non-Western societies such as Saudi Arabia because patients lack the verbal skills to articulate emotional distress and that cultural norms may encourage somatic presentations of stress.

Differential Diagnosis :

1- medical diseases e.g. SLE, endocrinopathies and chronic infection
2- depression
3- anxiety

Diagnose : APLLY DSM-IV TR DIAGNOSTIC CRIETERIA :

A. a history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning .

B. Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance

1-four pain symptoms: a history of pain related to at least four different sites or functions (e.g., head, abdomen, back, joints, extremities, chest, rectum, during menstruation, during sexual intercourse)

2-two gastrointestinal symptoms: a history of at least two gastrointestinal symptoms other than pain (e.g., nausea, bloating, vomiting other than during pregnancy, diarrhea, or intolerance)

3-one sexual symptom: a history of at least one sexual or reproductive symptom other than pain (e.g., sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy)

4- one pseudoneurological symptom: a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting

C. The symptoms cannot be explained by general medical condition or substance use

D. The symptoms are not intentionally feigned or produced (as in Factitious Disorder or Malingering).

Patient Health Questionnaire: Screening for Somatoform Disorders

During the past four weeks, how much have you been bothered by any of the following problems?

	Not at all	*A little*	*A lot*
Stomach pain			
Back pain			
Pain in your arms, legs, or joints (knees, hips, etc.)			
Menstrual cramps or other problems with your periods			
Pain or problems during sexual intercourse			
Headaches			
Chest pain			
Dizziness			
Fainting spells			
Feeling your heart pound or race			
Shortness of breath			
Constipation, loose bowels, or diarrhea			
Nausea, gas, or indigestion			

NOTE: *If a patient reports being bothered "a lot" by at least three of the symptoms without an adequate medical explanation, a somatoform disorder should be considered.*

Management:

- The initial steps in treating somatoform disorders are to consider and discuss the possibility of the disorder with the patient early in the work-up .
- Avoid additional diagnostic procedures
- Shift the patient awareness to psychological and support him
- Limit the number of doctors consulted, number of invasive investigation and amount of medication Benzodiazepines
- Minimize the use of psychotropic drugs: Antidepressant
- Educate and involve the family in management.
- Understand the need to repeat the reassurance, encouragement of activities and conditions of care (the limits).

The difference between somatoform , malingering and factitious disorder:

Patients with factitious disorder intentionally produce medical or psychological symptoms in order to assume the role of a sick patient. Primary gain is a prominent feature of this disorder

Malingering involves the feigning of physical or psychological symptoms in order to achieve personal gain. Common external motivations include avoiding the police, Secondary gain is a prominent feature of this disorder.

Somatoform disorder, the patients are not consciously feigning symptoms.

Role of Psychotherapy in Primary Care settings

Why is psychotherapy important in primary care?

(1) Primary care patient populations have significant psychological needs.

(2) Access to specialty mental health care is limited.

(3) More services would be delivered to more people.

(4) Mental health treatment in primary care may help improve physical problems.

Psychotherapy

Definition:

A group of non-pharmacological non-invasive techniques employed by a therapist to treat mental illness, emotional difficulties, or behavioral problems.

Classification of Psychotherapy

According to concept:

- Counselling.
- Supportive.
- Cognitive.

- Behavioral.

According to participants:

- Individual therapy.

- Group therapy.

- Couple (marital) therapy.

- Family therapy.

• A- Counselling

Definition:

An interactive learning process contracted between counsellor(s) and client(s), which approaches in a holistic way, social, cultural, economic and emotional issues.

- Goal: - Information.

- Education.

- Understanding.

- Indication: Any presenting difficulty.

-Techniques:

- Listening.

- Discussion.

- Problem solving.

- Enable decision making.

- Enable Learning.

• B- Supportive therapy

- Goal: - Support.

- Maintain or re-establish the usual level of functioning.

- **Indication**: Overwhelming problem.

- **Techniques:**

  - Building a reasonable doctor-patient relationship.

  - Careful listening.

  - Reassurance.

  - Empathy.

  - Facilitating emotional ventilation.

  - Giving explanations and advice.

  - Suggestion, reinforcement.

  - Instillation of hope and improving self-esteem.

- ## C- Cognitive therapy

- **Goal**: Modify thoughts.

- **Indication:**

- Depression , -GAD , - Phobias , - Panic.

- **Techniques:**

- Identify negative thoughts.

- Alternatives.

- Clarify mechanisms.

- ## D- Behavioral therapy

- **Goal:** Modify behavior.

- **Indication:** Any distressing behavior e.g.

1. Phobias.

2. Obsessions.

3. Compulsions.

- **Techniques:**

- Relaxation.
- Exposure.
- Response prevention.
- Thought stopping