PHC

432 Handouts

10

Common Psychiatric problems in primary care

Done By:

Nuha Al-Salameh, Hessa AlAbdulsalam,

Ahlam Al-Mutairi, Reem Al-Anazi

جامعة الملك سعود

King Saud University

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

Objectives

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

Depression

Classifications of depression: According to the DSM Classification:

Major Depressive Disorder MDD.

Dysthymic Disorder (Chronic Depression).

Postpartum Depressive Disorder.

Seasonal Depressive Disorder (Usually in Winter)

Unspecified Depressive Disorder.

1-Major Depressive Disorder MDD

Its persistent low mood and lack of interest for at least 2 weeks.

To be diagnosed with major depression, a person must **have five or more** of the following symptoms present most of the day nearly every day for at least **two consecutive weeks**. For the diagnosis, at least one symptom must be either depressed mood or loss of interest or pleasure.

Symptoms

1-Depressed mood

2-Loss of interest

3-Change in appetite or weight

4-Insomnia or hypersomnia

5-Psychomotor agitation or retardation

6-Fatigue or loss of energy

7-Feelings of worthlessness or excessive guilt

8-Poor concentration

9-Recurrent thoughts of death or suicide

Criteria to diagnose

DSM-IV Criteria for Major Depressive Disorder (MDD)

• Diagnosed if there are loss of interest or pleasure, and depressed mood in daily activities for more than two weeks plus five of the following:-

1- Significant weight change or change in appetite

2. Change in sleep: Insomnia or hypersomnia

3. Change in activity: Psychomotor agitation or retardation

4. Fatigue or loss of energy

5. Guilt/worthlessness: Feelings of worthlessness or excessive or inappropriate guilt

6. Concentration: diminished ability to think or concentrate, or more indecisiveness

7. Suicidality: Thoughts of death or suicide, or has suicide plan

2-DYSTHYMIC DISORDER

Diagnostic Criteria:

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

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

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

The symptoms are not due to the direct physiological effects drug or hypothyroid

3-postpartum major depression

A major depression episode associated with childbirth . Affects one in ten child bearing women.

Onset can begin 24 hours to several months after delivery

Management by group therapy or pharmacological therapy (SSRI, TCA)

4-postpartum blues

- Postpartum blues ("baby blues") refer to a transient condition characterized by mild depressive symptoms such as dysphoria (ie, sadness, tearfulness, irritability, and anxiety), insomnia, and decreased concentration. These symptoms develop in 40 to 80 percent of women within two to three days of delivery, Symptoms typically peak over the next few days and resolve within two weeks

Management

- General assessment: Assess patient concern & comorbidity. Assess his drug intake

- **Non pharmacological:**

Psychotherapy: Supportive Therapy. Cognitive & Behavior Therapy, Talk about side effect of drug

- Pharmacological

Pharmacological

Usually 3-5 weeks for desired effect

1-Selective Serotonin Reuptake Inhibitors (SSRI).

2-Tricyclic antidepressants

3- Selective Serotonin–Norepinephrine Reuptake Inhibitors (e.g. Venlafaxine, Duloxetine).

4- Monoamine Oxidase Inhibitors (MAOI): Don't give with it SSRI or Tricyclic antidepressants.

Selective serotonin reuptake inhibitors (SSRIs)

- Selective serotonin reuptake inhibitors (SSRIs) — SSRIs are considered **first line** for treatment of depressive disorders in older adults due to better tolerability, ease of use, and general safety, especially in overdose

USES: -

- Depression
- panic disorder
- obsessive-compulsive disorder, generalized anxiety disorder
- social anxiety disorder, posttraumatic stress disorder
- body dysmorphic disorder
- bulimia nervosa
- binge eating disorder, premenstrual dysphoric disorder
- somatoform disorders.

SIDE EFFECT

Patients are likely to experience some or all of the following:	
Fatigue	Nausea
Dry mouth	Diarrhea
Rash	Weight loss or weight gain
Drowsiness	Insomnia
Headaches	Increased sweating
Agitation	Decreased sexual desire
Difficulty reaching orgasm	Erectile dysfunction

Tricyclic Antidepressant TCA

Uses:

- Depressive disorders.
- Anxiety.
- Obsessive compulsive disorder.
- Tricyclics are dangerous in overdose and should be avoided with suicidal patients.

S/E

- Headache
- Nausea / vomiting
- Dry mouth
- Constipation
- Cardiac problems
- Decrease libido
- sedation

Generalized anxiety disorder (GAD):

Definition: is characterized by excessive and persistent worrying that is hard to control, causes significant distress or impairment, and occurs on more days than not for at least six months.
Other features include psychological symptoms of anxiety, such as apprehensiveness and, and physical (or somatic) symptoms of anxiety, such as increased fatigue and muscular tension.

Epidemiology:

- Generalized anxiety disorder (GAD) is common in both community and clinical settings.
- Epidemiologic studies of nationally representative samples in the United States have found a lifetime prevalence of GAD of 5.1 percent to 11.9 percent.
- GAD is one of the most common mental disorders in primary care settings and is associated with increased use of health services
- The disorder is approximately twice as common in women as it is in men
- GAD is probably the most common anxiety disorder among the elderly population

Risk factors:

- Female sex
- Recent adverse life events
- Chronic physical illness (respiratory, cardiovascular, metabolic, cognitive),
- Chronic mental disorder (depression, phobia and past GAD)
- Parental loss or separation
- Low affective support during childhood
- History of mental problems in parents

Clinical manifestations:

- Excessive and persistent worrying is widely regarded as the pathognomic feature of generalized anxiety disorder (GAD),

- Most patients present with other symptoms relating to autonomic hyperactivity and muscle tension.
- Many complain of poor sleep, fatigue and difficulty relaxing.
- Headaches and pain in the neck, shoulders, and back are commonly reported.
- It is common for patients with these symptoms to present to health professionals repeatedly, with pressing but long-standing concerns that prove to be medically unexplained.
- The nature of excessive and persistent worrying has not been investigated extensively. Individuals with GAD have reported a greater number of worries, but were found to share the same concerns about health, family and interpersonal relationships, work and finances as non-anxious control.
    - (Individuals with GAD have been distinguished from controls, and from patients with other anxiety disorders, by having greater worry over minor matters)

Diagnostic Criteria:

DSM-5 diagnostic criteria for generalized anxiety disorder require the presence of:

- Excessive anxiety and worry, occurring more days than not for at least six months, about a number of events or activities (such as work or school performance)
- The individual finds it difficult to control the worry.
- The anxiety and worry are associated with **three (or more)** of the following six symptoms (with at least some symptoms having been present for more days than not for the past six months):
- Note: Only one item is required in children.
    - Restlessness
    - Being easily fatigued
    - Difficulty concentrating
    - Irritability
    - Muscle tension
    - Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)
- The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance (eg, a drug of abuse, a medication) or another medical condition (eg, hyperthyroidism).
- The disturbance is not better explained by another mental disorder

Differential diagnosis:

- **Depression**
- **Hypochondriasis** — Concern about medically unexplained symptoms,
    - GAD is usually characterized by worries about multiple different things, while patients with hypochondriasis worry principally about illness.
- **Panic disorder**
    - Panic attacks can occur in GAD, arising out of uncontrollable worry: but the presence of unexpected panic attacks is unusual in GAD.
    - Patients with panic disorder tend to have episodic thoughts about life-threatening acute illnesses, whereas patients with GAD focus more persistently on less specific but more chronic complaints involving multiple organ systems.
- **Obsessive compulsive disorder** — Patients with GAD can show thoughts and behaviors with similarities to OCD.
    - GAD patients tend to be more day to day worries (finances, work, health, family) while OCD tends to be about more primal fears (eg, contamination or harm).
    - OCD compulsions are typically rule driven (has to be done a certain way) and either unrelated to the feared outcome they are intended to prevent (eg, avoiding cracks on side walk to prevent mother's death) and/or clearly excessive;
    - GAD checking is typically directly related to preventing the feared outcome (checking the locks on the front door before bedtime to prevent break-in) and is not usually excessive or time consuming.

Treatment:

- Effective treatments for generalized anxiety disorder *include*:
    - Educating the patient about the condition
    - Psychological interventions such as cognitive-behavioral therapy, biofeedback, and relaxation therapy
    - **Medications** including selective serotonin reuptake inhibitors.
        - Fluoxetine
        - Citalopram
        - Paroxetine
        - Drugs should be continued for 3-4 weeks before changing to another drug

Follow-up:

- Regular follow up weekly is mandatory in the beginning to asses response and side effects of medications
- After stabilizing, patient could attend monthly, and then every two months

When to refer?

- If patient has severe symptoms which need admissions
- If there's a predominant psychomotor disturbance or mixed psychiatric disorders
- If no good drug response after 4 weeks
- If patient uses illegal drugs

Red flags:

- Poor response to drugs
- Using illegal drugs
- Presence of chronic medical problems
- Presence of other psychiatric disorders

Summary And Recommendations:

- Generalized anxiety disorder (GAD) is characterized by excessive, persistent worrying which is hard to control, and by psychological and physical symptoms of anxiety that together cause significant distress.
- GAD is common in community and clinical settings
- Excessive and persistent worrying is most common symptom of GAD, but symptoms related to autonomic hyperactivity, motor tension, sleep disturbance and pain are all common
- GAD tends to run either a chronic course fluctuating in severity over time.
- Assessment of a patient with possible GAD should include a careful history, an evaluation for symptoms of GAD as well as alternative psychiatric disorders, and a physical exam and laboratory studies to rule out organic causes of anxiety.
- Distinguishing GAD from major depression and other psychiatric disorders is probably the most difficult part of the disorder's differential diagnosis.

Somatic symptom disorder

Somatic Symptom and Related Disorders:

- **Somatic Symptom Disorder**

is characterized as recurring and multiple physical complaints that begin before the age of 30. These symptoms are difficult to link to an identifiable medical condition

Illness Anxiety Disorder

excessive concern about having or developing a serious, undiagnosed general medical disease.

- **Conversion Disorder (Functional Neurological Symptom Disorder)**

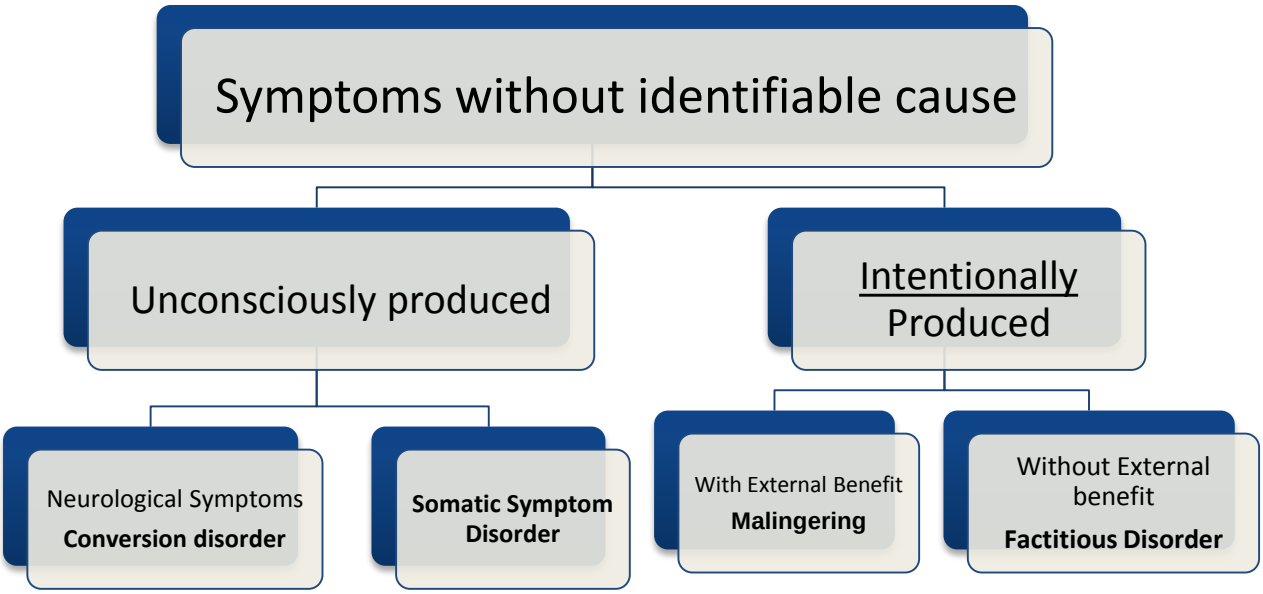
is characterized by neurologic symptoms (eg, weakness, abnormal movements, or nonepileptic seizures) that are inconsistent with a neurologic disease, but cause distress, and/or impairment

- **Factitious Disorder**

intentionally faking symptoms in order to assume the sick role, ie, to be a patient. In addition, there are no obvious external benefits such as financial gain, or avoiding work or criminal prosecution

- **Psychological Factors Affecting Other Medical Conditions**

a disorder that is diagnosed when a general medical condition is adversely affected by psychological or behavioral factors; the factors may precipitate or exacerbate the medical condition, interfere with treatment, or contribute to morbidity and mortality



Somatic Symptom Disorder:

Epidemiology

- Information about the prevalence of SSD is lacking due to the recent changes in the DSM-V code in 2013.
- 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
- Prevalence of somatization in Saudi Arabia : 19.3% of primary care patients reported to have somatization.

ETIOLOGY

- **Genetic and biological factors** such as an increased sensitivity to pain - The genetic basis for somatization is not clear.
- **Family influence**
- **Personality trait of negativity,** which can impact how you identify and perceive illness and bodily symptoms

Risk factors for somatic symptom disorder

- Female sex
- Having anxiety or depression
- Having a medical condition or recovering from one
- Being at risk of developing a medical condition, such as having a strong family history of a disease
- Experiencing stressful life events, trauma or violence
- Having experienced past trauma, such as childhood sexual abuse
- Having a lower level of education and socio-economic status

Clinical Features

- **Pain symptoms:** including headache, back pain, dysuria, joint pain, diffuse pain, and extremity pain
- **Gastrointestinal symptoms**, including nausea, vomiting, abdominal pain, bloating, gas, and diarrhea
- **Cardiopulmonary symptoms**, including chest pain, dizziness, shortness of breath, and palpitations

- **Neurologic symptoms**, including fainting, pseudoseizures, amnesia, muscle weakness, dysphagia, double or blurred vision, difficulty walking, difficulty urinating, deafness, and hoarseness or aphonia
- **Reproductive organ symptoms,** including dyspareunia, dysmenorrhea

Diagnostic criteria of somatic symptom disorder

A DSM-5 diagnosis of somatic symptom disorder requires each of the following criteria:

- A) One or more somatic symptoms that cause distress or psychosocial impairment
- B) Excessive thoughts, feelings, or behaviors associated with the somatic symptoms, as demonstrated by one or more of the following:
    - Persistent thoughts about the seriousness of the symptoms
    - Persistent, severe anxiety about the symptoms or one's general health
    - The time and energy devoted to the symptoms or health concerns is excessive
- C) Although the specific somatic symptom may change, the disorder is persistent (usually more than six months)

Management

- The goal of treatment is to improve the symptoms and ability to function in daily life.

Psychotherapy: Cognitive behavioral therapy can help in:

- Examine and adapt their beliefs and expectations about health and physical symptoms
- Learn how to reduce stress
- Learn how to cope with physical symptoms
- Reduce preoccupation with symptoms
- Reduce avoidance of situations and activities due to uncomfortable physical sensations
- Improve daily functioning at home, at work, in relationships and in social situations

- Address depression and other mental health disorders
- Family therapy may also be helpful by examining family relationships and improving family support and functioning.

Medications

Antidepressant medication can help reduce symptoms associated with depression and pain that often occur with somatic symptom disorder.

When to refer?

- Psychiatric referral — Primary care clinicians suspecting Somatic symptom disorder should consider sending their patients to a psychiatrist for a one-time psychiatric referral as an effective intervention. The referral can clarify the diagnosis and its nonlethal nature, and make specific recommendations for management, such as limiting tests

psychotherapy & Counseling

Why is psychotherapy important in primary care?

in majority of the cases it is the 1st line of treatment

(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.

Counseling:

Helps person to solve stressful problems through decision making

The counselor's role is not to provide solutions to the client's instead he assists the client to choose decision among alternative courses of actions.

Psychotherapy:

The *Oxford English Dictionary* defines it now as "The treatment of disorders of the mind or personality by psychological methods.

INDICATIONS FOR PSYCHOTHERAPY:

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 (eg, losing weight, quitting smoking, or increasing adherence to medical treatment).

5)Helping ameliorate a relational problem.

6)Increasing family cooperation in enhancing treatment.

FORMAT OF PSYCHOTHERAPY:

-Individual therapy:

Individual therapy is the most commonly practiced format of psychotherapy. Individual therapy allows for a confidential interaction between patient and provider, permitting maximal disclosure without fear of others listening or interrupting.

-Couple therapy:

Couple therapy or marital therapy allows two partners to overcome relationship difficulties with the therapist. Specific issues that may be addressed with couple therapy include sexual relations and parenting. It is a valuable adjunctive treatment in some disorders such as depression and substance use disorders

-Family therapy:

Family therapies, in which family members are seen together in treatment, focus on the family system and its ability to help both family problems and individual psychopathology

-Group therapy:

- Group psychotherapy offers supportive networks for people who have similar difficulties

Types:

●Cognitive and behavioral psychotherapies

●Psychodynamic psychotherapy

●Interpersonal psychotherapy

●Motivational interviewing

●Dialectical behavior therapy

Cognitive behavioral therapy (CBT):

-includes several different approaches to therapy, all of which focus on how thinking affects the way a person feels and acts. The idea of cognitive behavioral therapy is that you can change your way of thinking about a situation, and when you do, you also change the way you feel and act.

-CBT often includes education, relaxation exercises, coping skills training, stress management, or assertiveness training.

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.

Interpersonal psychotherapy:

Interpersonal therapy focuses on the behaviors and interactions a depressed patient has with family, friends, co-workers, and other important people encountered on a day-to-day basis.

works well for depression caused by loss and grief, relationship conflicts, major life events, social isolation, or role transitions (such as becoming a mother or a caregiver).

How Does Psychotherapy Help Depression?

-Understand the behaviors, emotions, and ideas that contribute to his or her depression

-Understand and identify the life problems or events -- like a major illness, a death in the family, a loss of a job or a divorce -- that contribute to their depression and help them understand which aspects of those problems they may be able to solve or improve

-Restructure ways of thinking, negative attributes and attitudes someone has about himself, and ways in which faulty thinking may perpetuate depression

-Regain a sense of control and pleasure in life

-Learn coping techniques and problem-solving skills

Questions

1) Nora is 48 years -old has been suffering of low self-esteem, insomnia, poor concentration, lack of interest for her hobbies, and fatigue for more than two year. She is Diabetic. The most likely diagnosis is: -
   a. Major Depressive disorder.
   b. postpartum depression.
   c. Bipolar I mood disorder.
   d. postpartum blue.
   e. Dysthymic disorder

2) DSM-5 diagnostic criteria for generalized anxiety disorder include all of the following except:
   a) The anxiety, worry, or physical symptoms cause clinically significant distress or impairment
   b) The disturbance is not better explained by another mental disorder
   c) Excessive anxiety and worry, occurring more days than not for at least six months
   d) The anxiety is associated with feeling the need to check things repeatedly, perform certain routines repeatedly, or have certain thoughts repeatedly.

3) Somatic Symptom disorder risk factors include all of the following except:
   a) Having anxiety or depression
   b) Experiencing stressful life events, trauma or violence
   c) Having a lower level of education and socio-economic status
   d) Medically Free

4) Which one of the following is the most effective psychotherapy?
   a) Cognitive Behavioral Therapy.
   b) Dialectical Behavioral Therapy.
   c) Interpersonal Therapy.
   d) Counseling.

Answers:

1st Question: E

2nd Question:D

3rd Question:D

4th Question: A