PHC

432 Team

26 Common Psychiatric problems in PHC

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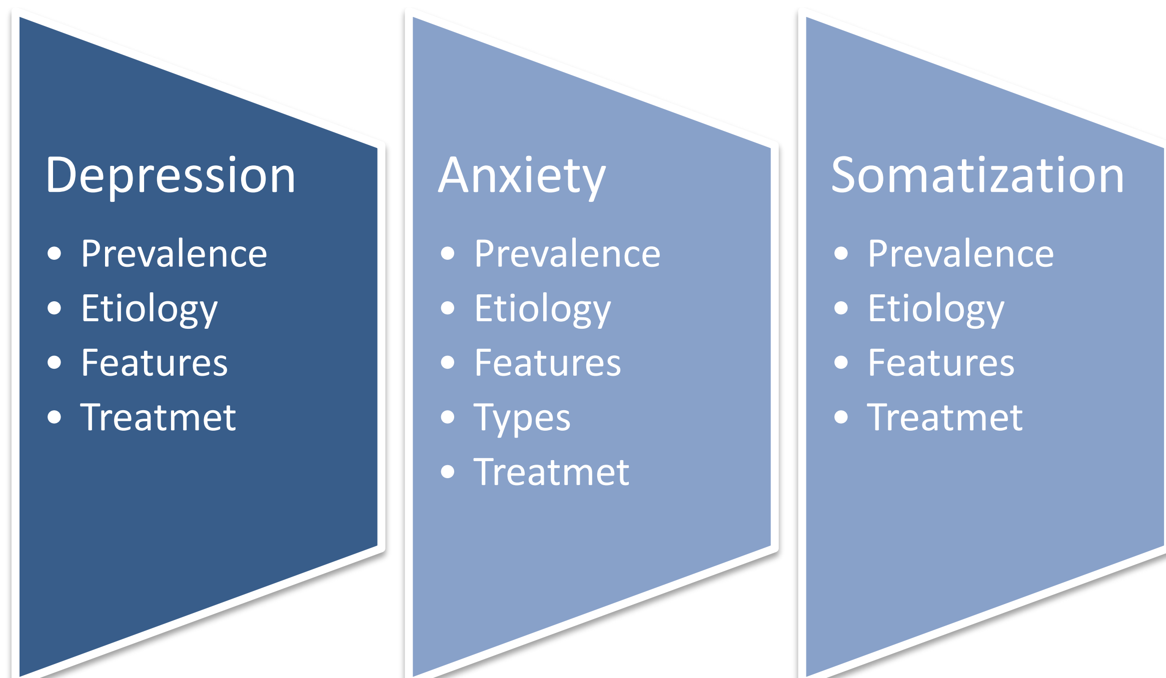
COLOR GUID : Doctor's Notes Team Notes **slides** Not important **Important** **431 team work**

Objectives

1. Highlight the prevalence of anxiety, depression, and somatization in Saudi Arabia.
2. Highlight the etiology of anxiety, depression and somatization.
3. Highlight on use of Tricyclic antidepressants and Selective Serotonin Reuptake Inhibitors "SSRI".
4. Discuss the clinical features and management of anxiety in family medicine setting.
5. Discuss the clinical features and management of depression in family medicine setting.
6. Discuss the clinical features and management of psycho-somatic illness in family medicine setting.
7. Brief discussion about the role of counseling and psychotherapy in the management of common psychiatric problems in family medicine.
8. When to refer to Psychiatrist.



Common psychiatric problems

Epidemiology

A cross-sectional study was conducted in 10 secondary schools for girls using the Arabic version of the symptom-revised checklist 90 (SCL 90-R), a mental health questionnaire that was administered to the girls by fourth- year female medical students.
The most prevalent mental symptoms in the 545 female students were phobic anxiety (16.4%), psychoticism (14.8%), anxiety (14.3%), and somatization (14.2%). The prevalence of depression, paranoid ideation and interpersonal sensitivity amounted to 13.9%, 13.8% and 13.8%, respectively. The least prevalent mental symptoms were hostility (12.8%) and obsessive-compulsive behavior (12.3%). Overall, psychological symptoms (in terms of a positive global severity index) were found in 16.3% of the girls. In a multivariate logistic regression analysis, no significant relationship was found with sociodemographic factors.

Depression

Definition

Depressive disorders are characterized 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.

Etiology

The etiology of depression remains poorly understood. Susceptibility to a depressive disorder is 2 to 4 times greater among the first-degree relatives of patients with a mood disorder than among other people. It is unclear whether a gene-environment interaction can help explain susceptibility to depression or predict response to treatment. A meta-analysis proposed by the National Institute of Mental Health in 2009 supported the previous finding that stressful life events have a potent relationship with the risk of depression. However, other studies suggest a role for genetic polymorphisms in predicting medication S/Es.

Classifications

According to the DSM Classification:

1. Major Depressive Disorder (Unipolar Depression): 2 weeks of depression at least and 5 symptoms.

2. Dysthymic Disorder (Chronic Depression): Low-grade depression for at least 2 years.

3. Postpartum Depressive Disorder.

4. Seasonal Depressive Disorder (Usually in Winter).

5. Depressive Disorder NOS (Not Otherwise Specified).

Diagnosis

Major Depressive Disorder: (DSM-IV-TR Criteria)

1. Presence of a single or more major depressive episode (each separated by at least 2 months) for at least 2 weeks.

2. 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.

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

Major Depressive Episode:

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

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

3. 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).

4. The symptoms are not better accounted for by grief.

Dysthymia Depressive Disorder: (DSM-IV-TR Criteria)

1. 2 of the mentioned clinical features for at least 2 years.

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

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

4. 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).

5. The symptoms are not better accounted for by grief.

Management

1. Pharmacological Therapy:

- a. Usually 3-5 weeks for desired effect, but unfortunately side effects can start within few days.
- b. These groups are more beneficial than tricyclic drugs (especially in dysthymic disorder).
- c. Selective Serotonin Reuptake Inhibitors (SSRI).
- d. Selective Serotonin–Norepinephrine Reuptake Inhibitors (e.g. Venlafaxine, Duloxetine).
- e. Monoamine Oxidase Inhibitors (MAOI): Don't give with SSRI or Tricyclic antidepressants.

2. Psychological Therapy:

- a. Supportive Therapy.
- b. Cognitive & Behavior Therapy.

3. Electroconvulsive Therapy (ECT):

- a. As a last resort.
- b. Safer in pregnant women than antidepressant.

Prognosis

1. Approximately 20 weeks for recovery.
2. Relapse in 25% of patients.

When to Refer to Psychiatrist for Admission

1. Suicidal or Homicidal Patients.

2. Severe Psychomotor Retardation and Malnutrition (For ECT).

3. Diagnostic Purpose.

4. Severe Depression with Psychotic Features (Possible ECT).

Summary

Characterized by persistent low mood, loss of interest and enjoyment, and reduced energy. It's common in primary care, affecting 5% to 10% of patients in this setting. Often have a personal or family history of depression; have experienced a recent stress, trauma, or loss; or have comorbid medical illness. Recommendations suggest that centers screening adults should have systems in place that ensure positive screening results are followed by accurate diagnosis, effective treatment, and careful follow-up. Most patients respond well to psychotherapy, antidepressants, or a combination of both. Suicidal ideation can occur before, during, or after treatment, so clinicians should assess this at each visit.

Anxiety

Definition:

Anxiety is a normal feeling 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 developing the disorder).

Primary anxiety disorders:

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

Diagnosis of anxiety

PRIMARY ANXIETY-SPECTRUM DISORDERS: (DSM-IV Diagnostic Criteria)

1. 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. 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.

2. Agoraphobia: 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.

3. 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 functioning.

4. 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.

5. 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. Persons 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.

6. 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.

7. 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.

8. 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.

Treatment

Pharmacotherapy and cognitive-behavioral (psychosocial) therapy are the most commonly used options available to primary care providers to treat patients with anxiety disorders Collaborative Care.

Pharmacotherapy:

a. First-line medications

- Selective-serotonin reuptake inhibitors (SSRIs) e.g. paroxetine
- Serotonin-norepinephrine reuptake inhibitors (SNRIs) e.g. Venlafaxine

b. Second-line medications

- Tricyclic antidepressant e.g. Imipramine
- Benzodiazepines e.g. diazepam

Treatment of anxious patients can be professionally rewarding for the primary care physician: many patients with anxiety disorders show remarkable improvement with treatment. For those patients who prove to be more difficult to treat, referral to a mental health professional should be initiated.

Somatization :

Introduction

Somatization is a syndrome of nonspecific physical symptoms that cannot be fully explained by a known medical condition after appropriate investigation.
In addition, the symptoms may be caused or exacerbated by anxiety, depression, and interpersonal conflicts, and it is common for somatization, depression, and anxiety to all occur together.
Somatization can be conscious or unconscious and may be influenced by a desire for the sick role or for personal gain.

Epidemiology

Somatization is common in the general population. More than 50 percent of patients presenting to outpatient medical clinics with a physical complaint do not have a medical condition.

Risk factors for somatization include:

1. Female sex. 2. Fewer years of education.

3. Minority ethnic status. 4. Low socioeconomic status.

Etiology

Controversy exists whether somatization is to be considered a purely psychiatric disorder, or if it should be viewed as a syndrome of multiple unexplained symptoms that complicate the presentation of a general medical condition.

1. The genetic basis for somatization is not clear. Some, but not all studies, indicate a familial pattern for somatization. The familial aggregation may be due to genetic or environmental factors, or both.

2. Childhood sexual abuse and recent exposure to physical or sexual violence are consistently associated with somatization in adult women.

3. Physical symptoms may offer a means to express distress when patients do not easily express emotions in words (alexithymia).

CLINICAL PRESENTATION

The essential feature of somatization is a chronic history of unexplained physical symptoms, which the patient attributes to a nonpsychiatric disease.
Somatizing patients present with a wide array of symptoms:

1. Pain symptoms, including headache, back pain, dysuria, joint pain, diffuse pain, and extremity pain.

2. Gastrointestinal symptoms, including nausea, vomiting, abdominal pain, bloating, gas, and diarrhea.

3. Cardiopulmonary symptoms, including chest pain, dizziness, shortness of breath, and palpitations.

4. Pseudoneurologic symptoms, including fainting, pseudoseizures, amnesia, muscle weakness, dysphagia, double or blurred vision, difficulty walking, difficulty urinating, deafness, and hoarseness or aphonia.

5. Reproductive organ symptoms, including dyspareunia, dysmenorrhea, and burning in sex organs.

The somatizing patient can also be recognized by the multiple unexplained symptoms, vague and inconsistent history, underlying sense of anguish, persistent unspoken demands, lack of factors that exacerbate or alleviate symptoms, and lack of positive findings on physical examination.

Coexisting psychiatric disorders

1. Somatization is strongly associated with anxiety.
2. In addition to depression and anxiety, somatization is often associated with personality disorders. The most common were avoidance, paranoia, self-defeating, and obsessive-compulsive

Medical evaluation

The evaluation of a patient presenting with possible somatization includes taking a history, performing a physical examination, reviewing laboratory data, and communicating with other clinicians.

1. History of present illness

In taking a history, the clinician should pay attention to how the physical symptoms are related to the patient's emotions and social situation, and if any stressful personal events such as losses have occurred.

The pattern of pain should be assessed. The clinician should determine what exacerbates or alleviates the symptoms, and why the patient believes he/she is suffering. The patient may be convinced he/she has a specific disease, is seriously ill, or is dying. Assess whether the patient can be reassured.

The patient should be asked about medications, including over-the- counter, prescription, and complimentary medications.

Additionally, patients should be questioned about substance use, including alcohol.

It is important to ask whether the patient has experienced physical or sexual abuse, whether the patient feels safe in his/her current relationships, and whether he/she feels threatened or afraid in any way, either at home or in other settings.

2. Past medical illness

Some patterns of somatization are characterized by a longitudinal course beginning in childhood. Patients may report that their parents were attentive only when they were sick.

Ask about a lifetime history of anxiety disorder, depressive disorder, or multiple unexplained symptoms.

In addition, prior treatment with psychotropic medications should be assessed.

3. Family history

The family history should be examined for a model of disability or somatization, and the presence of depression or anxiety disorder.

4. Social history

Consider the social context in which the physical symptoms appear, including likely stresses at the patient's stage of development. Financial pressures, work, unemployment, disability history, history of arrests, time in prison may provide context for the symptoms.

5. Physical examination

The physical examination should satisfy the clinician that the patient does not have a medical disease. The examination provides a baseline for detecting change over time. Additionally, patients believe their complaints are taken seriously when a physical examination is performed.

6. Laboratory evaluation

Laboratory testing should be done judiciously to evaluate current and new physical symptoms. Often, extensive testing has previously been done to look for a diagnosis.

Diagnosis

1. Somatization is too often a diagnosis of exclusion.

2. The DSM-IV establishes the following five criteria for the diagnosis:

    a. History of somatic symptoms prior to the age of 30
    b. Pain in at least four different sites on the body
    c. Two gastrointestinal problems
    d. One sexual symptom.
    e. One pseudoneurological symptom.

Multisomatoform disorder:

1. Factitious disorder: The essential feature of factitious disorder is intentionally faking symptoms in order to assume the sick role, i.e. to be a patient.
No external incentives such as financial gain are present.
Patients with factitious disorder tend to have some medical knowledge.

2. Malingering: The essential feature of malingering is intentionally faking or grossly exaggerating symptoms for an obvious, external incentive such as avoiding work, avoiding criminal prosecution, obtaining financial compensation, or obtaining medications.
The motivation for symptom production in malingering is an external incentive, whereas in factitious disorder the motivation is to assume the role of patient.

Screening

Primary care and other clinicians can use a brief screening instrument to assess for somatoform disorders.

Differential diagnosis

The symptoms that occur in somatization occur in many other medical and psychiatric conditions, like:

1. Depression.

2. Panic disorder.

3. Substance use disorder: Many symptoms of substance intoxication and withdrawal also occur in somatization.

Management

1. After appropriate investigation, inform the patient that no further investigations are indicated.

2. Limit the number of doctors consulted.

3. Limit the number of invasive investigation.

4. Limit the amount of medication. Benzodiazepines, stimulants and analgesics should be strenuously limited.

5. Diagnose and adequately treat comorbid psychiatric disorders. Be alert for depression and anxiety. Personality disorder will make management more difficult.

6. Encourage return to normal activities. Encourage hobbies, exercise, education and cultural pursuits – these will distract the patient from his/her body, stretch and strengthen the body and assist the return to normal function. Reward attempts at activities with praise.

7. Educate and involve the family in management.

8. Understand the need to repeat the reassurance, encouragement of activities and conditions of care.

Psychotherapy

Introduction

Psychotherapy is an interpersonal treatment based on psychological principles. It is individualized to the patient, seeking to help him or her with a psychiatric disorder, problem, or adverse circumstance.

There are many types of psychotherapy with varying methods and levels of empirical support. The choice of the most appropriate type of psychotherapy is in part based upon the patient's specific problem or diagnosis.

1. Evidence-based psychotherapies

In some cases, psychotherapy may be more effective when administered in conjunction with medication. Efficacy data are described in detail separately under individual disorders.

2. Cognitive and behavioral therapies

CBT often includes education, relaxation exercises, coping skills training, stress management, or assertiveness training. In cognitive therapy, the therapist helps the patient identify and correct distorted, maladaptive beliefs. Behavioral therapy uses thought exercises or real experiences to facilitate symptom reduction and improved functioning. Cognitive behavioral therapy is an evidence- based treatment for psychiatric disorders.

3. Psychodynamic psychotherapy

Psychodynamic therapy primarily relies on developing patient insight. Psychodynamic psychotherapy is based upon the idea that childhood experiences, past unresolved conflicts, and previous relationships significantly influence an individual's current situation in life.

4. Interpersonal therapy (IPT)

IPT addresses interpersonal difficulties that lead to psychological problems. Interpersonal psychotherapy focuses on the individual's interpersonal life in four problem areas: grief over loss, interpersonal disputes, role transitions, and interpersonal skill deficits.

5. Motivational interviewing

Motivational interviewing is a type of psychotherapy that is used in primary care and mental health care to encourage patients to change maladaptive behaviors.

6. Supportive psychotherapy

Supportive psychotherapy or counseling is widely used in medical practice, e.g. to help individuals cope with illness, deal with a crisis or transient problem, and maintain optimism or hope. Techniques vary but most models emphasize communication of interest and empathy; supportive therapy may also include guidance on available services, advice, respect, praise, and/or encouragement.

Format of psychotherapy

In addition to the orientation of therapy, treatment is offered in different formats:

1. Individual therapy: Individual therapy is the most commonly practiced format of psychotherapy.

2. Couple therapy.

3. Family therapy.

4. Group therapy.

Indications for psychotherapy

The clinician should consider initiating or referring a patient for psychotherapy for the following purposes:

1. Treatment of a psychiatric disorder, with the goal of reducing or ameliorating symptoms and improving functioning.

2. Changing maladaptive thoughts, behaviors, or relationships.

3. Providing support when a crisis, a difficult period, or a chronic problem impairs functioning.

4. Enhancing a patient's capacity to make behavioral changes, e.g. losing weight, quitting smoking, or increasing adherence to medical treatment.

COUNSELING

Definition

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

Goal

1. Information.
2. Education.
3. Understanding.

Indication

It's indicated for any presenting difficulty.

Techniques

1. Listening. 2. Discussion. 3. Problem solving. 4. Enable decision-making. 5. Enable Learning.

Summary

- Common psychiatric diseases in PHC includes: Depression, Anxiety and Somatization.

1) Depression: characterized by persistent low mood, loss of interest and enjoyment, and reduced energy.

    - **Prevalence:** 5-10%
    - **Etiology:** gene-environment interaction
    - **Diagnosis:** Page 3
    - **Treatment:** Pharmacological, Psychological and Electroconvulsive Therapy.

2) Anxiety: abnormal states in which the most striking features are worry, dread and physical symptoms.

    - **Prevalence:** 2-3%
    - **Etiology:** physical or emotional trauma + Genetic factors.
    - **Diagnosis:** Page 6
    - **Treatment:** Pharmacotherapy and cognitive-behavioral (psychosocial)
    - **Primary anxiety disorders:**
    - 1. Generalized anxiety disorder.
    - 2. Agoraphobia without history of panic disorder.
    - 3. Panic disorder without or with agoraphobia.
    - 4. Specific phobias and social phobia (social anxiety disorder).
    - 5. Obsessive-compulsive disorder.
    - 6. Acute stress disorder.

3) Somatization: nonspecific physical symptoms that cannot be fully explained by a known medical condition.

    - **Prevalence:** 50% of patients presenting to outpatient medical clinics.
    - **Etiology:** Genetics, Childhood sexual abuse & distressed emotions.
    - **Diagnosis:** Page 12
    - **Treatment:** mainly support.

Psychotherapy: Page 14

Questions

1) A 41-year-old man presented with a 3-week-history of lack of motivation, fatigue, excessive self blame, poor appetite, social isolation, and delaying his tasks. He has no previous history of psychiatric or medical disorders. What is the most likely diagnosis?

a. Major Depressive Disorder, recurrent type.
b. Dysthymic disorder.
c. Major depressive Disorder, single episode.
d. Depression due to underlying medical problem.

2) A depressed patient should be referred to psychiatric clinics when the patient displays:

a. Loss of appetite
b. Fatigue
c. Diminished pleasure
d. Suicidal thoughts

3) In order to diagnose General Anxiety Disorder (GAD), the symptoms of anxiety and excessive worrying must be present of at least:

a. Month
b. 3 Months
c. 6 Months
d. 1 Year

4) According to DSM V criteria for diagnosing mental disorders a patient showing 3 to 4 depressive symptoms over a period of more than two years is diagnosed with:

a. Minor depression
b. Major depression
c. Dysthymia
d. Bipolar depression

5) Somatization usually occurs with:

a. Medical diseases/Physical diseases
b. Anxiety disorders or/and depression
c. Neurodevelopmental disorders
d. All of the above

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Answers:

1st Questions: C

2nd Questions: D

3rd Questions: C

4th Questions: C

5th Questions: B