Common psychiatric problems

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Objectives:

- Estimate the prevalence of anxiety, depression ,and somatic symptom disorder in Saudi Arabia
- Explain the aetiology of anxiety, depression and somatic symptom disorder
- Interpret the clinical features of anxiety, depression and somatic symptom disorder in a family medicine setting
- Design a management plan for anxiety, depression and somatic symptom disorder.
- Summarize about the role of counselling and psychotherapy in the management of common psychiatric problems.
- Judge when to refer patients to Psychiatrist.

Anxiety

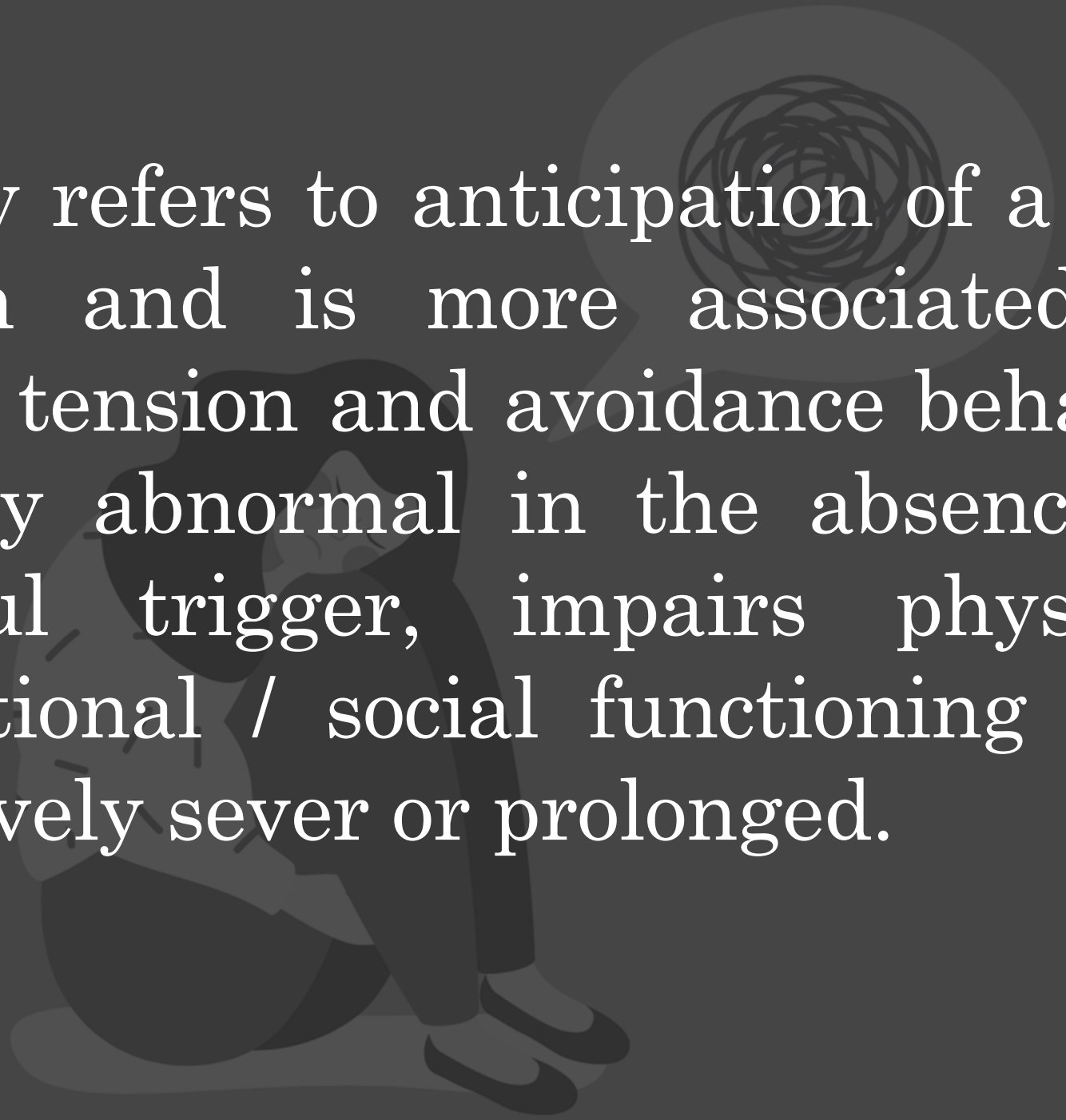
Table 2. GAD-7 Screening Tool

Over the last 2 weeks, how often have you been bothered by the following problems?	*Not at all*	*Several days*	*More than half the days*	*Nearly every day*
(Use "✓" to indicate your answer)				
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total score _____	= ____	+ ____	+ ____	+ ____

NOTE: *Total score for the 7 items ranges from 0 to 21. Scores of 5, 10, and 15 represent cutoffs for mild, moderate, and severe anxiety, respectively. Although designed primarily as a screening and severity measure for GAD, the GAD-7 also has moderately good operating characteristics for panic disorder, social anxiety disorder, and posttraumatic stress disorder. When screening for anxiety disorders, a recommended cutoff for further evaluation is a score of 10 or greater.*

GAD = generalized anxiety disorder.

Reprinted from Spitzer RL, Williams JB, Kroenke K, et al., with an educational grant from Pfizer Inc. Patient health questionnaire (PHQ) screeners. http://www.phqscreeners.com/overview.aspx?Screener=03_GAD-7. Accessed July 22, 2014.



Anxiety refers to anticipation of a future concern and is more associated with muscle tension and avoidance behaviour, it's only abnormal in the absence of a stressful trigger, impairs physical / occupational / social functioning and/or excessively sever or prolonged.

Prevalence

- **Saudi Arabia:**

(2012) 822 males who attended PHC centres were the sample of a study that took place in Eastern Saudi Arabia. The study shows an overall prevalence of 22.3% with 17% of the attendees having a mild degree of anxiety.

- **US:**

Anxiety disorders are the most common mental illness, affecting 40 million adults in the United States age 18 and older, or 18.1% of the population every year.

Aetiology

Biological causes	Psychological causes	Social causes
• Genetics • Medications (cocaine, LSD, decongestants, Caffeine, steroids)	• Personality traits • Low self-esteem	• Work stress • Lack of social support • Childhood trauma

Common Clinical Features

All anxiety disorders share some general symptoms:

- Panic, fear, and uneasiness
- Sleep problems
- Not being able to stay calm and still
- Cold, sweaty, numb or tingling hands or feet
- Shortness of breath
- Heart palpitations
- Dry mouth
- Nausea
- Tense muscles
- Dizziness

Anxiety disorders:

- Generalized anxiety disorder
- Obsessive compulsive disorder (OCD)
- Panic disorder
- Post traumatic stress disorder
- Social phobia

Generalized anxiety disorder

- It is characterized by excessive, exaggerated anxiety and worry about everyday life events with no obvious reasons for worry.
- The worry is often unrealistic or out of proportion for the situation. Daily life becomes a constant state of worry, fear, and dread.
- Eventually, the anxiety so dominates the person's thinking that it interferes with daily functioning, including work, school, social activities, and relationships.
- GAD affects 6.8 million adults, or 3.1% of the U.S. population, in any given year. Women are twice as likely to be affected.

Table 1. Diagnostic Criteria for Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. 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):

Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. 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).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Diagnosis criteria DSM-5

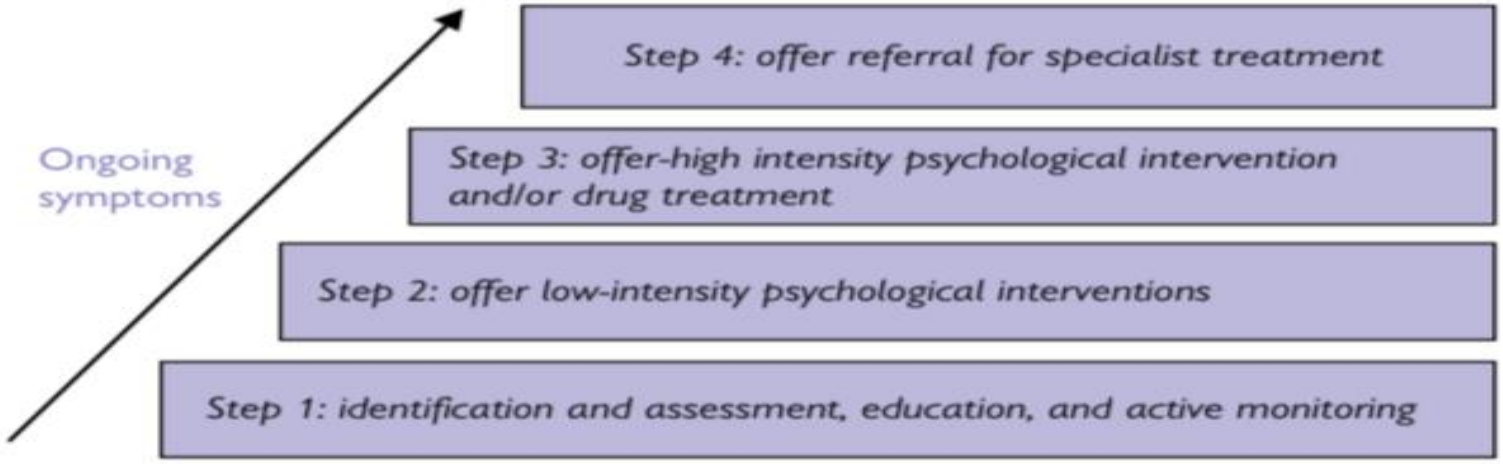
Management of GAD

- Avoid caffeine, excess alcohol, and illicit drugs
- Use a stepped treatment approach (see Figure next slide)
- Provide information about self-help organizations / support groups
- Try to identify causes of anxiety

Management of GAD

Psychological therapies 📖 p. 990

- **Low intensity**—individual non-facilitated self-help; individual guided self-help; psychoeducational groups
- **High intensity**—CBT or applied relaxation



❗ Offer the least obtrusive, most effective treatment first

Management of GAD

Drug treatment

- SSRIs (e.g. sertraline 50–150mg od)—warn patients medication may take >1wk to work and of possible side effects (short-term ↑ in anxiety; GI symptoms). If >60y or other risk factors for GI bleeding, consider co-prescribing a PPI
- Follow-up every 2–4wk in the first 3mo then every 3mo
- If drug treatment is effective, continue for >1y
- If no benefit, consider alternative SSRI/SNRI or adding a psychological therapy; pregabalin is an option if unable to tolerate SSRI/SNRI. Do not offer antipsychotic medication
- Avoid benzodiazepines except for acute crises; restrict use to <4wk

⚠ Patients <30y may have ↑ suicidal thoughts when they start an SSRI/SNRI—warn about this risk and follow-up <1wk after starting medication and then weekly for 1mo to monitor suicide/self-harm risk.

Refer to specialist mental health services if severe anxiety with marked functional impairment plus:

- Risk of self-harm/suicide, or
- Significant co-morbidity (e.g. substance misuse, personality disorder or complex physical health problems), or
- Self-neglect, or
- Inadequate response to step 3 interventions

Panic disorder

- characterized by episodic, unexpected panic attacks that occur without a clear trigger. Panic attacks are defined by the rapid onset of intense fear (typically peaking within about 10 minutes) with at least four of the physical and psychological symptoms in the DSM-5 diagnostic criteria
- Another requirement for the diagnosis of PD is that the patient worries about further attacks or modifies his or her behaviour in maladaptive ways to avoid them. The most common physical symptom accompanying panic attacks is palpitations. Although unexpected panic attacks are required for the diagnosis, many patients with PD also have expected panic attacks, occurring in response to a known trigger

Table 3. Diagnostic Criteria for Panic Disorder

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or "going crazy."
13. Fear of dying.

Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").
2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

C. 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, cardiopulmonary disorders).

D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-

Diagnosis criteria DSM-5

Management of panic disorder

Management of panic disorder Use a stepped treatment approach:

- **Step 1** Recognition and diagnosis. Educate about the condition, signpost to support in the community, and discuss treatment options. Commence active monitoring. Avoid alcohol, illicit drugs, and caffeine
- **Step 2** Treatment in primary care—offer (in order of effectiveness) psychological therapy (CBT), drug treatment or self-help (bibliotherapy or CCBT). Choice depends on severity of symptoms, co-morbidities and patient preference
- **Step 3** Consideration of alternative treatment—if one step 2 treatment is ineffective, change to or add another
- **Step 4** Offer referral for specialist treatment if ≥2 primary care treatments have failed

Drug treatment ❗ Do not use benzodiazepines for treatment of patients with panic disorder—associated with poorer long-term outcome.

- Offer SSRI, e.g. paroxetine, citalopram. Warn about possible transient ↑ in anxiety on starting treatment. Minimize initial side effects by starting at low dose and ↑ slowly. Review in <2wk and at 4, 6, and 12wk
- If SSRI is not suitable or ineffective, offer a TCA (e.g. imipramine, clomipramine) or non-drug treatment
- If effective, continue for ≥6mo, reviewing every 8–12wk
- Minimize discontinuation symptoms by tapering dose over time

Obsessive compulsive disorder (OCD)

It is characterized by recurrent, unwanted thoughts (obsessions) and/or repetitive behaviours (compulsions). Repetitive behaviours such as hand washing, counting, checking, or cleaning are often performed with the hope of preventing obsessive thoughts or making them go away. Performing these so-called "rituals," however, provides only temporary relief, and not performing them markedly increases anxiety.

Management of OCD

Management in adults

- **Mild functional impairment** Offer short CBT (<10h), including exposure-response prevention (ERP) or group therapy
- **Moderate functional impairment** Offer more intensive CBT (>10h) or drug therapy (SSRI, e.g. fluoxetine 20–40mg od)
- **Severe functional impairment** Offer psychological therapy + drug treatment. If inadequate response at 12wk, offer a different SSRI or clomipramine. Refer if symptoms persist

Management in children and young people

- **Mild functional impairment** Consider guided self-help. Include support and help for family and carers
- **Moderate/severe functional impairment** Offer CBT including ERP adapted to patient's age in a group or individual setting. Refer if symptoms do not improve. Drug therapy should only be initiated in secondary care

Post-Traumatic Stress Disorder

It is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or human-caused disasters, accidents, or military combat.

Management of PTSD

Management Treat any other associated psychiatric illness.

- **Watchful waiting** If mild symptoms have been present <4wk. Be supportive and listen. Arrange follow up in <1mo
- **Trauma-focussed psychological treatment** CBT and/or eye movement desensitization and reprocessing (EMDR). Refer if severe symptoms <4wk or ongoing intrusive symptoms >4wk after trauma
- **Drug treatment** (e.g. paroxetine, mirtazapine) Not first-line treatment. Reserve for those refusing or with continuing symptoms despite psychological therapy

❗ Debriefing after traumatic events is unhelpful.

Social Phobia

- It is an anxiety disorder characterized by overwhelming anxiety and excessive self-consciousness in everyday social situations. Social phobia can be limited to only one type of situation - such as a fear of speaking in formal or informal situations, or eating or drinking in front of others or, in its most severe form, may be so broad that a person experiences symptoms almost anytime they are around other people.
- There are three types of phobia recognized by the American Psychiatric Association including:

1. Specific Phobia: simple phobia characterized by irrational and out of proportion fear to specific object or situation (e.g. animals, insects, blood, needles, flying, heights).
2. Social Phobia: Profound fear of public humiliation and being singled out or judged by others in a social situation.
3. Agoraphobia: The fear of being alone in public places, particularly places from which a rapid exit would be difficult or help might not be available.

Phobias As GAD but limited to certain situations. 2 main features:

- **Avoidance** Of the circumstances that provoke anxiety
- **Anticipatory anxiety** If there is a prospect of meeting that situation

Simple phobia Inappropriate anxiety in the presence of ≥1 object/situation, e.g. flying, enclosed spaces, spiders. Common in early life; most adult phobias are a continuation of childhood phobias. *Lifetime prevalence*: 4% ♂; 13% ♀.

Management Treatment is only needed if symptoms are frequent, intrusive, or prevent necessary activities. Exposure therapy is effective. Obtain through psychological therapy services or through the private sector, e.g. British Airways' 'fear of flying' course.

Social phobia Intense/persistent fear of being scrutinized or negatively evaluated by others leads to fear and avoidance of social situations (e.g. using a telephone, speaking in front of a group). Significantly disabling; not just shyness. May be generalized (person fears most social situations) or specific (related to certain activities only).

Management

- **Drug therapy** SSRIs—continue ≥12mo or long-term if symptoms remain unresolved, there is a co-morbid condition (e.g. depression, GAD, panic attacks), a history of relapse, or early onset
- **Psychological therapies** CBT (cognitive restructuring) ± exposure

Agoraphobia Onset is often aged 20–40y with an initial panic attack. Subsequently, panic attacks, fear of fainting and/or loss of control are experienced in crowds, away from home, or in situations from which escape is difficult. Avoidance results in patients remaining within their homes where they know symptoms will not occur. Other symptoms include depression, depersonalization, and obsessional thoughts.

Management Difficult to manage in general practice. Diagnosis is often delayed as patients will not come to the surgery and ongoing management complicated by refusal to be referred to psychiatric services. Prognosis is best when there is good marital/social support. *Options:*

- **Behaviour therapy,** e.g. exposure, coping with panic attacks. Home visits may be required but should be resisted as part of therapy
- **Drug treatment** SSRIs (citalopram and paroxetine are licensed); MAOIs; TCAs (imipramine and clomipramine are commonly used). Relapse rate is high. Benzodiazepines can be used if frequent panic attacks, particularly if initiating other treatment but beware of dependence

Management of phobias

Management of anxiety

1. Education.
2. lifestyle modifications
3. Medications.

- Antidepressant: SSRIs (e.g. paroxetine) or SNRIs (e.g. Venlafaxine).
- Buspirone: effective in reducing cognitive symptoms of GAD.
- Benzodiazepines.

4. Psychotherapy And Relaxation Therapies:

- Cognitive behaviour therapy.
- Mindfulness-based stress reduction.

depression

TABLE 3

PHQ-9 Screening Instrument for Depression

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed; or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Scoring: 1 to 4 points = minimal depression, 5 to 9 points = mild depression, 10 to 14 points = moderate depression, 15 to 19 points = moderately severe depression, 20 to 27 points = severe depression.

PHQ = Patient Health Questionnaire.

Adapted from Patient Health Questionnaire (PHQ) screeners. http://www.phqscreeners.com. Accessed February 8, 2018.

Screening of depression PHQ-9

Depression is a common and serious medical illness that negatively affects how you feel, the way you think and how you act. Fortunately, it is also treatable. Depression causes feelings of sadness and/or a loss of interest in activities once enjoyed. It can lead to a variety of emotional and physical problems and can decrease a person's ability to function at work and at home.

Prevalence

- **Saudi Arabia:**

(2012) 822 males who attended PHC centres were the sample of a study that took place in Eastern Saudi Arabia. The overall prevalence of depression was 32.8% with mild depression accounting for 22.9%

- **US:**

Depression affects an estimated **one in 15 adults (6.7%)** in any given year. And **one in six people (16.6%)** will experience depression at some time in their life. Depression can strike at any time, but on average, first appears during the **late teens to mid-20s**. Women are more likely than men to experience depression. Some studies show that one-third of women will experience a major depressive episode in their lifetime.

Aetiology

Depression can affect anyone !

Several factors can play a role in depression:

Medications :

isotretinoin and corticosteroids.

Genetics:

Depression can run in families. For example, if one identical twin has depression, the other has a 70 percent chance of having the illness sometime in life.

Personality:

- low self-esteem.
- overwhelmed by stress.

Environmental factors:

exposure to violence, neglect, abuse or poverty.

Clinical features (DSM-5)

DSM-5 Diagnostic Criteria for Major Depressive Disorder

Depressed mood **and/or** loss of interest or pleasure **(A MUST).**

Appetite or weight change (5% change over 1 month).

Insomnia or hypersomnia.

Psychomotor agitation or retardation.

Fatigue or loss of energy.

Feeling worthlessness or excessive guilt.

Diminished concentration.

Recurrent thoughts of death or any suicide attempt.

Clinical Features

A. Five (or more) of the above symptoms have been present during the same 2-week period and represent a change from previous functioning; 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 episode is not attributable to the physiological effects of a substance or to another medical condition.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders

E. There has never been a manic episode or a hypomanic episode

Management

- **Mild** depression (PHQ-9 of 5-9): Usually managed by psychological therapy alone.
- **Moderate** depression (PHQ-9 of 10-14): Psychological therapy and/or antidepressant.
- **Severe** depression (PHQ-9 of >20): Antidepressant, and consider addition of psychological therapy to maintain remission.

Management

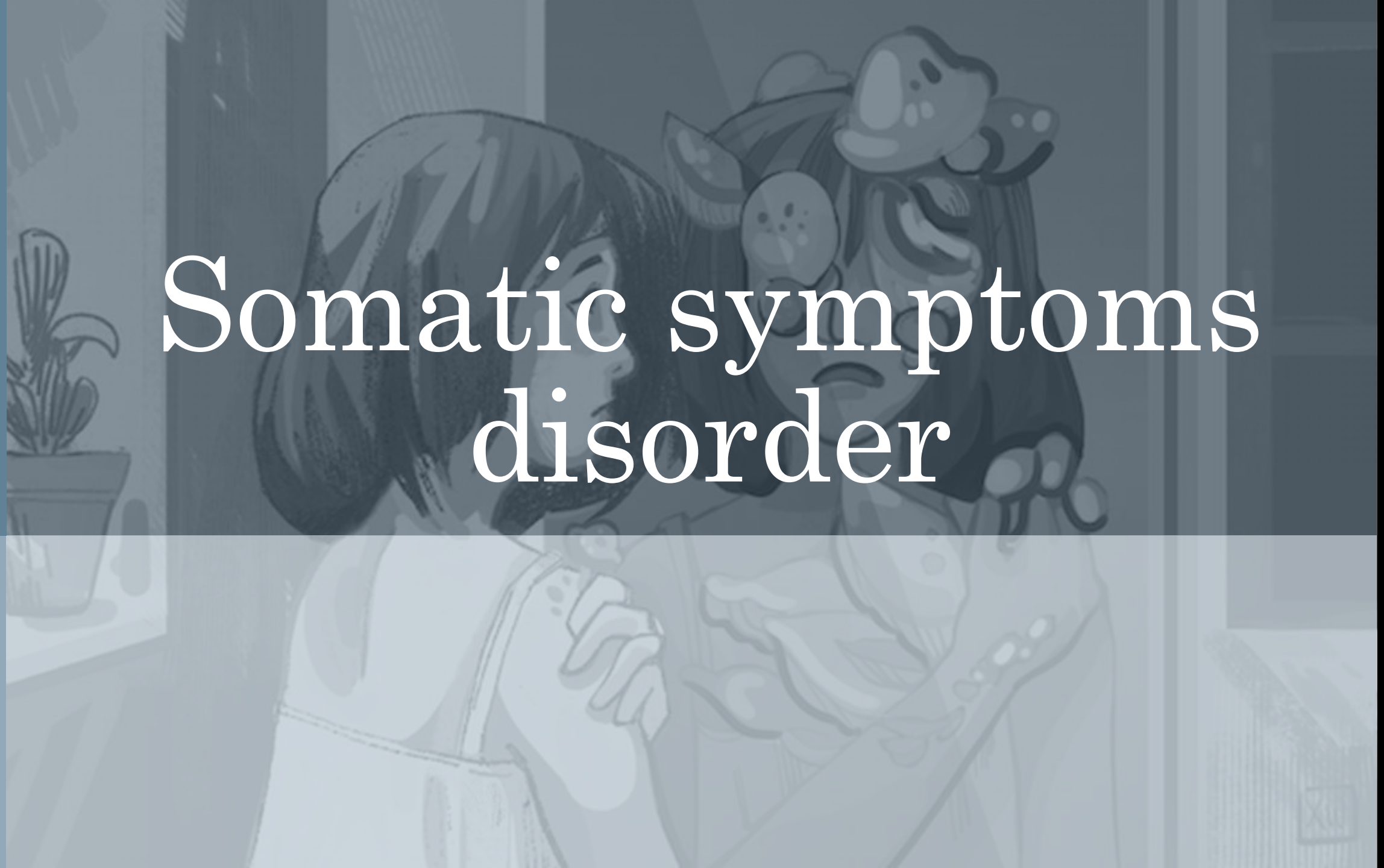
Medications : (Usually, 2–12 weeks at a therapeutic dose, with assumed adherence to the regimen, are needed for a clinical response to become evident)

- Selective serotonin reuptake inhibitors (**SSRIs**): (fluoxetine, paroxetine) the **initial antidepressants of choice**
- Serotonin/norepinephrine reuptake inhibitors (**SNRIs**): (venlafaxine, duloxetine) in patients with **significant fatigue or pain syndromes** associated with the episode of depression..
- Atypical antidepressants: (bupropion) has the advantage over the SSRIs of causing less sexual dysfunction and less GI distress.

Management

Psychological therapy:

- Interpersonal psychotherapy (IPT)
- Cognitive behaviour therapy (CBT)
- Problem-solving therapy (PST)
- Behavioural activation (BA)/contingency management



Somatic symptoms disorder

screening of SSD

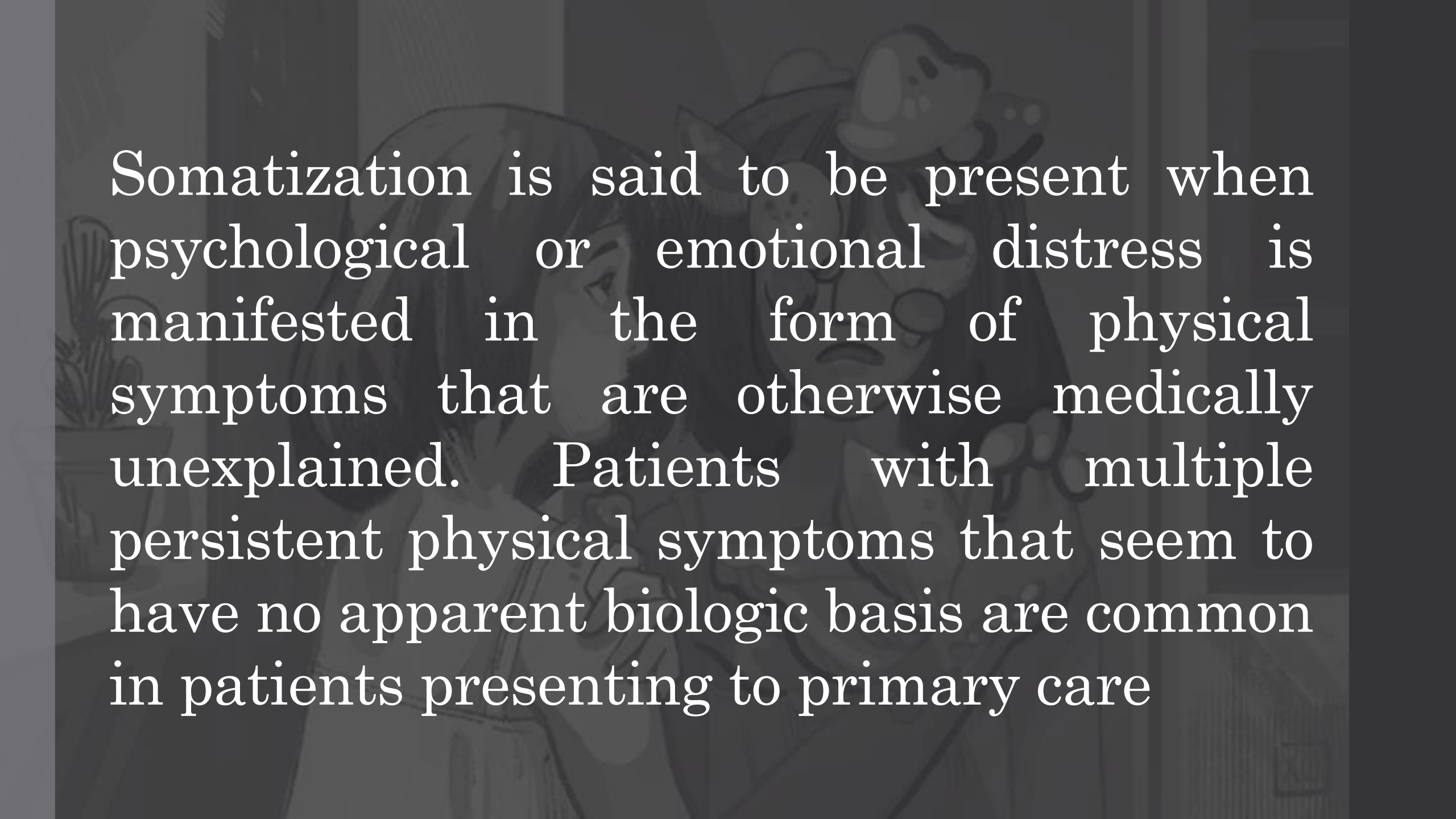
Table 3. The Somatic Symptom Scale-8

During the past seven days, how much have you been bothered by the following symptoms?

Symptom	*Not at all*	*A little bit*	*Somewhat*	*Quite a bit*	*Very much*
Back pain	0	1	2	3	4
Chest pain or shortness of breath	0	1	2	3	4
Dizziness	0	1	2	3	4
Feeling tired or having low energy	0	1	2	3	4
Headaches	0	1	2	3	4
Pain in your arms, legs, or joints	0	1	2	3	4
Stomach or bowel problems	0	1	2	3	4
Trouble sleeping	0	1	2	3	4
Score:	_____				

Scoring: None to minimal (0 to 3); low (4 to 7); medium (8 to 11); high (12 to 15); very high (16 to 32).

Adapted with permission from Gierk B, Kohlmann S, Kroenke K, et al. The Somatic Symptom Scale-8 (SSS-8): a brief measure of somatic symptom burden. JAMA Intern Med. *2014;174(3):400.*



Somatization is said to be present when psychological or emotional distress is manifested in the form of physical symptoms that are otherwise medically unexplained. Patients with multiple persistent physical symptoms that seem to have no apparent biologic basis are common in patients presenting to primary care

Prevalence

- **Saudi Arabia:**

1. (2008) A study was performed in Asir region 2008, of the 227 patients who were approached, the prevalence of somatization detected by general health questionnaire was 16%

2. (2002) Another cross sectional study in 2002 of 431 male and female Saudi Arabian primary care patients revealed that The prevalence of somatization in a primary care population in Saudi Arabia is 19.3% which is similar to published rates in the U.S. and worldwide

- **US**:

1. The prevalence of somatic symptom disorder (SSD) is estimated to be 5-7% of the general population, with higher female representation (female-to-male ratio 10:1), and can occur in childhood, adolescence, or adulthood. The prevalence increases to approximately 17% of the primary care patient population.

Aetiology & associated Co-morbidities

The aetiology of somatic symptom disorder is unclear. However, higher percentages of SSD has been found in persons with:

- Depression
- Irritable bowel syndrome
- Fibromyalgia
- Chronic pain
- Childhood neglect
- Post-traumatic stress disorder
- Antisocial personality disorder
- History of sexual or physical abuse

Clinical Features

Cardiac
- Shortness of breath
- Palpitations
- Chest pain

Gastrointestinal
- Vomiting
- Abdominal pain
- Difficulty swallowing
- Nausea
- Bloating
- Diarrhea

Musculoskeletal
- Pain in the legs or arms
- Back and joint pain

Neurological
- Headaches
- Dizziness
- Amnesia
- Vision changes
- Paralysis or muscle weakness

Table 1. Somatic Symptom Disorder

Diagnostic criteria:

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

   1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
   2. Persistently high level of anxiety about health or symptoms.
   3. Excessive time and energy devoted to these symptoms or health concerns.

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Specify if:

With **predominant pain** (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

Specify if:

Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).

Specify current severity:

Mild: Only one of the symptoms specified in Criterion B is fulfilled.

Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.

Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

Reprinted with permission from the American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. *5th ed. Washington, DC: American Psychiatric Association; 2013:311.*

Diagnosis of SSD

Management

Table 4. CARE MD Approach to Somatic Symptom Disorder

Component	*Description*
Consultation (psychiatry or cognitive behavior therapy)	Consult and collaborate with mental health professionals
Assessment	Evaluate for other medical and psychiatric diseases
Regular visits	Schedule short-interval follow-up to stop overuse of medical care (e.g., inappropriate emergency department visits, excessive calls) and avoid the need for symptoms to get an appointment; stress coping rather than cure
Empathy	Spend most of the time listening to the patient and acknowledge that what he or she is feeling is real
Medical-psychiatric interface	Emphasize the mind-body connection; avoid comments such as "there is nothing medically wrong with you"
Do no harm	Limit diagnostic testing and referrals to subspecialists; reassure the patient that serious medical diseases have been ruled out

Information from reference 17.

The management of somatic symptom disorders requires a multifaceted approach tailored to the individual patient. To choose the correct treatment plan, primary care clinicians should keep in mind psychological, social, and cultural factors that influence somatic symptoms.

Management

The components of SSD currently treated include the following:

- Somatic symptoms
- Rumination and anxiety related to the health concerns

Interventions for these components include:

- Psychiatric consultation intervention (PCI)
- Cognitive based therapy (CBT)
- Behavioural techniques (relaxation training and mindfulness)
- Psychotropic medications

Management

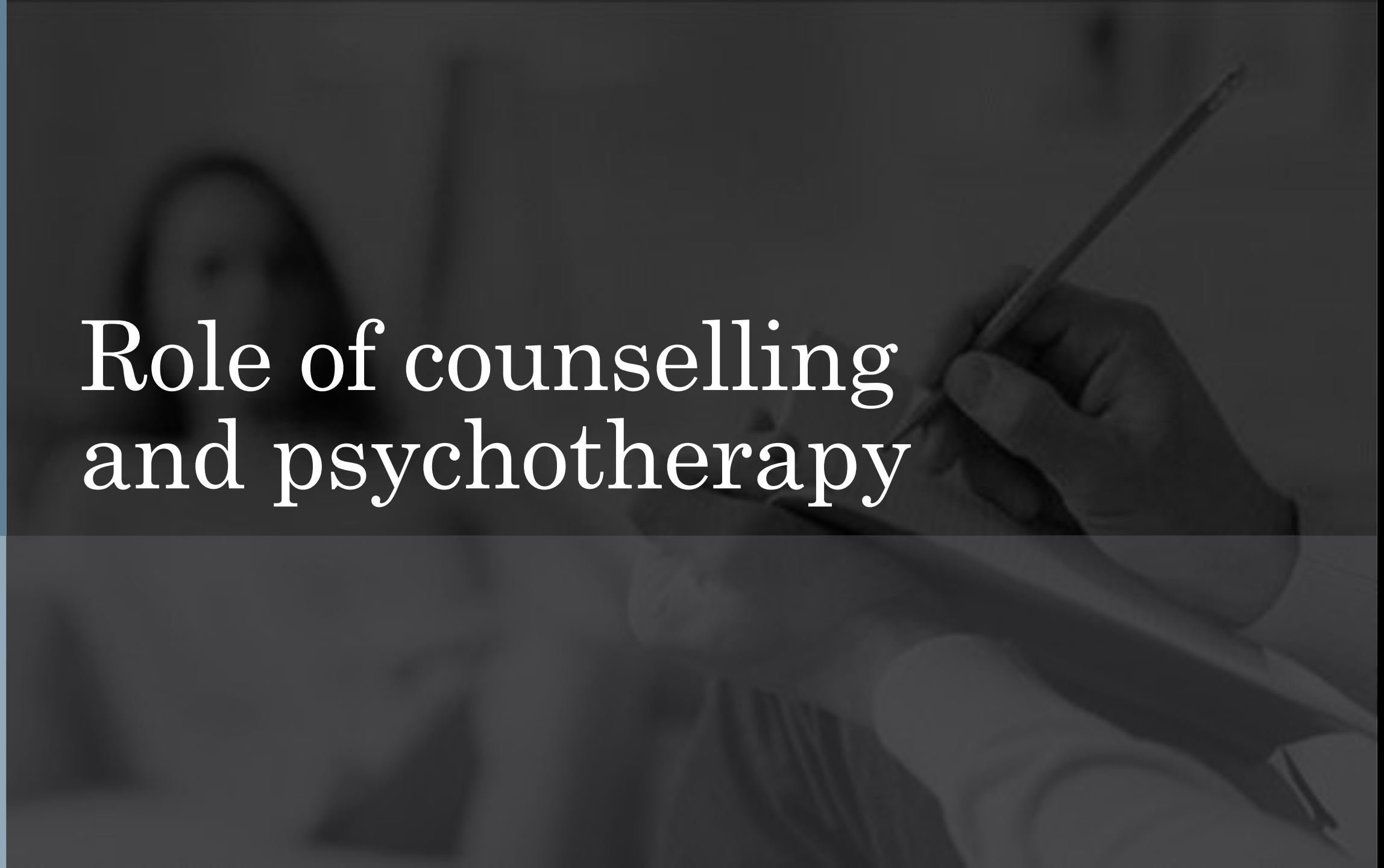
The most effective treatments according to the American Family Physician are:

1. CBT
2. Mindfulness-based therapy
3. Pharmacological: systematic reviews of controlled trials support the use of antidepressants for the treatment of somatic symptom disorder

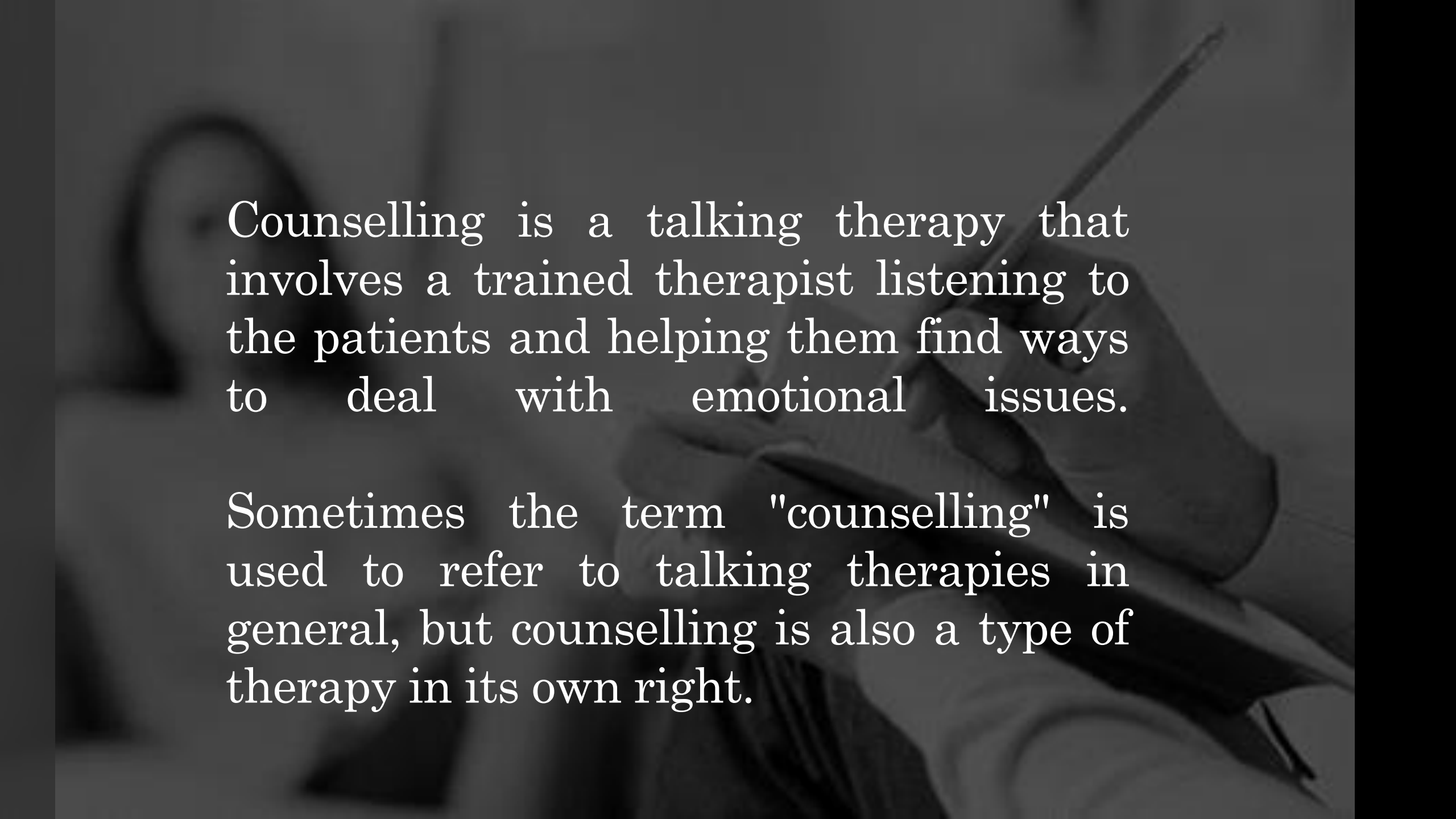
-TCA: **Amitriptyline**

- SSRI: **Fluoxetine**

- Monoamine oxidase inhibitors, bupropion (Wellbutrin), antiepileptics, and antipsychotics should not be used since that they showed no benefit.



Role of counselling and psychotherapy

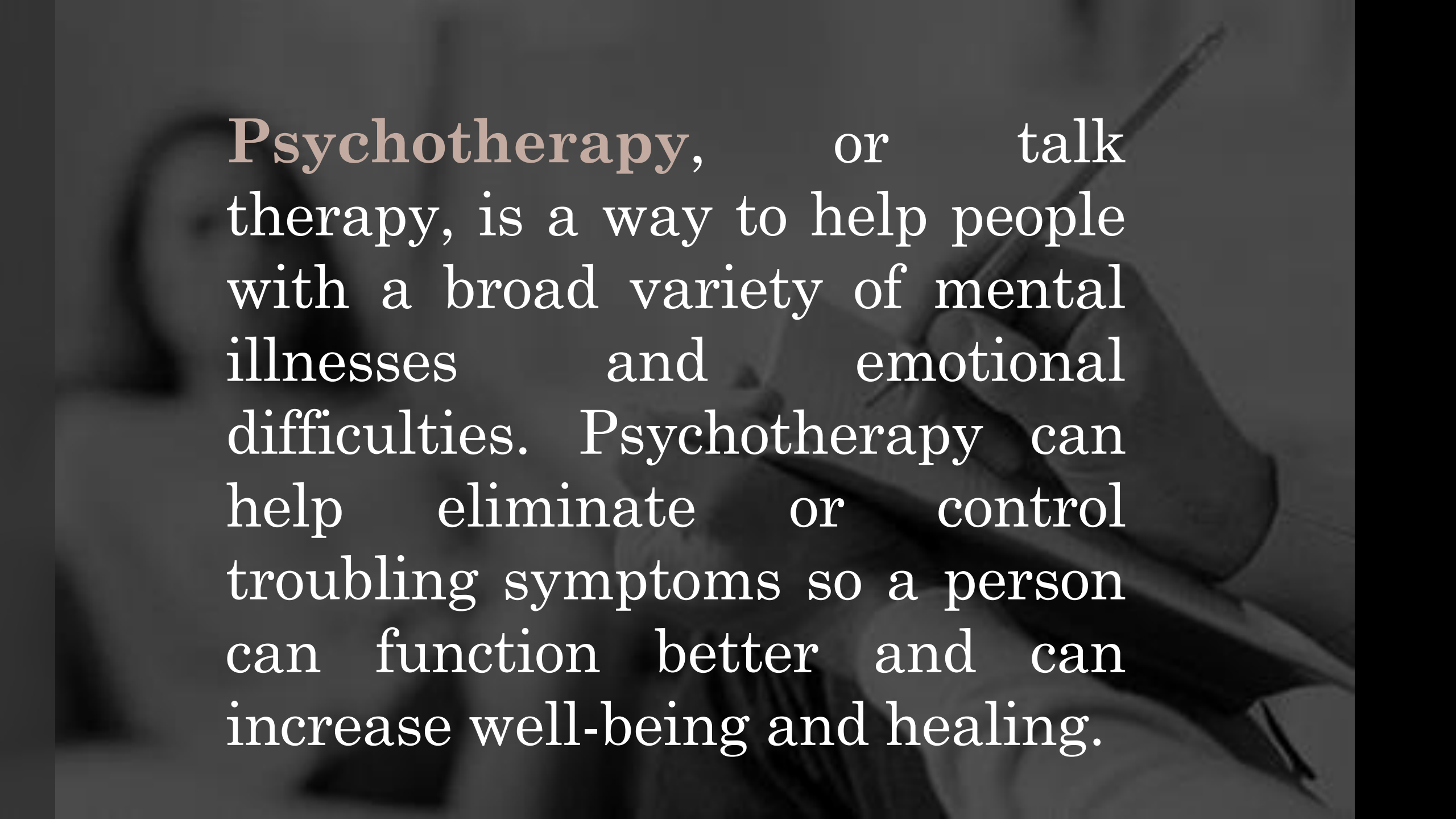


Counselling is a talking therapy that involves a trained therapist listening to the patients and helping them find ways to deal with emotional issues.

Sometimes the term "counselling" is used to refer to talking therapies in general, but counselling is also a type of therapy in its own right.

Types of counselling

- Individual counselling
- Couples counselling
- Family counselling
- Group counselling



Psychotherapy, or talk therapy, is a way to help people with a broad variety of mental illnesses and emotional difficulties. Psychotherapy can help eliminate or control troubling symptoms so a person can function better and can increase well-being and healing.

Benefits of psychotherapy

- Resolve conflicts
- Relieve anxiety or stress
- Cope with major life changes
- Learn to manage unhealthy reactions
- Come to terms with an ongoing or serious physical health problem
- Recover from physical or sexual abuse
- Cope with sexual problems
- Sleep better

psychotherapy

- Psychotherapy vs Medication.
- Counselling is associated with significantly greater clinical effectiveness in short-term mental health outcomes compared to usual care.
- Healthy lifestyle improvements support recovery.

Types of psychotherapy

1. Cognitive behavioural therapy (CBT):
   A. Behavioral therapies: Aim to change behavior, uses a system of graded exposure
   B. Cognitive therapy: Focusses on people's thoughts and the reasoning behind their assumptions on the basis that incorrect assumptions

2. Problem-solving therapy (PST): drawing up a list of problems and generating and agreeing solutions, broken down into steps.

3. 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

4. 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

Types of psychotherapy

1. Guided self-help: Uses books/printed materials under the supervision of a trained facilitator who introduces, monitors, then reviews the outcome of each treatment
2. Mindfulness-based cognitive therapy: Skills training programmed designed to enable patients to prevent the recurrence of depression
3. Behavioral activation: Therapist and patient work together, with the aim of identifying effects that the patient's behavior might have on symptoms, mood, and problems.
4. 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
5. Applied relaxation: Group or individual therapy that teaches patients to relax quickly in different situations

When to refer to a psychologist

- Medically unexplained symptoms
- Psychotically depressed (with delusions or hallucinations)
- Substance abuse/addiction
- Signs of dementia
- Suicidality
- harmful drinking or alcohol dependence
- Self-neglect
- in risk to self or others
- Poor response to treatment

MCQs

(rapid onset of intense fear) is the definition of:

a) Generalized anxiety disorder
b) Panic attack
c) OCD
d) PTSD

MCQs

Treatment of choice for panic disorder:

a) Cognitive behavioural therapy
b) Selective Serotonin Reuptake Inhibitor
c) Benzodiazepine
d) None of the above

MCQs

Which of the following symptoms is a MUST in the diagnosis of depression

a) Sleep disturbances
b) Loss of interest
c) Fatigue
d) Feeling of worthlessness

MCQs

Which of the following is the 1st line medications for treating depression

a) venlafaxine
b) Bupropion
c) fluoxetine
d) duloxetine

MCQs

A 45 years old female came to you 3 times within 2 weeks C/O severe abdominal pain. Her vital signs was normal, on examination her abdomen is soft and there is no remarkable signs. Her brother died 2 months ago due to colon cancer. What is the most likely diagnosis:

a) IBD
b) Peptic Ulcer
c) SSD
d) PD

MCQs

What type of therapy that helps the patient develop skills to deal with stressful situations?

a) Interpersonal therapy

b) Psychodynamic therapy

c) Cognitive behavioural therapy

d) Humanistic therapy

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Thank You