Common Psychiatric Problems

Objectives:

- To understand the prevalence of anxiety, depression, and somatic symptom disorder in Saudi Arabia.
- To understand the etiology of anxiety, depression and somatic symptom disorder.
- To understand the clinical features and management of anxiety in setting a family medicine.
- To understand the clinical features and management of depression in a family medicine setting.
- To understand the clinical features and management of psycho-somatic illness in a family medicine setting.
- To have knowledge of counseling and psychotherapy in the management of common psychiatric problems in family medicine.
- To understand appropriate time to consult a psychiatrist.

Resource:

- oxfords handbook
- 434 team
- Dr.Alzougyr Psychiatry handout

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Anxiety

What is Anxiety?

- "An emotion characterized by feelings of tension, worried thoughts and physical changes like increased blood pressure."
- **When anxiety considered abnormal?** When it occurs in the absence of a stressful trigger, impairs physical, occupational, or social functioning, and/or is excessively severe or prolonged.
- **Generalized Anxiety Disorder**:
  - Anxiety lasting > 6 months unrelated to a specific person, situation, or event.Associated with restlessness, irritability, sleep disturbance, fatigue, muscle tension, difficulty concentrating.

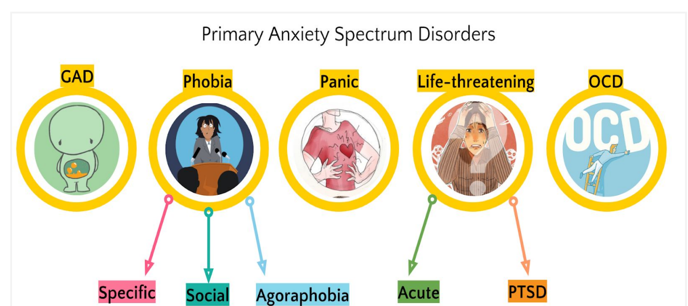
Prevalence:

- According to a study done in Riyadh, with 411 consecutive new patients of both gender, between ages of 16 - 65 years, who came to the selected PHC centers. According to Hospital Anxiety and Depression Scale (HAD), it was found:
  - 15.3% had a score above 11.
  - 15.8% were having borderline anxiety.
- Most of patients with score >11 were: under 25 years old, females, non-saudi, divorced or widowed, well educated.

Etiology:

- **Environmental:** such as difficulties at work, relationship problems, family issues.
- **Genetics:** family members with an anxiety disorder.
- **Medical factors:** symptoms of a different disease, medication effects, stress of an intensive surgery or prolonged recovery.
- **Brain chemistry:** Misalignments of hormones and electrical signals in the brain.
- **Substance withdrawal.**

Clinical features:



Primary Anxiety Spectrum Disorders
(DSM-5 Diagnostic Criteria):

1. Generalized anxiety disorder:

- Excessive anxiety and worry, occurring more days than not for **at least 6 months**, about a number of events or activities.
- 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 6 months): Restlessness, Being easily fatigued, Difficulty concentrating, Irritability, Muscle tension. Sleep disturbance
- 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 (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
- The disturbance is not better explained by another medical disorder.

2. Panic disorder

Panic attacks: “symptoms not disorder”

- Sudden self-limited bouts of intense anxiety, with feeling of death and an urge to escape.
- Physical symptoms: may include chest pain, dizziness, nausea, chills, trembling, and palpitations

Panic disorder: “How to diagnose?”

- Recurrent sudden unexpected panic attacks.
- At least one of the attacks has been followed by **≥ 1 the month** of ≥ one of the following:
  1- Persistent concern about having additional attacks.
  2- Worry about the implications / consequences of the attacks (e.g. going mad or death).
  3- A significant change in behavior related to the be induced by attacks.
- Not due to medical disease, substance abuse or axis I psychiatric disorder.

3. Agoraphobia:

- Anxiety about being in **places** or situations from which escape might be difficult, or in which help would not be readily available in the event of a panic attack (shopping malls, social gathering, tunnels, and public transport).
- Situations are avoided, endured with severe distress, or faced only with the presence of a companion.
- Symptoms cannot be better explained by another mental disorder.
- Functional impairment.

4. Social phobia (social anxiety disorder):

- Marked irrational performance anxiety when a person is exposed to a possible scrutiny by others particularly unfamiliar people or authority figures leading to a desire for escape or avoidance associated with a negative belief of being socially inadequate. The problem leads to significant interference with functioning (social, occupational, academic…). The person has anticipatory anxiety.

5. Specific phobias:

- Persistent irrational fear of a specific object or situation (other than agoraphobia and social phobia) accompanied by strong desire to avoidance, with absence of other psychiatric problems.

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).**
- Patients with obsessive-compulsive disorder may have only obsessions or only compulsions or both obsessions and compulsions.
- Despite patients’ awareness of the irrational nature of their condition, they feel unable to control their obsessions or to prevent their compulsions.
- Recurrent obsessions or compulsions that are severe enough to be time consuming (> 1 hour a day) or causes marked distress or significant impairment.
- The person recognizes that the obsessions or compulsions are excessive and unreasonable.
- The disturbance is not due to the effect of a medical condition, substance or another mental disorder.

7. Acute stress disorder and Posttraumatic stress disorder (PTSD):

- Exposure to a traumatic threatening event (experienced, or witnessed) & response with horror or fear.
- Persistent re-experience of the event (e.g. flashback, recollections, or distressing dreams.
- Persistent avoidance of reminder (activities, places, or people).
- Increased arousal (e.g. hypervigilance, irritability).
- In case of Acute stress disorder: onset is **within 1 month** after exposure to a stressor
  Duration: a minimum of 2 days and a maximum of 4 weeks
- In case of Posttraumatic stress disorder (PTSD): **≥ 1 month** duration of the disturbance.

Management:

★ **Psychosocial:**

- **Cognitive-behavioral therapy**

★ **Pharmacotherapy:**

- **First-line medications:**
  - Selective-serotonin reuptake inhibitors (SSRIs) e.g. paroxetine
  - Serotonin-norepinephrine reuptake inhibitors (SNRIs) e.g. Venlafaxine
- **Second-line medications:**
  - Tricyclic antidepressant e.g. Imipramine
  - Benzodiazepines e.g. diazepam

Depression

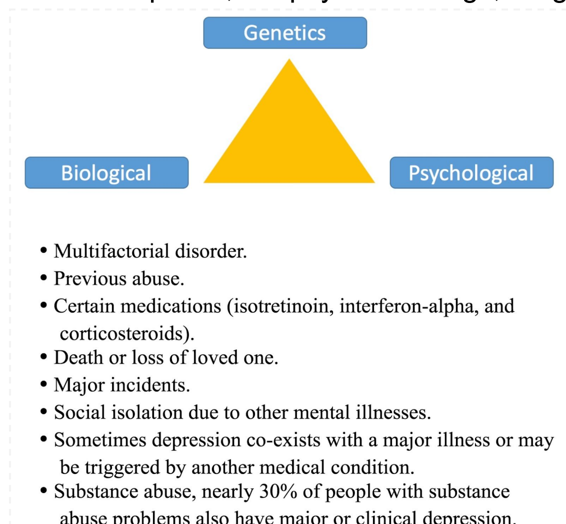
Depressive disorders are characterized by persistent low mood, loss of interest and enjoyment, neurovegetative disturbance, and reduced energy, causing varying levels of social and occupational dysfunction.

Prevalence:

- More common in:
  - Female 2:1 Male
  - young adults
- Depression is estimated to affect **350** million people worldwide (WHO 2012).
- In a study done on 822 male patients that attended Primary Health Care Centers, Eastern Saudi Arabia: The overall prevalence of depression was **32.8%** with **mild** depression accounting for **22.9%.**

Causes and co-morbidity:

- **Psychiatric disorders,** e.g. anxiety, alcohol abuse, substance abuse, eating disorders
- **Physical disorders,** e.g. PD[1], MS, dementia, thyroid disorders, Addison's disease, hypercalcaemia, RA, SlE, cancer, HIV and other chronic infections, cardio- and cerebrovascular disease, learning disability
- **Drugs causing symptoms of depression** β-blockers, anticonvulsants, Ca 2+ channel blockers, corticosteroids, oral contraceptives, antipsychotic drugs, drugs used for PD (e.g. levodopa)



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[1] Parkinson's disease.

Clinical Features and Diagnosis:

Depressive features/symptoms include:

- Depressed mood
- Anhedonia: inability to feel pleasure in normally pleasurable activities
- Weight changes (overeating or undereating)
- Libido changes
- **Sleep disturbance** (over sleeping or under sleeping)
- Psychomotor problems
- Low energy
- Excessive guilt
- Poor concentration
- Suicidal ideation

Screening questions for depression PHQ-9

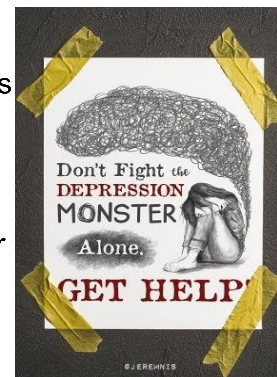
Assessing severity of depression:

Can be done using a depression symptom count or patient self-complete measure, such as the PHQ-9

- **Subthreshold:** depressive symptoms Fewer than 5 symptoms of depression (PHQ-9 of <5)
- **Mild** depression: ≥5 symptoms of depression that result in only mild functional impairment (PHQ-9 of 5–9)
- **Moderate** depression: Symptoms or functional impairment are between 'mild' and 'severe' (PHQ-9 of 10–14 indicates moderate depression; PHQ-9 of 15–19 indicates moderately severe depression)
- **Severe** depression: Most symptoms and the symptoms markedly interfere with functioning ± psychotic symptoms (PHQ-9 ≥20)

DSM-IV-TR Criteria:
1. Major Depressive Disorder
• Presence of a single or more major depressive episode (each separated by at least 2 months) for at least 2 weeks. • 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.
2. Major Depressive Episode
A. 5 of the mentioned clinical features & at least one of the symptoms is either a. depressed mood or b. 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.
3. 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.

Management:



- Step 1 In all patients—assess severity. Provide education about depression and information about support available to both the patient and carers/family members as appropriate.
- Discuss treatment options:
    - If **sleep is a problem** Discuss sleep hygiene , establish regular sleep/wake times; avoid excess eating, smoking, or alcohol before sleep; create a proper environment for sleep; take regular exercise.
    - **Subthreshold or mild depression** Active monitoring watchful waiting **for <2wk** to see if spontaneous recovery occurs. Simple problem-solving strategies may be useful in the GP surgery.

- Stepe 2 Persistent subthreshold or mild/moderate depression.
    - Low-intensity psychosocial interventions
    - Drug treatment Do not use routinely for subthreshold/mild depression—consider if: past history of moderate/severe depression; subthreshold symptoms that have been present >2y; subthreshold/mild depression that persists after other interventions
- Step 3 Moderate/severe depression or mild/subthreshold depression that has not responded to treatment.
    - High-intensity psychological interventions
    - Drug treatment Usually SSRI[2]
    - **Combined** treatments Antidepressant medication + high-intensity psychological intervention
- Step 4 Referral to psychiatry **U = Urgent; S = Soon; R = Routine**
    - High suicide risk—**U**
    - Severe self-neglect—**U**
    - Depression complicated by psychotic symptoms—**U**
    - Depression complicated by significant psychiatric co-morbidity or psychosocial factors—**R/S**
    - Inadequate response to multiple treatments—**R**

Pharmacological Therapy

- Usually 3-5 weeks for desired effect, but unfortunately side effects can start within few days.
- Selective Serotonin Reuptake Inhibitors **(SSRI):**
    - Usually **first choice** as less likely to be discontinued due to side effects and safer in overdose.
    - Elderly people—particularly those taking SSRIs—are prone to **hyponatremia** when taking antidepressants.
    - Warn of possible short-term in anxiety/agitation when starting medication and advise patients to stop if significant. GI side effects, including dyspepsia are common.
    - Consider co-prescribing a PPI for stomach protection if >60y or other risk factors for GI bleeding

- Selective Serotonin–Norepinephrine Reuptake Inhibitors **(SNRI):**(e.g. Venlafaxine, Duloxetine)
    - Avoid if uncontrolled hypertension. Venlafaxine is also contraindicated if high risk of arrhythmia.

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

- Tricyclic and related antidepressants **(TCAs):**
    - Common side effects include drowsiness, dry mouth, blurred vision, constipation, urinary retention, and sweating.
        - Use with caution for patients with CVD because of risk of arrhythmia, patients with prostatic hypertrophy (risk of retention), and patients with raised intraocular pressures (risk of acute glaucoma).

[2] Only fluoxetine has been shown to be of benefit for the treatment of depression in children

Psychological Therapy :

- Supportive Therapy.
- Cognitive & Behavior Therapy.

Electroconvulsive Therapy (ECT) :

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

Somatic symptoms disorders (somatization)

What is Somatic Symptom Disorder?

- Multiple somatic symptoms (affecting multiple organ system) that cannot be explained adequately based on physical examination and laboratory investigations. The symptoms are not intentionally produced. The disorder is chronic .
- It is a associated with excessive medical help-seeking behavior.
- It leads to significant distress and functional impairment (social, occupational…)

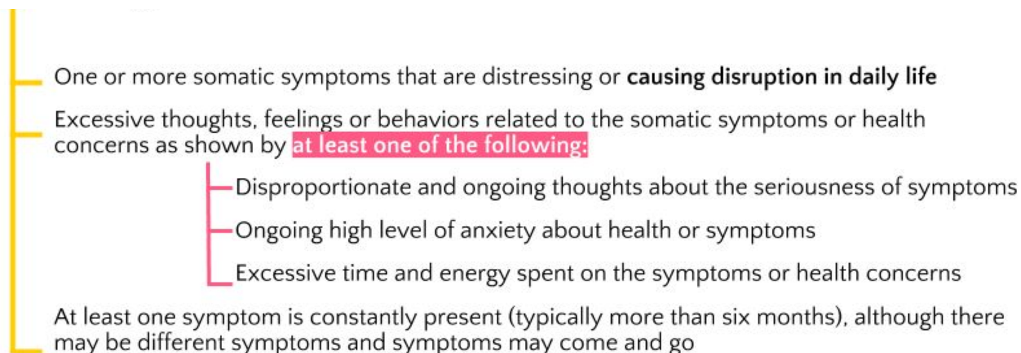
Epidemiology:

- Women > men 5 – 10 : 1.
- The lifetime prevalence in the general population is about 2%.
- More common in patients who bottle up their emotions and are less assertive.

Etiology:

- Faulty perception and assessment of somato-sensory inputs due to characteristic attention impairment.
- Displacement of unpleasant emotions into a physical symptom.
- Alleviation of guilt through suffering to obtain attention or sympathy.

Diagnostic criteria:



Management of somatization disorder

- Reattribution involves acknowledging/taking symptoms seriously, offering necessary examination and investigations, asking about psychosocial problems, and explaining the link between symptoms and stress
- Treat comorbid psychiatric problems (e.g. depression, anxiety, panic)
- Refer to the specialist mental health team if risk of suicide, marked functional impairment, impulsive or antisocial behaviour

Other related disorders:

Illness anxiety disorder	involves a person preoccupied with having an illness or getting an illness – constantly worrying about their health. They may frequently check themselves for signs of illness, focus on health behaviors and take extreme precautions to avoid health risks. This condition was previously referred to as "hypochondriasis." Unlike somatic symptom disorder, a person with illness anxiety disorder generally doesn't experience symptoms.
Conversion disorder	is a condition in which symptoms affect a person's perception, sensation or movement with no evidence of a physical cause. A person may have numbness, blindness or trouble walking. The symptoms tend to come on suddenly and may last for a while or may go away quickly. People with conversion disorder also frequently experience depression or anxiety disorders.
Factitious disorder	involves a person producing or faking physical or mental illness when he/she is not really sick, or intentionally making a minor illness worse. A person with factitious disorder may also create an illness or injury in another person. For example a person might fake the symptoms of a child in his/her care. The person may or may not seem to benefit from the situation they create.

Psychotherapy

- **Problem-solving therapy (PST):** drawing up a list of problems and generating and agreeing solutions, broken down into steps.
- **Cognitive behaviour therapy**
  - Behavioural therapies.
  - Cognitive therapy.
- **Individual non-facilitated self-help:** involves a self-help resource (usually a book, workbook or online) usually with minimal therapist contact, for example an occasional short telephone call of no more than 5 minutes.
- **Guided self-help:** uses books/printed materials under the supervision of a trained facilitator who introduces, monitors, then reviews the outcome of each treatment.
- **Mindfulness-based cognitive therapy:** Skills training programme designed to enable patients to prevent the recurrence of depression.
- **Behavioural activation:** Therapist and patient work together, with the aim of identifying effects that the patient's behaviour might have on symptoms, mood, and problems.
- **Interpersonal therapy (IPT):** Individual or group therapy concentrating on the difficulties that arise in maintaining relationships with others. Focusses on current, not past, relationships and works on the premise that if interpersonal conflicts are resolved.
- **Psychoeducational Group therapy:** can be used to explore depression or chronic physical health conditions, e.g. diabetes. Run by trained practitioners, they also involve the element of peer support.
- **Applied relaxation:** Group or individual therapy that teaches patients to relax quickly in different situations