Swanson's FAMILY MEDICINE REVIEW

A PROBLEM-ORIENTED APPROACH

Alfred F. Tallia
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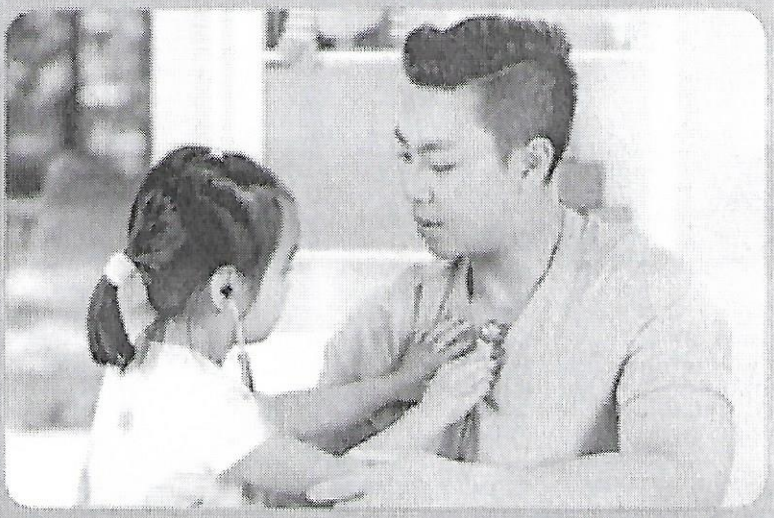

8th Edition

ELSEVIER

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A PROBLEM-ORIENTED APPROACH

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Behavioral Health

CHAPTER 141

Depressive Disorders

CLINICAL CASE PROBLEM 1

A 28-Year-Old Man Who Is "Just Not Interested in Going Out Anymore"

A 28-year-old man comes to the office with his wife because he has been "feeling tired" during the past 4 months. He says he always feels "run down," but also notes that he does not sleep well. He says he is able to fall asleep when he goes to bed at approximately 10 PM, but he wakes up routinely at 3 AM and is unable to get back to sleep.

He notes that he often has trouble with focus and concentration, and he lacks the energy to finish his tasks at home. He used to be more active but has recently stopped playing softball with his league on Wednesday nights because he says he is "just not interested in going out anymore." His wife says he seems on edge. "He has a short fuse ... it seems like even the smallest things set him off," she says. His appetite has decreased, and you note a 10-pound weight loss since his last visit 6 months ago. He denies fever, chills, nausea, vomiting, or night sweats. He has no other medical problems and denies taking any other medication except for a "megavitamin," which he hoped would help him feel more energetic. His physical examination is completely normal.

SELECT THE BEST ANSWER TO THE FOLLOWING QUESTIONS

1. What is the most likely diagnosis in this patient?
   a. adjustment disorder with depressed mood
   b. generalized anxiety disorder
   c. major depressive disorder (MDD)
   d. mood disorder caused by a general medical condition
   e. persistent depressive disorder (dysthymia)

2. What class of drugs is most often used in the disorder described?
   a. selective serotonin reuptake inhibitors (SSRIs)
   b. tricyclic antidepressants (TCAs)
   c. monoamine oxidase inhibitors (MAOIs)
   d. benzodiazepines
   e. lithium carbonate

3. Which of the following types of psychotherapy is generally considered most effective in the illness previously described?
   a. psychoanalytic psychotherapy
   b. supportive psychotherapy
   c. psychodynamic psychotherapy
   d. cognitive-behavioral psychotherapy (CBT)
   e. all of the above

4. Which of the following is least likely to induce withdrawal symptoms if it is abruptly discontinued?
   a. fluoxetine (Prozac)
   b. sertraline (Zoloft)
   c. citalopram (Celexa)
   d. paroxetine (Paxil)
   e. all of the above, being from the same class of medications, present an equal risk of inducing withdrawal symptoms

CLINICAL CASE PROBLEM 2

A 39-Year-Old Man Who Is Sad All the Time

A 39-year-old man comes to your office with a 3-year history of "feeling down." He states that he feels "depressed most of the time," although there are periods when he feels better. He is "always tired," admits to trouble concentrating at work, and says this is starting to affect his job performance. He has had no other symptoms. His health is otherwise good. He is not taking any medications.

5. This patient most likely suffers from which of the following?
   a. adjustment disorder
   b. persistent depressive disorder (dysthymia)
   c. MDD
   d. mood disorder caused by a general medical condition
   e. none of the above

6. What is the treatment of choice for this patient?
   a. relaxation therapy
   b. pharmacologic antidepressants

c. CBT
d. exercise
e. b, c, and d

CLINICAL CASE PROBLEM 3

A 35-Year-Old Woman Who Is Distressed at Work

A 35-year-old woman comes to your office with a 3-month history of feeling "depressed." She feels "extremely distressed at work" and tells you that she is "burned out." You discover that she moved into a managerial position at work 4 months ago and is having a great deal of difficulty (interpersonal conflict) with two of her employees.

The patient has no history of psychiatric illness. She has no other symptoms. She is not taking any medications.

7. What is the most likely diagnosis in this patient?
   a. adjustment disorder with depressed mood
   b. persistent depressive disorder (dysthymia)
   c. MDD
   d. mood disorder caused by a general medical condition
   e. burnout

8. What is the treatment of choice for this patient?
   a. a TCA
   b. an SSRI
   c. supportive psychotherapy
   d. a and c
   e. b and c

CLINICAL CASE PROBLEM 4

A 45-Year-Old Hard-Driving Man

A 45-year-old man who is a "hard-driving" executive comes to your office with a 4-month history of feelings of sadness and irritability, loss of appetite, inability to concentrate, and a significantly decreased ability to function in his job. He tells you that he is "completely burned out."

When you question him, he tells you that he has been "using anything and everything possible to try to relax." He has missed a number of days of work recently because he "hasn't felt up to it." He also complains of increasing stomach pains and headaches during the past 2 months. Physical examination and endoscopy are completely normal.

9. From these findings, what is the most likely diagnosis in this patient?
   a. MDD
   b. persistent depressive disorder (dysthymia)
   c. mood disorder caused by a general medical condition
   d. substance-induced mood disorder
   e. adjustment disorder with depressed mood

10. What is the treatment of choice for this?
    a. an SSRI
    b. a TCA
    c. an MAOI
    d. lithium carbonate
    e. none of the above

CLINICAL CASE PROBLEM 5

A 33-Year-Old Woman Who Has Lost Interest in Life

A 33-year-old woman presents to your office complaining of fatigue and decreased interest in "the things that used to make me happy." She is sleeping less and eating less, and she says that she is forcing herself to eat "because I know I have to eat something." She had been looking forward to the winter snow and had promised to help build snowmen with her two young sons. Instead, she finds herself spending less time with them as she retreats to her room. Her husband says, "It seems like this happens every year! I'm beginning to think she just doesn't like the winter."

11. On the basis of the information given, which of the following conditions is the most likely possibility in this patient?
    a. generalized anxiety disorder
    b. substance-induced mood disorder
    c. adjustment disorder with depressed mood
    d. MDD with a seasonal pattern
    e. dysthymia

12. What is the first-line treatment for this patient?
    a. an SSRI
    b. a TCA
    c. an MAOI
    d. lithium carbonate
    e. none of the above

As physicians, we need to inform our patients that depression is a disease like any other; it often affects body chemistry, just as diseases such as hypothyroidism, hyperthyroidism, and diabetes mellitus do.

13. Which of the following hypotheses support(s) this argument?
    a. loss of the normal feedback mechanism inhibiting adrenocorticotropic hormone
    b. lack of normal suppression of blood cortisol with the 1-mg dexamethasone suppression test
    c. generalized decrease in noradrenergic function in patients who are depressed
    d. a and b
    e. all of the above

14. Which of the following neurotransmitters appears to be the most important mediator of depressive illness in humans?

a. norepinephrine
b. acetylcholine
c. dopamine
d. serotonin
e. tryptophan

CLINICAL CASE PROBLEM 6

A 62-Year-Old Man after a Myocardial Infarction

A 62-year-old man is in your office to follow up a recent myocardial infarction requiring hospitalization and bypass surgery. During the visit, his wife tells you her husband "just doesn't seem like himself" and goes on to describe symptoms consistent with depression.

15. Which of the following is true?
    a. people who are depressed and who have preexisting cardiovascular disease have a risk of death 3.5 times greater than that of patients who are not depressed
    b. there is no evidence demonstrating a connection between cardiovascular disease and depression
    c. the use of SSRI medication can exacerbate cardiovascular disease
    d. TCAs are first-line treatment in patients who have undergone coronary artery bypass and who present with depression

16. A thorough patient interview is most important in evaluating patients who are depressed. In a patient with depression, which of the following questions is the most important and urgent question to ask?
    a. Is there a family history of psychiatric disorders?
    b. Is there a personal history of previous episodes of depression?
    c. Have you had any thoughts of suicide?
    d. Have you had hallucinations?
    e. Have you experienced any delusion?

CLINICAL CASE MANAGEMENT PROBLEM

Discuss a strategy for the pharmacologic management of major depressive disorder.

ANSWERS

1. c. The diagnosis in this patient is MDD. This is based on the presence for at least 2 weeks of a distinct change in mood (sadness or lack of pleasure) accompanied by changes in appetite and activities, including decreased energy, psychomotor agitation or retardation, decreased appetite for food or sex, weight loss, changes in sleep-wake cycles, and depressive rumination or thoughts of suicide. Adjustment disorder with depressed mood is not diagnosed when symptoms are severe enough to be considered MDD.

Generalized anxiety disorder is characterized by excessive worry and nervousness about many problems. Mood disorders caused by general medical conditions are initiated and maintained by physiologic problems. Persistent depressive disorder (dysthymia) is characterized by a depressed mood that persists for more than 2 years without meeting the full criteria for MDD.

The criteria for MDD according to the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-V), are as follows:

1. The presence of five or more of the following symptoms during the same 2-week period. These must represent a change from previous functioning. At least one of these two symptoms must be either a or b from the following list:
    a. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feeling sad or empty) or observation made by others (e.g., appears tearful)
    b. Markedly diminished interest or pleasure in all or almost all activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
    c. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or a decrease or increase in appetite nearly every day
    d. Insomnia or hypersomnia nearly every day
    e. Psychomotor agitation or retardation nearly every day (observable by others and not merely subjective feelings of restlessness or being slowed down)
    f. Fatigue or loss of energy nearly every day
    g. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
    h. Diminished ability to think or concentrate or indecisiveness nearly every day (either by subjective account or observed by others)
    i. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, a suicide attempt, or a specific plan for committing suicide
2. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
3. The symptoms are not caused by direct physiologic effects (e.g., drug abuse or a medication) or a general medical condition.
4. The symptoms are not accounted for by bereavement (after the loss of a loved one); the symptoms persist for longer than 2 months or are characterized by a marked functional impairment, morbid preoccupation with worthlessness, suicidal

ideation, psychotic symptoms, or psychomotor retardation.

5. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other schizophrenia spectrum and other psychotic disorders.
6. There has never been a manic episode or a hypomanic episode.

A mnemonic for MDD is SIG-EM-CAPS. A diagnosis is made if a patient has five of the nine following symptoms, which must include energy/fatigue or mood:

Sleep (hypersomnia or insomnia)
Interest (lack of interest in life in general)
Guilt or hopelessness
Energy/fatigue
Mood (depressed, sadness)
Concentration (lack of)
Appetite (increased or decreased; weight loss or weight gain)
Psychomotor (retardation or agitation)
Suicidal ideation

The other choices in this question are discussed in various other answers in this chapter.

2. a. The pharmacologic treatment for patients with MDD is most often a member of the class of drugs known as SSRIs. The agents in this class include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), fluvoxamine (Luvox), and citalopram (Celexa) or escitalopram (Lexapro). These agents have significantly fewer side effects than older antidepressants do. Major side effects may include gastrointestinal distress, decreased libido and inhibited orgasm, tremor, insomnia, somnolence, dry mouth, and a small amount of weight gain.

The SSRIs act exactly as they are named: they block the reuptake of serotonin in the brain. Mixed reuptake inhibitors (norepinephrine, 5-hydroxytryptamine, and dopamine or serotonin-norepinephrine reuptake inhibitors) are sometimes used instead of SSRIs and include duloxetine (Cymbalta), venlafaxine (Effexor), desvenlafaxine (Pristiq), and mirtazapine (Remeron). Bupropion (Wellbutrin) and nefazodone (Serzone) block only dopamine and norepinephrine uptake. They are not sedating and are useful because they do not have sexual side effects. Nefazodone has been associated with life-threatening liver failure and is rarely used because of this potential side effect.

TCAs are used less commonly because they exhibit more anticholinergic side effects, including dry mouth, urinary retention, constipation, and blurred vision. They are more sedating than most SSRIs and mixed reuptake inhibitors. Other serious side effects may include orthostatic hypotension (an alpha-blockade side effect) and cardiac conduction abnormalities (an increased risk for patients with second-degree and third-degree heart block or right or left bundle branch block from a quinidine-like action). However, in select cases, the sedative action of TCAs may be beneficial in the treatment of a patient who is depressed.

Antidepressants have comparable efficacy overall, but individual patients may respond to some antidepressants and not to others. A family history of a positive response to a specific antidepressant may be helpful in determining which new antidepressant may be more effective, but it is impossible to predict with any certainty which antidepressant will be effective for a particular patient; therefore, a trial of two or more antidepressants is sometimes necessary. A patient should have dosage adjustment or be switched to a different antidepressant if he or she does not respond after 6 weeks of treatment or if side effects are intolerable. Antidepressants exert multiple effects on central and autonomic nervous system pathways, at least partially by presynaptic blockade of norepinephrine or serotonin reuptake.

MAOIs, such as phenelzine and tranylcypromine, may be effective in the treatment of patients with MDD who are not responsive to SSRIs and tricyclics. The most common side effects of this class of drugs are dizziness, orthostatic hypotension, sexual dysfunction, insomnia, and daytime sleepiness. The greatest risk with MAOIs is the occurrence of hypertensive crises, which may be induced by the consumption of large amounts of certain foods (i.e., aged cheese and red wine) or drugs containing sympathetic stimulant activity. MAOIs are rarely prescribed in a primary care setting because side effects and significant interactions with a multitude of other medications are common.

Pharmacologic treatment of MDD is effective in approximately 70% to 75% of cases. Electroconvulsive therapy (ECT) may be useful for individuals who do not respond to antidepressants, have contraindications to antidepressants, or are in immediate danger of committing suicide. Unlike antidepressants, which often require 4 to 6 weeks to have a full effect, ECT is effective almost immediately. Although there are no absolute contraindications to its use, ECT should be prescribed only by a psychiatrist; an appropriate referral is necessary.

3. d. Most studies suggest that CBT is an effective treatment for depression. CBT helps patients change the way they interpret events and encourages a greater sense of optimism and empowerment. This method of brief psychotherapy was developed during the past two decades by Aaron T. Beck. It is used primarily for the treatment of mild to moderate depression and for patients with low self-esteem. It is a form of behavioral therapy that aims to directly remove symptoms rather than to resolve underlying conflicts, such as is attempted in psychodynamic psychotherapies. Cognitive-behavioral therapists view the patient's conscious thoughts as central to production. The cornerstone

of treatment is the belief that how patients think informs how they feel. If negative thoughts can be adjusted, the negative feelings and low mood can be improved. Both the content of thoughts and the thought processes are seen as distorted in people with such symptoms. Therapy is directed at identifying and altering these cognitive distortions.

4. a. SSRI discontinuation syndrome can be manifested with a range of symptoms, including anxiety, agitation, gastrointestinal distress, myalgias, and a sensation of "electrical shocks" through the arms and legs. The chance of this occurring is directly related to the half-life of a given SSRI. Fluoxetine is the least likely of the drugs to produce a discontinuation syndrome on abrupt cessation of use because of its long half-life (up to 7 days). On the other hand, paroxetine has the shortest half-life (21 hours) and therefore is most likely to cause symptoms. The other SSRIs listed, sertraline and citalopram, have intermediate half-lives and have an intermediate likelihood of precipitating discontinuation symptoms.

5. b. This patient has a persistent depressive disorder, or dysthymia. Persistent depressive disorder (dysthymia) is defined as a depressive syndrome in which the patient is bothered all or most of the time by depressive symptoms. The diagnosis of dysthymic disorder is best made by following the rule of 2's: two of the following six symptoms (poor appetite or overeating; insomnia or hypersomnia; low energy or fatigue; low self-esteem; poor concentration or difficulty making decisions; feelings of hopelessness), in addition to depressed mood, for at least 2 years, without interruption of symptoms for longer than 2 months. Although the symptoms of dysthymia are chronic, and certainly impair occupational and social function, they are not of sufficient severity to warrant a diagnosis of major depressive disorder.

Adjustment disorder is generally more time limited and related to a specific stressor. Mood disorders caused by general medical conditions have specific physiologic causes.

6. e. Because of the long history, this patient probably should be treated with a combination approach of exercise, psychotherapy, and pharmacotherapy. Medications used for this disorder are as described previously, although agents with more side effects should be avoided. In general, if medications are used, the lowest effective dose is used, treatment is continued for at least 6 months, and the patient is reevaluated periodically afterward. Exercise has been shown to be effective in the treatment of this disorder and should be strongly encouraged. Psychotherapy (CBT as described previously) is an important component of the treatment of this condition and has been shown to reduce recurrences. Importantly, a dysthymic disorder that evolves into MDD, known as double depression, can often be difficult to treat and often requires a combination of medication and therapy. Relaxation therapy is more appropriate for treatment of anxiety than for depression.

7. a. This patient has an adjustment disorder with depressed mood, which is defined as a reaction to some identifiable psychosocial stressor that occurs within 3 months of the onset of the depressed mood. As with any other psychiatric disorder, there is a clear impairment of occupational or social functioning. The severity of the depression is not sufficient to warrant a diagnosis of MDD. Treatment of individuals with adjustment disorder includes counseling about stress management and brief psychotherapy; medications are rarely used.

Dysthymia is characterized by 2 years or more of chronically depressed mood. A mood disorder caused by a general medical condition is a dysthymic reaction secondary to a loss of function or perceived loss by a known pathologic process. Substance-induced mood disorder is directly caused by a particular substance, commonly alcohol or psychostimulants. Substance-induced mood disorder should be considered in individuals with depressive symptoms, especially those who may be under psychological stress and using inappropriate coping mechanisms, such as the use of alcohol or drugs.

8. c. The treatment of choice for adjustment disorder is brief psychotherapy consisting of counseling and stress management. If the stressful situation cannot be changed, cognitive restructuring, relaxation and other stress management techniques, and exercise are useful for improving the ability to cope with stress. The physician should suggest specific coping strategies, with specific goals and objectives negotiated with the patient.

9. d. This patient most likely has a substance-induced mood disorder. The tip-offs to this diagnosis are as follows: (1) symptoms and signs of depression, (2) a self-described burnout syndrome, (3) the missing of a number of days of work recently, and (4) the clue of "I am using anything and everything to try to relax."

The sequence of events that likely took place in this patient is described in the following way: The drive to keep going faster and faster "to stay on the treadmill" eventually led to a depressive disorder and occupational burnout. This was followed by inappropriate "coping mechanisms," including the use of alcohol or drugs to keep going. Eventually, he reached a point at which he was unable to function because of depression, burnout syndrome, and the number of days missed at work. Therefore, his work suffered.

10. e. The steps that should be pursued in this patient's case are as follows. (1) Ask the patient about alcohol intake (specific amounts, specific times, and total intake); (2) Administer an alcohol abuse questionnaire; (3) Involve the patient's family, if possible; (4) If a diagnosis of substance-induced mood disorder is confirmed, get the patient's cooperation for initiation of treatment; and (5) Include an ongoing recovery program, possibly after detoxification. Individual, group, and family psychotherapy is often helpful. Referral to a 12-step program such as Alcoholics Anonymous is extremely useful for both rehabilitation and relapse prevention.

11. d. This patient most likely has MDD with a seasonal pattern (or seasonal affective disorder). Patients meet the criteria for MDD, but symptoms occur only during certain seasons and often remit with the transition to the next season. The most common seasons of the year for patients to experience symptoms are fall and winter, with cessation of symptoms during spring and summer. In a given year, about 5% of the U.S. population experiences seasonal affective disorder, with symptoms present for about 40% of the year. Typical symptoms include loss of interest in activities, sleep disturbances, and loss of libido. Once the pattern is identified, the treatment can include prophylactic treatment with SSRI medication to prevent the onset of disabling mood symptoms. Seasonal affective disorder can often be treated with light therapy (with exposure to the eye, not the skin), which appears to have a low risk of adverse effects. Light therapy is more effective if it is administered in the morning, and studies are beginning to show that light therapy can be as effective as SSRI medication.
The psychiatric differential diagnosis in this patient would include adjustment disorder with depressed mood, but this is less likely with the repeated pattern temporally related to the change of seasons.

12. a. Although both TCA and MAOI classes of antidepressants are often helpful in depression, the SSRI class is associated with less morbidity, and drugs in this class are generally considered first-line treatment.

13. e. Depression is associated with significant chemical and morphologic changes in the brain. When patients understand this, it helps decrease the stigma of the diagnosis and decrease feelings of shame and inadequacy.

14. d. The following physiologic abnormalities have been described in MDD: (1) "neurotransmitter imbalance," which appears to be caused by a relative deficiency of the neurotransmitter serotonin (the new SSRIs add confirming evidence to this hypothesis); (2) hyperactivity of the hypothalamic-pituitary-adrenal axis, which results in elevated plasma cortisol levels and nonsuppression of cortisol after a screening 1-mg overnight dexamethasone suppression test; (3) blunting of the normally expected increase in plasma growth hormone induced by alpha$_2$-adrenergic receptor agonists; and (4) blunting of serotonin-mediated increase in plasma prolactin.

15. a. Approximately 65% of patients with acute myocardial infarction report experiencing symptoms of depression. Major depression is present in 15% to 22% of these patients. Depression is an independent risk factor in the development of and mortality associated with cardiovascular disease in otherwise healthy people. People who are depressed and who have preexisting cardiovascular disease have a risk of death 3.5 times greater than that of patients who have cardiovascular disease and are not depressed. Physicians should assess patients for depression with any cardiovascular disease. SSRIs are the first-line treatment in this case. TCAs are associated with cardiac arrhythmias, which are also an increased risk in the weeks after a patient has sustained a myocardial infarction.

16. c. The most important question to ask a patient who presents with signs and symptoms of depression is whether or not he or she has contemplated suicide. The following questions are useful in exploring suicidality:
    1. You seem so terribly unhappy. Have you had any thoughts about hurting yourself?
    2. If you have, have you thought of the means by which you would do it? Have you considered a specific plan for ending your life? Under what circumstances would you carry it out?
    3. What would it take to stop you (from killing yourself)?
    4. Do you feel that your situation is hopeless?

    The overall mortality from suicide in individuals with MDD is 15%. Symptoms that place a patient who is depressed at higher risk for suicide are a practical and lethal plan with feelings of hopelessness. Patients must be directly asked about suicidal ideations, and steps must be taken to protect those at high risk. Such steps include making a treatment contract, mobilizing support systems, providing close observation, ensuring immediate availability of a clinician, and placing the patient in the hospital if necessary. Suicidal risk is an acute, not a chronic, problem and has to be handled as a crisis.

SOLUTION TO THE CLINICAL CASE MANAGEMENT PROBLEM

A strategy for the pharmacologic management of MDD is as follows:

1. Identify and treat causes unrelated to MDD (e.g., hypothyroidism or substance abuse).
2. Use single-agent pharmacotherapy as the first step.
3. If there is no satisfactory response after 4 to 6 weeks and an increase of the dose does not improve the patient's condition, or if the patient cannot tolerate the first drug, switch to a different drug that minimizes the troublesome side effects or is from a different chemical class.
4. If trials of two or three antidepressants are ineffective, refer to a psychiatrist for possible augmentation or other intense treatments.

A psychiatrist may elect to use ECT if several antidepressant trials in addition to nonpharmacologic treatment options have been ineffective, if there are contraindications to the use of antidepressants, or if there is a high risk of immediate suicide.

SUMMARY

Prevalence

1. Major depressive disorder
   a. Lifetime prevalence: 5.4% to 8.9% of the U.S. general population
   b. Gender difference: more common (1.5- to 3-fold higher rates) in women than in men
   c. Age: occurs in children, adolescents, adults, and the elderly; threefold higher prevalence in 18- to 29-year-old individuals than in those age 60 years or older
2. Persistent depressive disorder (dysthymia)
   a. Lifetime prevalence: 2.1% to 4.7%
   b. Gender difference: more common in women than in men
3. Prevalence for depression in medical settings has been reported to be as high as 15%.
4. Depression accounts for more than $43 billion in medical care costs and $17 billion in lost productivity annually.
5. Depression is projected to become the second largest cause of disability by 2020.

Differential Diagnosis

As described in the DSM-V criteria: (1) MDD, (2) dysthymia, (3) depression caused by a general medical condition, (4) adjustment disorder with depressed mood, (5) substance-induced mood disorder, (6) manic episodes with irritable mood or mixed episodes, and (7) sadness (periods of sadness are inherent aspects of the human experience, and the distinction from a major depressive episode is based on severity, duration, and clinically significant distress or impairment)

Distinguishing Major Depressive Disorder from Persistent Depressive Disorder (Dysthymia)

In addition to depressed mood, there are significant changes in appetite and activities, such as sleep disturbance, weight loss, severe fatigue or lack of energy, and suicidal rumination. Dysthymia, also now classified as persistent depressive disorder in the DSM-V, is perhaps best described as "a chronic ongoing depressed mood" that lasts years rather than weeks or months.

Subclassifications of Major Depressive Disorder

Once a diagnosis of depression has been made, the clinician should characterize the syndrome further, if possible, into the following categories:

1. Single episode or recurrent episode
2. Melancholic versus nonmelancholic: 40% to 60% of all hospitalizations are for melancholic depression. Symptoms include anhedonia, excessive or inappropriate guilt, early morning waking, anorexia, psychomotor disturbance, and diurnal variation in mood. The patient who is depressed and melancholy may appear frantic, fearful, agitated, or withdrawn.
3. Psychotic versus nonpsychotic: Psychotic depressions are not rare. Studies suggest that approximately 10% to 25% of patients hospitalized for major depression suffer from a psychotic depression. Often, patients with a psychotic depression will endorse "mood congruent" symptoms, such as auditory hallucinations characterized by a voice telling them they are worthless or "no good." These are also known as self-deprecating auditory hallucinations.
4. Atypical depression: Atypical depression denotes symptoms that include hypersomnia instead of insomnia, hyperphagia (sometimes as a carbohydrate craving) rather than anorexia, reactivity (mood changes with environmental circumstances), and a long-standing pattern of interpersonal rejection sensitivity. It is much more common in women. Patients with atypical depression are frequently reported to have an anxious or irritable mood rather than dysphoria. They may also describe "leaden paralysis," which is the sensation that their limbs are extremely heavy, making it difficult to move.

Continued

SUMMARY—cont'd

5. Masked depression: Masked depression is similar to atypical depression. Instead of overt depression, the depression is expressed as many psychosomatic signs and symptoms.
6. With peripartum onset
7. With seasonal pattern

Treatment

1. Follow the guidelines provided in the Solution to the Clinical Case Management Problem.
2. Consider the SSRIs as the drugs of first choice unless specific contraindications to their use are present.
3. Treat for at least 4 weeks before you consider the therapy you are using to be a therapeutic failure.
4. MDD should be treated with a combination of pharmacotherapy, psychotherapy, and exercise.
5. MDD is a recurrent disease: 1 year after the start of therapy 33% will be free of the disease, 33% will have had a relapse, and 33% will still be depressed. Use of psychotherapy along with pharmacologic treatment significantly reduces the rate of relapse. A three-phase approach to the treatment of depression is outlined:
   a. Acute treatment phase, phase 1: time, 6 to 12 weeks. The goal of this phase of therapy is the remission of symptoms of depression.
   b. Continuation treatment, phase 2: time, 4 to 9 months. The goal of this phase of therapy is to prevent a relapse of the depressive symptoms.
   c. Maintenance treatment, phase 3: time, patient dependent, perhaps lifetime. The goal of this phase of therapy is to treat patients who have had three or more episodes of depression. Prevention of recurrence is the treatment goal.

   Too often, medication is tapered or discontinued soon after symptoms have been brought under control; this greatly increases the patient's risk of relapse. There is no justification for lowering the effective dose of an antidepressant drug during maintenance treatment. Once the patient is asymptomatic for at least 6 months after a depressive episode, recovery from the episode is thereafter declared.

   The termination of therapy must be accompanied by patient education. The key concern is the likelihood of a recurrent episode. If this is the patient's first bout of depression that needed to be treated, the recurrence rate is approximately 50%. If there have been previous episodes of depression, or a family history of depression exists, the probability of a recurrence increases significantly. The patient must be made aware of the symptoms that indicate another episode and needs to know that subsequent attacks can be treated effectively, especially if therapy is initiated early in the onset of the disease.

Suggested Reading

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CHAPTER 143

Generalized Anxiety Disorder

CLINICAL CASE PROBLEM 1

A 27-Year-Old Woman with Restlessness and Chronic Worry

A 27-year-old woman comes to your office expressing concern about a number of bothersome issues. She says things were going "pretty well" until a few months ago, when she started feeling restless and on edge. She notes feeling tired and run down and "constantly stressed out." She also describes problems falling asleep as she lies awake worrying about all of the things she needs to get done: "But even though I'm worrying about all of the things I need to get done, I have such a hard time concentrating that I can't even start on my "to-do list!" She is seeking help now because this problem with focus and concentration is affecting her job performance and threatening her relationship with her long-term boyfriend.

At this point in the interview, she becomes very tense and tells you, "You know, doctor, this is really getting out of control. I feel I can't function anymore."

On physical examination, the patient's blood pressure is 130/70 mm Hg, and her pulse is 94 beats per minute and regular. Her thyroid gland is within normal limits and nontender. Her cardiac examination reveals no abnormalities outside the tachycardia. Her neurologic examination is normal. The remainder of the physical examination is normal.

SELECT THE BEST ANSWER TO THE FOLLOWING QUESTIONS

1. What is the most likely diagnosis in this patient?
   a. panic disorder
   b. major depressive disorder
   c. generalized anxiety disorder (GAD)
   d. hyperthyroidism
   e. hypochondriasis

2. Of patients with the disorder described, what percentage have at least one other similar psychiatric disorder at some time in their life?
   a. 10%
   b. 30%
   c. 50%
   d. 80%
   e. no data are available

3. All except which of the following are true regarding anxiety seen in the primary care setting?
   a. it is the most common psychiatric illness seen by family physicians
   b. it is associated with high utilization of medical services
   c. patients often present with somatic complaints
   d. anxiety can be a normal part of other medical issues, such as asthma and cardiac disease
   e. it is often associated with other psychiatric conditions, such as depression

4. Which of the following symptoms is generally not characteristic of the disorder described?
   a. awakening with apprehension and unrealistic concern about future misfortune
   b. worry out of proportion to the likelihood or impact of feared events
   c. a 6-month or longer course of anxiety and associated symptoms
   d. association of the anxiety with depression
   e. anxiety exclusively focused on health concerns

5. Which of the following statements regarding the disorder described is (are) true?
   a. this disorder may develop between attacks in panic disorder
   b. the symptoms of this disorder are often present in episodes of depression
   c. medical conditions that produce the major symptom associated with this disorder must be excluded
   d. the disorder is accompanied by symptoms of motor tension, autonomic hyperactivity, hypervigilance, and scanning
   e. all of the above are true

6. What is the psychotherapy of choice for this disorder?
   a. cognitive-behavioral therapy (CBT)
   b. hypnosis
   c. supportive psychotherapy
   d. psychoanalytic psychotherapy
   e. none of the above

7. Which of the following pharmacologic agents is not recommended in the treatment of this disorder?
   a. venlafaxine
   b. buspirone
   c. benzodiazepines
   d. selective serotonin reuptake inhibitors (SSRIs)
   e. clozapine

8. Which of the following benzodiazepines has the shortest half-life?
   a. diazepam (Valium)
   b. chlordiazepoxide (Librium)
   c. clorazepate (Tranxene)
   d. alprazolam (Xanax)
   e. clonazepam (Klonopin)

9. This disorder is more common in which of the following?
   a. elderly white men
   b. school-age children

c. married people
d. those of higher socioeconomic status
e. young to middle-aged women

10. Which of the following statements is (are) true regarding this disorder?
a. this disorder displays autosomal dominant genetic transmission
b. the mechanism of symptom development in this disorder may relate to a conditioned response to a stimulus that the individual has come to associate with danger
c. a relation between the onset of this disorder and the cumulative effects of stressful life events is possible
d. b and c
e. a, b, and c

CLINICAL CASE PROBLEM 2

A 22-Year-Old Law Student Unable to Answer Questions in Class

A 22-year-old law student comes to your office in a state of anxiety. He is taking a law class in which 50% of the class grade is based on class participation. Although he knows the material well, he is unable to answer the questions posed to him by the professor. He has gone through 2 months of the 6-month class and has not been able to answer any of the 14 questions that the professor has asked him in class.

The professor asked him to make an appointment for a "little chat" the other day. At that time, he was told that he would (in the professor's words) "fail the class" unless he began to participate.

The student describes himself as a loner. He tells you that he has always been shy, but this is the first time the shyness has really threatened to have a major impact on him. His family history is significant for what he terms "this shyness." His mother has the same characteristic, but it does not seem to be causing the kind of life difficulties for her that it is causing for him.

His mental status examination is essentially normal.

11. What is the most likely diagnosis in this patient?
a. panic disorder with agoraphobia
b. panic disorder without agoraphobia
c. panic disorder with social phobia
d. social phobia
e. specific phobia

12. Which of the following is not a characteristic of the disorder described?
a. persistent fear of humiliation
b. exaggerated fear of humiliation
c. embarrassment in social situations
d. high levels of distress in particular situations
e. fear of crowds or fear of closed-in spaces

13. With which of the following personality disorders is this disorder likely to be confused?
a. avoidant personality
b. borderline personality
c. histrionic personality
d. obsessive-compulsive personality
e. shy personality not otherwise specified

14. The neurochemical basis of the disorder described has been associated with which of the following neurotransmitters?
a. epinephrine
b. norepinephrine
c. serotonin
d. a and b
e. a, b, and c

15. Which of the following pharmacologic agents is used most commonly to treat this disorder?
a. benzodiazepines
b. monoamine oxidase inhibitors (MAOIs)
c. tricyclic antidepressants
d. newer antipsychotic medications
e. beta blockers

16. With respect to this disorder, which of the following psychotherapies is (are) most effective?
a. CBT
b. brief psychodynamic therapy
c. psychoanalysis
d. biofeedback
e. all of the above

CLINICAL CASE PROBLEM 3

An Anxious Young Man

A lab technician calls to tell you that a 22-year-old man you have sent for a blood draw is very anxious. He says he is terrified of having his blood drawn and almost faints at the sight of the needle.

17. Which of the following disorders is the most likely diagnosis?
a. panic disorder
b. social phobia
c. GAD
d. specific phobia
e. obsessive-compulsive disorder

CLINICAL CASE MANAGEMENT PROBLEM

List four groups of symptoms that may be manifested in the presentation of anxiety.

ANSWERS

1. c. This patient has GAD, which is defined as unrealistic or excessive worry about several life events or activities for a period of at least 6 months, during which the person has been bothered more days than not by these concerns. In addition, the following six symptoms are present: muscle tension, restlessness or feeling keyed up or on edge, easy fatigability, difficulty concentrating or a sensation of the "mind going blank" because of anxiety, trouble falling or staying asleep, and irritability. Finally, the anxiety, worry, or physical symptoms significantly interfere with the person's normal routine or usual activities, or they cause marked distress.

2. d. At least 80% of patients with GAD have had at least one other anxiety disorder in their lifetime.

3. a. The most common psychiatric illness seen by family physicians is major depression. Anxiety is associated with high utilization of medical services, and patients often present with somatic complaints. Acute anxiety can be a normal part of other medical issues, such as asthma and cardiac disease. The most common psychiatric comorbidity with anxiety is major depression.

4. e. GAD is characterized by awakening with apprehension and concern about future misfortune, worry out of proportion to the likelihood or impact of feared events, a duration of 6 months or more of anxiety or associated symptoms, and an association with depressed moods.

GAD is usually not associated exclusively with health concerns. When health concerns become the focus of worry, a diagnosis of hypochondriasis or another somatoform disorder becomes more likely.

5. e. Generalized persistent anxiety may develop between attacks in panic disorder. GAD symptoms are often present during episodes of depression. As with panic disorder, medical conditions that may produce anxiety symptoms must be excluded (see answer 3). GAD is characterized by chronic anxiety about life circumstances accompanied by symptoms of motor tension, autonomic hyperactivity, hypervigilance, and scanning.

6. a. CBT is often effective in the treatment of GAD. Cognitive therapy challenges the distortions in patients' thinking that trigger and heighten their anxiety. This technique can be combined with relaxation training, including deep breathing and progressive muscle relaxation. Biofeedback and imagery are also useful to achieve systematic desensitization. Because relaxation and anxiety are mutually exclusive, these techniques help patients achieve relief from their symptoms. Although cognitive therapy alone may alleviate GAD symptoms, the combination of cognitive and other behavioral techniques is more effective than cognitive therapy alone.

7. e. SSRIs are often used in the pharmacologic treatment of GAD. Venlafaxine and duloxetine, mixed serotonin-norepinephrine reuptake inhibitors, can be used for short- and long-term treatment. Although benzodiazepines are commonly used, they have mostly short-term benefits. Longer acting agents are preferred to short-acting benzodiazepines, but their use should be limited, if possible, because of withdrawal symptoms, habituation, and impaired mental and physical performance. Buspirone, a nonbenzodiazepine anxiolytic, and other agents such as tricyclic antidepressants are used as well. Clozapine is an antipsychotic agent used in the treatment of patients with schizophrenia. It has no role in the treatment of GAD, and its use in the United States is restricted.

8. d. Alprazolam has the shortest half-life at 6 to 12 hours; clonazepam has a half-life of 25 hours; and diazepam, clorazepate, and chlordiazepoxide have half-lives of up to 50 hours.

9. e. GAD is slightly more common in young and middle-aged women, ethnic minorities, those not currently married, and those of lower socioeconomic status.

10. d. Behavioral theories consider GAD, like panic disorder, to be a conditioned response to a stimulus that the individual has come to associate with danger. There is indeed some suggestion that the onset of GAD may be related to the cumulative effects of several stressful life events that have not been properly processed. There is no convincing evidence of a specific form of genetic transmission of GAD.

11. d. This patient has a social phobia, which is characterized by a marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. These patients fear that they may act in a manner that will be humiliating or embarrassing. Examples include (as in this patient) not being able to talk when asked to speak in public, choking on food when eating in front of others, being unable to urinate in a public lavatory, hand trembling when writing in the presence of others, and saying foolish things or not being able to answer questions (as in this patient) in social situations.

In addition, exposure to the feared social situation almost invariably provokes anxiety. The individual realizes that his or her behavior is abnormal and unreasonable. The feared social or performance situation is either avoided or endured with intense anxiety. The avoidance, anxious participation, or distress in the feared social or performance situation interferes significantly with the person's normal occupational, academic, or social functioning and relationships with others.

12. e. Fear of crowds, in which escape may not be possible, is known as agoraphobia. Fear of closed spaces is known as claustrophobia. All the other choices correctly describe symptoms of social phobia.

13. a. Avoidant personality disorder has many symptoms in common with social phobia and may be difficult to differentiate. The core feature of avoidant personality is an excessive discomfort or fear in intimate and social relationships that results in pathologic avoidance as a means of self-protection. Like patients with social phobia, these patients fear humiliation and rejection. However, patients with social phobia tend to have more specific fears with regard to social performances rather than close relationships.

14. e. Symptoms reported by patients with social phobia in phobic situations suggest heightened autonomic arousal. When they are placed in a phobic situation, social phobics experience significant increases in heart rate that are highly correlated with self-perceived physiologic arousal (in contrast to claustrophobics, who experience less heart rate increase and negative correlations between perceived and actual physiologic arousal). Stressful public speaking situations result in twofold or threefold increases in plasma epinephrine levels. Increases in norepinephrine are also seen.

Until recently, epinephrine and norepinephrine were the only neurotransmitters associated with the neurochemical basis of this disorder. However, now that the new SSRI agents have been shown to be effective in socially phobic situations, serotonin is also likely to be involved. In this case, it would seem that patients with social phobia would demonstrate a relative deficiency of serotonin-mediated activity rather than an excess, as with epinephrine and norepinephrine.

15. e. Beta blockers (e.g., atenolol and propranolol) are commonly used to treat circumscribed forms of social phobia, such as fears of public speaking or performances.

Generalized social phobia is often less responsive to pharmacologic interventions. Although SSRIs are considered the drug class of choice, MAOIs, specifically phenelzine (45 to 90 mg per day), buspirone, and benzodiazepines, have been reported to be effective occasionally. Phenelzine is usually started at 15 mg once or twice daily. It may be increased to a total dose of 60 to 90 mg per day based on response. It can take 4 to 6 weeks for a response. At times it takes longer for a meaningful clinical response.

16. a. CBT is particularly effective for treatment of social phobia. The treatment consists of desensitization through graduated exposure to social situations, modification of cognitive distortions, psychoeducation, and relaxation training.

17. d. The most likely diagnosis in this patient is specific phobia, with a blood injection injury subtype. This is the only specific phobia with a clear genetic link, and it is commonly seen in the primary care setting.

Specific phobias involve intense fear and avoidance of specific objects or situations. The individual recognizes the fear and avoidance as excessive, and the symptoms result in occupational or social impairment. Other common specific phobias include certain animals, heights, flying, closed spaces, crossing bridges, darkness, and blood. Benzodiazepines can be used to decrease acute anxiety, although CBT with exposure and desensitization to the feared stimulus is often required to fully extinguish the symptoms in the long term.

SOLUTION TO THE CLINICAL CASE MANAGEMENT PROBLEM

1. Physical symptoms related to autonomic arousal, such as tachycardia, tachypnea, diaphoresis, diarrhea, and lightheadedness
2. Affective symptoms that may include increased irritability or may be experienced as "sheer terror"
3. Behavioral symptoms, such as avoidance of anxiety-provoking stimuli
4. Cognitive symptoms, such as worry, apprehension, and inability to concentrate and to focus

SUMMARY

Generalized Anxiety Disorder

1. Epidemiology: The lifetime prevalence of GAD is 5.1%.
2. Differential diagnoses include the following: (a) panic disorder; (b) somatoform disorder; (c) hypochondriasis; (d) substance abuse, including caffeine and diet pills; (e) depression (with secondary anxiety); (f) hyperthyroidism; and (g) other organic disorders (less likely).
3. Symptoms: GAD is characterized by chronic excessive anxiety concerning life circumstances accompanied by symptoms of motor tension, autonomic hyperactivity, vigilance, and scanning. These symptoms of anxiety, worry, or physical signs significantly interfere with the person's normal routine of usual activities and cause marked distress.
4. Treatment
   a. Nonpharmacologic treatment options combine behavioral interventions including (i) CBT that challenges distortions in thinking and uses positive affirmations; (ii) relaxation training, including abdominal breathing and progressive muscle relaxation techniques; (iii) systematic desensitization using imagery or biofeedback; and (iv) assertiveness training.
   b. Pharmacologic treatment options include the following: (i) SSRIs, (ii) tricyclic antidepressants, (iii) venlafaxine and duloxetine, (iv) benzodiazepines, and (v) buspirone.

Social Phobia

1. Epidemiology: The estimated 6-month prevalence of social phobia is 1.2% to 2.2%.
2. Definition: Social phobia is a persistent and overwhelming fear of one or more social or performance situations in which the individual is exposed to unfamiliar people or to possible scrutiny by others. Fear of speaking in public, hand trembling, and answering questions are examples. The fear is one of not being able to perform the particular activity and of being humiliated in public because of this. It produces both embarrassment and high levels of distress.

   The individual either avoids the situation or endures it with intense anxiety. The individual also realizes that the fear is unreasonable but is powerless to do anything about it. In addition, the individual experiences occupational, social, or academic impairment with normal life activities and goals.
3. Symptoms: The individual experiences not only intense anxiety and fear but also symptoms of autonomic hyperactivity, such as blushing, trembling, tachycardia, and elevated blood pressure.
4. Neurochemistry: There is probable increased noradrenergic and adrenergic activity related to autonomic hyperarousal. Serotonin systems may also be involved, given the therapeutic effects of SSRIs in this disorder.
5. Treatment
   a. Nonpharmacologic: CBTs (including relaxation training, systematic desensitization, flooding, and cognitive reframing) are most effective for decreasing symptoms of hyperarousal.
   b. Pharmacologic: The drug class of choice is the SSRIs. Other drug classes of benefit are MAOIs (particularly phenelzine) and beta blockers (particularly atenolol and propranolol).
6. Concomitant disorders: One third of patients with social phobia report a history of major depressive disorders.

Suggested Reading

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SUMMARY

1. Prevalence: (a) The prevalence of eating disorders is 4%. (b) The prevalence of abnormal eating behaviors not classified strictly as eating disorders may be as high as 8%. (c) The prevalence of these disorders has increased significantly during the past several decades. (d) These diseases are more common in females than in males (9:1).
2. Symptoms: The symptoms of both anorexia nervosa and bulimia nervosa have been described previously. The major diagnostic clues are as follows:
   a. Anorexia nervosa: (i) failure to maintain normal weight (less than 85% of ideal weight), (ii) having an intense fear of gaining weight, (iii) having a distorted body image (feeling fat despite being grossly underweight), and (iv) having amenorrhea.
   b. Bulimia nervosa: (i) repeated episodes of rapid binge eating, (ii) severe compensatory behaviors to attempt to lose weight, and (iii) an unrelenting overconcern with weight and body image.
3. Relationships between the two disorders: (a) Both disorders involve abnormal eating behaviors and concern with body image. (b) Of individuals with anorexia nervosa, 50% have binge eating and purging behavior. (c) A diagnosis of bulimia nervosa is not made if the criteria for diagnosis of anorexia nervosa are present.
4. Complications
   a. Anorexia nervosa: the physical complications of starvation, namely, (i) depletion of fat, (ii) muscle wasting (including cardiac muscle in severe wasting), (iii) bradycardia, (iv) cardiac arrhythmias (sudden death may follow), (v) leukopenia, (vi) amenorrhea, (vii) osteoporosis, (viii) cachexia, and (ix) lanugo (fine body hair).
   b. Bulimia nervosa: (i) dental caries and dental disease from vomiting; (ii) metabolic abnormalities (hypokalemia secondary to vomiting); (iii) black stools from laxative abuse; and (iv) if significant weight loss occurs, physical symptoms as listed previously for anorexia nervosa may develop.
5. Treatment
   a. Anorexia nervosa: (i) for severe cases, hospitalization to reestablish weight and to correct metabolic abnormalities; (ii) CBT and often family therapy focusing on dynamics related to issues of control; and (iii) SSRIs for coexisting depression.
   b. Bulimia nervosa: (i) CBT and (ii) SSRIs to treat the binge eating component.

Suggested Reading

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CHAPTER 151

Somatoform Disorders

CLINICAL CASE PROBLEM 1

A 29-Year-Old Woman with 22 Different Symptoms

A 29-year-old woman comes to your office for an evaluation of multiple complaints. She has seen several other physicians but has not been satisfied with her treatment to date. She has heard from her best friend that "you are the best doctor for complicated medical problems." She tells you that she has been "sickly" for most of her adult life and describes the following chronic but intermittent complaints: chest pain, palpitations, shortness of breath, muscle weakness, nausea, periodic vomiting, difficulty swallowing, abdominal pain, diarrhea, dizziness, double vision, occasional numbness of the hands and feet, dysuria, back pain, joint pain, headaches, dyspareunia, intolerance to fatty foods, intolerance to high-fiber foods, heartburn, and "constant gas." She notes that she is sleeping well and denies feeling depressed or anxious.

Her vital signs are within normal limits. A thorough physical examination reveals no physical cause for any of her complaints.

SELECT THE BEST ANSWER TO THE FOLLOWING QUESTIONS

1. What is the most likely diagnosis in this patient?
   a. somatization disorder
   b. conversion disorder
   c. thyroid cancer
   d. hypochondriasis
   e. masked depression

2. At this first visit, what is the next step in the initial management of this patient?
   a. order a computed tomography scan of the head and abdomen
   b. start a selective serotonin reuptake inhibitor (SSRI) and explain the importance of patient insight in the treatment of this disorder
   c. prescribe a benzodiazepine and explain the importance of patient insight in the treatment of this disorder
   d. make another appointment with the patient to establish a more trusting relationship and to perform a thorough history and physical examination
   e. refer her to a psychotherapist specializing in this disorder

3. What is the pharmacologic treatment of choice for the disorder described?
   a. a benzodiazepine
   b. divalproex
   c. an SSRI
   d. a monoamine oxidase inhibitor
   e. none of the above

CLINICAL CASE PROBLEM 2

A 23-Year-Old Woman Complaining of Having "a Peculiarly Prominent Jaw"

A 23-year-old woman comes to your office with a chief complaint of having "a peculiarly prominent jaw." She tells you that she has seen a number of plastic surgeons about this problem, but "everyone has refused to do anything."

On examination, there is no protrusion that you can see, and it appears to you that she has a completely normal jaw and face. Although the physical examination is completely normal, she appears depressed.

4. What is the most likely diagnosis in this patient?
   a. dysthymia
   b. major depressive disorder (MDD) with somatic concerns
   c. somatic symptom disorder
   d. body dysmorphic disorder
   e. hypochondriasis

5. Therapies that reportedly have produced successful results in this disorder include which of the following?
   a. cognitive-behavioral therapy (CBT)
   b. SSRIs
   c. tricyclic antidepressants (TCAs)
   d. individual or group psychotherapies
   e. all of the above

CLINICAL CASE PROBLEM 3

A Mother of Five with a Constant Headache

A 29-year-old mother of five comes to your office with a "constant headache." She states that she is unable to ambulate without assistance because of her neck, abdominal, pelvic, and rib pain. She goes on to say that she has been diagnosed as having fibromyalgia. After performing a complete history, physical examination, and laboratory and radiologic workup, you make a diagnosis of tension headache. She then tells you that she has seen a number of other physicians about the same problem and that they have come to the same conclusion (which she believes is totally incorrect). You ask her to return for a further discussion about this problem next week, shake hands, and are about to leave. However, she continues to discuss the details of her pain and the difficulties that the pain causes her.

You tell her that you will continue discussion of these problems with her when you see her next week. You again attempt to leave the office.

6. What is the most likely diagnosis in this patient?
   a. schizophrenia
   b. conversion disorder
   c. chronic pain syndrome
   d. somatic symptom disorder
   e. none of the above

7. What is the preferred treatment for this patient?
   a. weekly (daily, if needed) visits with you
   b. group psychotherapy
   c. CBT
   d. supportive psychotherapy
   e. treatment in a multidisciplinary pain clinic

CLINICAL CASE PROBLEM 4

A 23-Year-Old Woman Suddenly Becomes Blind

A 23-year-old patient is brought by her husband to the emergency department with a complaint of "having suddenly gone blind." She tells you that she was walking down the street trying to "cool off" after an argument on the phone with her mother and suddenly she could not see. The visual impairment that she describes is bilateral, complete (no vision), and associated with "numbness, tingling, and weakness" in both lower extremities.

The physical examination of the patient suggests a significant difference between the subjective symptoms and the objective observations. Specifically, both the knee jerks and the ankle jerks are present and brisk; however, motor strength and sensation in both lower extremities appear diminished, not following anatomic pathways.

8. On the basis of the information provided, what is the most likely diagnosis?
   a. factitious disorder
   b. conversion disorder
   c. bilateral ophthalmic artery occlusion and spinal artery occlusion
   d. somatic symptom disorder
   e. malingering

9. What is the most appropriate next step at this time?
   a. call an ophthalmologist immediately (stat)
   b. call a neurologist stat
   c. call a psychiatrist stat
   d. call a social worker stat
   e. reassure the patient and initiate discussion about stressors

ANSWERS

1. a. This patient has somatic symptom disorder. Somatic symptom disorder was formerly called somatization disorder, and the criteria for this condition was broadened in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). Somatic symptom disorder is characterized by the following symptoms: (1) multiple physical complaints of long-standing occurrence; (2) these symptoms usually have resulted in significant medical diagnostic testing, medical interventions, and invasive procedures often causing iatrogenic sequelae; (3) the illness has resulted in significant occupational or social malfunction; (4) the patient's complaints include symptoms that are not fully explained by a known medical condition or by clinical findings; (5) pain is experienced in at least four different sites (e.g., headache or related pain, abdominal pain, back pain, joint pain, extremity pain, chest pain, rectal pain, or dyspareunia); (6) the symptoms include two or more gastrointestinal symptoms (e.g., nausea, diarrhea, bloating, vomiting, and food intolerance); (7) also included are one or more sexual symptoms (e.g., erectile or ejaculatory dysfunction, menstrual irregularities, or decreased libido or indifference); (8) the symptoms include one or more pseudoneurologic symptoms (e.g., a conversion symptom or a dissociative symptom); and (9) these symptoms are not produced consciously.

The patient has no volitional control over these manifestations, which are thought to be expressions of underlying unacceptable emotion.

2. d. For this patient, another visit is reasonable to establish a more trusting relationship and to perform a thorough history and physical examination. The goal of treatment is to provide care for the patient without focusing on "curing" the disease. The best treatment hinges on the long-term relationship between the patient and an empathic primary care provider. The physician must allow the patient to play the "sick role." Also important is the scheduling of regular visits with a defined length and a set agenda. Limits should be set for contacts outside of the visit time. Diagnostic procedures and therapeutic interventions must be chosen carefully to minimize adverse reactions and problems with indeterminate results fueling the disease. The dialogue that occurs between the physician and the patient must address symptoms and signs from both a somatic and a psychosocial viewpoint, including the emotional precipitants and consequences of the symptoms. Once the patient has gained insight into the psychological nature of the condition, a referral to a therapist may be indicated.

3. e. Pharmacologic treatment is not helpful in somatoform disorders. However, pharmacologic treatment of symptoms is sometimes helpful in establishing therapeutic alliance. Concomitant psychiatric conditions may be treated with appropriate medications.

4. d. This patient has body dysmorphic disorder, a condition characterized by the following: (1) preoccupation with an imagined or grossly exaggerated body defect; (2) clinically apparent distress associated with social, occupational, or functional impairment; and (3) psychiatric conditions such as obsessive-compulsive disorder, anorexia nervosa, psychosis, or other psychiatric disorders cannot account for the preoccupation and the impairment.

In addition, the differential diagnosis of body dysmorphic disorder includes the following: (1) anxiety disorders, (2) MDD, (3) hypochondriasis, (4) other somatoform disorders, (5) factitious disorders, and (6) malingering.

5. e. General principles for somatization disorders discussed previously apply to management of body dysmorphic disorder; however, the somatic preoccupations are often persistent. Individual or group psychotherapy is sometimes useful. CBT is used increasingly for the treatment of this condition. SSRIs or TCAs have been used for some patients, especially in cases with coexisting depression. Overall, however, pharmacologic approaches are not the mainstay of therapy for this condition.

6. c. The diagnosis for this patient is chronic pain syndrome, sometimes called pain disorder associated with

psychological factors. The criteria for this diagnosis are as follows: (1) pain is the central clinical feature and is of sufficient severity to require assessment; (2) the pain results in social, occupational, or functional impairment or clinically significant distress; (3) psychological factors precipitate, exacerbate, or maintain the pain or contribute to the severity of the pain; and (4) the pain is not a component of somatization disorder or other psychiatric disorders including sexual dysfunction.

The differential diagnosis of chronic pain syndrome must take into consideration other psychiatric disorders, such as psychological factors affecting a general medical condition, somatization disorder, hypochondriasis, depressive disorders, generalized anxiety disorder, factitious disorder, and malingering. It is sometimes very difficult to differentiate this somatoform disorder from established medical conditions such as degenerative disk disease. In addition, pain disorders often develop after an initial injury or illness. Chronic pain syndrome is more common in women than in men and may occur at any age. Often, patients have severe functional impairment and use pain medications extensively.

7. e. The treatment of choice for this patient is treatment in a multidisciplinary pain clinic. Such treatment has several objectives. Often, patients first must be detoxified from analgesics and sedative-hypnotics. Other nonpharmacologic treatments for pain control, including transcutaneous nerve stimulation, biofeedback, and other forms of behavioral psychotherapy, are substituted. The therapeutic emphasis must be shifted from elimination of all pain to management of pain and its consequences. Both psychological and physical therapies are used to minimize the functional limitations caused by the pain. Patients are encouraged to increase their social, occupational, and physical activities. These techniques are similar to those used in the management of patients with chronic pain caused by general medical conditions. Specialized pain clinics are often the optimal treatment setting.

Depressive symptoms must also be addressed in pain management. Antidepressants are indicated when depressive disorders are present in these patients.

8. b. This patient has conversion disorder. Conversion disorders represent a type of somatoform disorder in which there is a loss of or alteration in physical functioning during a period of psychological stress that suggests a physical disorder but that cannot be explained on the basis of known physiologic mechanisms. Often, symptoms are brought on by stressful and overwhelming events. Contrary to malingering or factitious disorder, conversion disorder is not volitional. The disorder occurs more frequently in women, with its highest prevalence in rural areas and among underserved and undereducated patients.

The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5), criteria for conversion disorder are as follows: (1) the symptom or deficit is not consciously or intentionally produced; (2) the symptom or deficit is not medically explained after clinical assessment; (3) the initiation or exacerbation of the symptom or deficit is usually preceded by conflicts or stressors; psychological factors are prominent; (4) the symptom or deficit impairs social or occupational functioning, creates significant distress, or requires medical intervention; and (5) the symptom or deficit is not limited to pain or sexual dysfunction and is not a component of somatization disorder or other psychiatric syndrome. Common examples of conversion symptoms include paralysis, abnormal movements, aphonia, blindness, deafness, and pseudoseizures.

9. e. A wide variety of treatment techniques have been used successfully for the treatment of conversion disorder. The initial step in the management of acute symptoms is to quickly decrease the psychological stress. Brief psychotherapy focusing on stress and coping, suggestive therapy, and sometimes hypnosis may be extremely effective. Pharmacologic interventions, including the acute use of benzodiazepines, may also be useful. Brief hospitalization may sometimes be indicated, particularly when symptoms are disabling or alarming. Hospitalization may serve to remove the patient from the stressful situation and to assess for possible underlying general medical conditions.

SUMMARY

1. Somatic symptom disorder
   Diagnostic clues include multiple physical complaints with onset before the age of 30 years. The tendency is for these complaints to be both chronic and long-standing. The complaints involve each of the following: pain symptoms, gastrointestinal symptoms, sexual dysfunction symptoms, and pseudoneurologic symptoms. Impairment of social or occupational functioning is associated with these symptoms.
2. Conversion disorder
   Diagnostic clues include physical symptoms primarily involving loss of motor or sensory function that are produced because of psychological conflicts or stressors. They cannot be fully explained on an anatomic

SUMMARY—cont'd

basis and result in impairment of social or occupational functioning. Conversion disorder is more common among medically unsophisticated groups; it may also be a manifestation of a disturbed family or marital situation.

3. Chronic pain syndrome
   Diagnostic clues include pain as the prominent clinical presentation, and it results in social, occupational, or functional impairment. This diagnosis is made when psychological factors are believed by the physician to have a significant role in the onset, severity, exacerbation, or perpetuation of the pain syndrome. Major depression or anxiety is often present and may be a component of the pain syndrome. The best therapeutic strategy is to limit inappropriate use of analgesics and other medical resources and to modify the patient's therapeutic expectations from cure to management of the pain while attempting to appreciate the role of psychosocial or psychological factors and stress. A multidisciplinary pain clinic is the treatment of choice in most cases.
4. Body dysmorphic disorder
   The fundamental diagnostic feature is a pervasive feeling of ugliness or physical defect based on a grossly exaggerated perception of a minor (or even absent) physical anomaly. Patients frequently consult multiple primary care physicians, dermatologists, and plastic surgeons. Depressive symptoms, anxiety symptoms, social phobia, obsessive personality traits, and psychosocial distress frequently coexist. Intervention includes group or family therapy and, occasionally, the use of SSRIs or other medication to decrease obsessive concerns and depression.
5. Malingering
   The essential feature of malingering is the intentional production of illness consciously motivated by external incentives, such as avoiding military duty, obtaining financial compensation through litigation or disability, evading criminal prosecution, obtaining drugs, or securing better living conditions. Malingering is more likely when the medical and legal context overshadows the presentation, a marked discrepancy exists between the clinical presentation and objective findings, and a lack of cooperation is experienced with the patient. Confrontation in a confidential and empathic but firm manner that allows an opportunity for constructive dialogue and appreciation of any psychological or psychosocial problems is imperative.
6. Factitious disorder and Munchausen syndrome
   Factitious disorder must be carefully distinguished from malingering and somatoform disorders.

   In malingering or feigning illness, the expressed purpose is to avoid work or to obtain money. Factitious disorders have no incentive other than to be a patient and to obtain medical care.

Malingering and factitious disorder differ from somatoform disorders in that symptoms and signs of illness are consciously created by the patient, whereas in somatoform disorders, the symptoms are subconscious The most extreme and dramatic form of factitial disease is Munchausen syndrome; it frequently includes extensive travel and purposeful seeking of multiple invasive procedures and operations, sometimes with serious risk to life. Impersonation, fabrication, and pseudologia fantastica (creation of fantastical stories of accomplishment or travel) often accompany Munchausen syndrome. In addition, those patients who travel from one medical facility to another to maintain a sense of confidentiality about their many medical encounters are engaged in a process referred to as peregrination.

In the most damaging form of Munchausen syndrome, adults purposefully use children as surrogates or victims of inflicted purposeful illness; so called Munchausen by proxy syndrome.

Patients may fake illness in a variety of ways:

- Confabulated history alone (e.g., cancer, acquired immune deficiency syndrome [AIDS], cardiopulmonary disease)
- Faking symptoms only
- Creating a "real" illness by artificial means (e.g., injection of fecal material or other potential pathogens subcutaneously or intravenously)
- Use of excessive doses of medications (thyroid, digoxin)
- Bleeding by swallowing blood or purposeful cutting
- Tampering with thermometers, intravenous lines, or laboratory specimens

The diagnosis relies heavily on the astuteness of the clinician. The best information comes from careful checking with other sources (e.g., hospitals, physicians, family) when there are suspicious omissions or stories that seem too good to be true. Unfortunately, regulations regarding medical privacy and confidentiality may create difficulty in obtaining data from other medical facilities. The patient's refusal to allow sharing of medical information from other institutions is an important clue to the diagnosis.

Discovery by a medical facility or physician that the patient has Munchausen syndrome usually results in the patient's rapidly leaving that care facility and moving on to another sufficiently distant so that the patient can play out the scenario again and again.

No specific therapy for factitious disorders has been established. General principles are as follows:

- Treat the self-induced medical or surgical conditions, as indicated, and protect the patient from self-harm or repeated dangerous procedures.
- Attempts to limit the patient's care to one primary care physician or facility are usually unsuccessful.

SUMMARY—cont'd

and previous sexual abuse; (f) consider the possibility of family violence in the present (e.g., spousal abuse leading to rape); and (g) use the LEDO approach (guidelines described in the Solution to the Clinical Case Management Problem).

4. Pharmacologic treatment of male sexual dysfunction: (a) ED may be treated with sildenafil, vardenafil, or tadalafil; (b) premature ejaculation may be ameliorated with SSRIs; and (c) although no reliable aphrodisiacs exist, some patients with hypoactive sexual desire disorder may respond to androgenic steroids or yohimbine. If a medication causes side effects that cannot be controlled, a change to a different medication class should be considered.
5. Pharmacologic treatment of female sexual dysfunction is under investigation.
6. Other treatments: ED can also be treated with nonprescription vacuum devices or with surgical implants.

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CHAPTER 153

Psychotherapy in Family Medicine

CLINICAL CASE PROBLEM 1

A 29-Year-Old Working Mother with Two Young Children Who Is Unable to Cope

A 29-year-old mother who holds a full-time out-of-the-home job has just gone back to work after the birth of her second child. The child is currently 8 weeks old. She works as an accountant in a large company. Her company is restructuring, and she worries that her job is not secure. Her husband has been laid off from his job as an assembly line worker at an automobile assembly plant.

After her maternity leave, she fears that the management is unhappy with her for "taking so much time off to have a baby." She is staying up late every night to get the housework done. She wakes up often during the night to feed the baby. She is too tired to spend quality time with the older child and feels guilty about that. She is crying, fatigued, and absolutely exhausted after 10 days back on the job. She finds herself becoming "very sleepy every day at work," and the management has commented on that. She tells you, "I just can't take it any longer. I have to work to pay the mortgage and put food on the table. There are no other jobs available. What am I going to do? I just can't go on this way."

She has no history of psychiatric problems or sleep disorders. She has no family history of psychiatric disorders or personal or family history of drug or alcohol use. She is not taking any drugs at present.

SELECT THE BEST ANSWER TO THE FOLLOWING QUESTIONS

1. What is the most likely diagnosis in this patient at this time?
   a. major depressive disorder (MDD)
   b. generalized anxiety disorder
   c. adjustment disorder
   d. dysthymic disorder
   e. panic disorder

2. Which of the following would be the next therapeutic step in the care of this patient?
   a. schedule regular follow-up to allow the patient to "vent" her concerns
   b. if the patient is not nursing, start fluoxetine for 1 week with the addition of zolpidem as needed for sleep
   c. refer this patient and her husband to social services, such as vocational rehabilitation, to facilitate a more ordered entry into the workforce
   d. none of the above
   e. any of the above

3. You decide to initiate psychotherapy. At this time, in this patient and given this diagnosis, what is the best psychotherapy to initiate in a primary care setting?
   a. cognitive psychotherapy
   b. brief psychodynamic psychotherapy
   c. behavioral psychotherapy (behavior modification)
   d. supportive psychotherapy
   e. intensive psychoanalytically oriented psychotherapy

4. What is the major goal of the psychotherapy in this patient's situation?
   a. to identify and to alter cognitive distortions
   b. to understand the conflict area and the particular defense mechanisms used
   c. to maintain or to reestablish the best level of functioning
   d. to eliminate involuntary disruptive behavior patterns and to substitute appropriate behaviors
   e. to resolve symptoms and to rework major personality structures related to childhood conflicts

5. What is the first priority at this time?
   a. foster a good working relationship with the patient
   b. approach the patient as a "blank screen"
   c. develop a "therapeutic alliance" with the patient
   d. begin the assignment of tasks for the patient to complete
   e. develop "free association" with the patient

6. What is the therapeutic method at this time?
   a. validate and explore the patient's concerns, provide direction for problem solving, and help her deal with the situation
   b. have the patient express her anger in the "here and now"
   c. prescribe a sedative to "get things under control"
   d. have the patient "intellectualize" her concerns
   e. have the patient discuss her dreams and free associations

7. Which of the following is (are) a technique(s) of supportive psychotherapy?
   a. support problem-solving techniques and behaviors
   b. develop a short-term "mentoring" relationship
   c. develop a short-term "guiding" relationship
   d. suggest, reinforce, advise, and reality test
   e. all of the above

8. Depression is the most frequent psychiatric condition seen in the primary care setting. Which of the following psychotherapies has been shown to be most efficacious in the treatment of psychiatric conditions encountered in primary health care settings?
   a. intensive analytically oriented psychotherapy
   b. psychoanalysis
   c. cognitive-behavioral therapy (CBT)
   d. brief psychodynamic psychotherapy
   e. gestalt psychotherapy

CLINICAL CASE PROBLEM 2

A 39-Year-Old Woman with a 4-Month History of Depression

A 39-year-old woman comes to your office with a 4-month history of depression. She meets the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, criteria for major depressive disorder (MDD). She was prescribed an antidepressant 6 weeks ago, and it appears to be helping significantly.

9. Which of the following statements is (are) true regarding the therapeutic approach to this disorder?
   a. the combination of cognitive therapy and antidepressants has been shown to effectively manage severe or chronic depression
   b. supportive psychotherapy is the ideal psychotherapy for this patient
   c. there is little evidence to support a combination of medication and psychotherapy in preference to psychotherapy alone
   d. brief psychodynamic psychotherapy has been shown to be the most effective psychotherapy when it is used in combination with a selective serotonin reuptake inhibitor (SSRI)
   e. all of the above statements are true

10. Which of the following statements regarding CBT is (are) true?
    a. cognitive therapy is a treatment process that enables patients to correct false self-beliefs that can lead to negative moods and behaviors

b. CBT has proved beneficial in treating patients who have only a partial response to adequate antidepressant therapy
c. formal CBT is generally conducted for a period of 15 to 25 weeks in weekly sessions
d. CBT is best suited to patients who have depressive disorders without psychotic features
e. all of the above statements are true

11. What is the major goal of CBT?
a. to help patients "pick themselves up by the bootstraps" and change their lives
b. to reestablish a previous best level of functioning
c. to understand the major conflict area and the particular defense mechanisms being used
d. to identify and to alter cognitive distortions
e. to clarify and to resolve the focal area of conflict that interferes with current functioning

CLINICAL CASE MANAGEMENT PROBLEM

Describe the forms of psychotherapy that are useful in the family practice setting.

ANSWERS

1. c. This patient has an adjustment disorder. Although this condition is detailed in Chapter 141, the basic characteristics of adjustment disorder are provided here again: (1) the development of a psychological reaction to identifiable stressors or events; (2) the reaction reflects a change in the individual's normal personality and is different from the person's usual style of functioning; (3) the psychological reaction is either "maladaptive" in that normal functioning (including social and occupational functioning) is impaired or greater than normally expected of others in similar circumstances; and (4) the psychological reaction does not represent an exacerbation of another psychiatric disorder.

2. d. Although it is important to address target symptoms such as sleep, the first-line treatment of adjustment disorder does not involve medication. Rather, a supportive and empathic approach is applied with a strong development of therapeutic alliance to facilitate therapy. Allowing patients to vent may be helpful in the short term, but this approach lacks the structured guidance that is required to promote change in the patient's thinking, feeling, or behavior necessary to lead to clinical improvement. Furthermore, this patient would be likely to feel overwhelmed in any work environment, making a "job change" an unlikely therapeutic intervention.

3. d. The type of psychotherapy that best fits treatment of this patient's life situation in a primary care setting is supportive psychotherapy. Supportive psychotherapy is discussed in detail in answers 4 through 7.

4. c. The major goal of supportive psychotherapy is to reestablish the best possible level of functioning given the patient's current circumstances, personality, and previous coping style. In general, this distinguishes supportive psychotherapy from the change-oriented psychotherapies that aim to modify primary disease processes, to adjust thinking style, to change behavior, or to restructure personality.

5. a. The first priority of supportive psychotherapy is to foster a good working relationship with the patient. This will make the patient feel competent and connected, which are the two basic social needs of any human being. When people feel overwhelmed, they lose the sense of being competent and connected.

6. a. Once a working relationship is established between patient and physician, the physician encourages the patient to explore his or her concerns and validates the patient's feelings. In this clinical case problem, enlisting the husband's practical support, exploring options for temporary part-time employment, and validating the patient's need to take care of herself are important. It is extremely useful to elicit her stories about overcoming previous difficult times.

The prescription of a sedative risks compounding her problem and is contraindicated.

7. e. Specific techniques used in supportive psychotherapy include the following: (1) regular sessions in which therapy for the patient is consistently available; (2) support by the therapist of problem solving by the patient; (3) guiding or mentoring on the part of the therapist; (4) concomitant use of medication (especially antidepressant medication) if indicated; and (5) depending on the physician's level of expertise, specific techniques such as suggestion, reinforcement, advice, teaching, reality testing, cognitive restructuring, reassurance, encouragement of alternative behavior, and discussion of social and interpersonal skills.

8. c. An increasing amount of literature supports the efficacy of CBT in primary care settings. Studies examining the outcome of CBT have found it to be an effective treatment in ambulatory patients with mild to moderate degrees of depression. One advantage of CBT is that the therapeutic techniques can often be learned more easily than psychodynamic techniques and integrated into primary care treatment.

Cognitive techniques include the questioning of maladaptive assumptions about problems, provision of

information, and assignments for dealing with specific situations. There is a trend to combine these techniques with behavioral techniques, such as relaxation training and desensitization, which are also very useful in the family practice setting.

9. a. Family physicians are usually the first to diagnose and to treat patients with depression. Studies have shown that the best treatment of MDD is a combination of antidepressant medications with CBT, not supportive psychotherapy. Physicians should inform patients that psychotherapy and pharmacotherapy are valid options and that cognitive therapy, and therefore CBT, is the most studied psychotherapy. If the patient and physician initially elect to use pharmacotherapy and the patient does not respond adequately, the physician should again suggest adding psychotherapy or CBT. A combination of psychotherapy and pharmacotherapy is more effective than either method alone in patients with MDD without psychotic features.

Some qualitative studies have suggested that full implementation of the CBT model by primary care physicians can be difficult in the context of visit and time constraints of a primary care practice, even with adequate training. If the family physician is unable to provide the psychotherapy because of either lack of training or lack of time, a referral to a psychotherapist is indicated.

10. e. The process of CBT helps patients reinterpret their views about their lives. It helps them to edit their stories. Although formal CBT is generally conducted for a period of 15 to 25 weeks in weekly sessions, family physicians can make effective interventions during brief visits. CBT can also be used in patients who refuse to take antidepressant medication, fail to respond to antidepressant medication, or are unable to tolerate antidepressant medications.

11. d. CBT is a method of brief psychotherapy developed during the past 25 years primarily for the treatment of mild to moderate depression and other psychiatric conditions encountered in the primary care setting.

People who are depressed tend to have negative interpretations of the world, themselves, and the future. Also, patients who are depressed interpret events as reflecting defeat, deprivation, or disparagement and view their lives as being filled with obstacles and burdens. They also view themselves as unworthy, deficient, undesirable, or worthless and see the future as bringing a continuation of the miseries of the past.

The major goal of cognitive psychotherapy is to identify and to alter cognitive distortions and thoughts. CBT helps patients identify and alter these cognitive distortions (negative stories). The techniques that are used include behavioral assignments, reading materials, and teaching that helps these patients recognize the difference between positively and negatively biased automatic thoughts. At first glance, it may seem completely straightforward, but it is sometimes difficult for the patient to tell the difference between the two. It also helps patients identify negative schemas, beliefs, and attitudes.

SOLUTION TO THE CLINICAL CASE MANAGEMENT PROBLEM

Family physicians can incorporate effective psychotherapeutic interventions into a brief office visit. Supportive psychotherapy and CBT are the two most appropriate psychotherapeutic approaches for use in a family physician's practice.

CBT is useful in the treatment of nonpsychotic depressive disorders and in stress management. Supportive psychotherapy is useful in the treatment of adjustment disorders, family and marital conflicts, and any condition to which importance is attached by the patient.

Family physicians should be familiar with some of the differences in goals among popular forms of psychotherapy:

1. Psychoanalysis aims to resolve symptoms and to perform major reworking of personality structures related to childhood conflicts.
2. Psychoanalytically oriented psychotherapy aims to understand a conflict area and the particular defense mechanisms used to defend it.
3. Brief psychodynamic psychotherapy is used to clarify and to resolve focal areas of conflict that interfere with current functioning.
4. Cognitive psychotherapy primarily identifies and alters cognitive distortions.
5. Supportive psychotherapy aims to reestablish the optimal level of functioning possible for the patient.
6. Behavioral therapy (behavioral modification) aims to change disruptive behavior patterns through reinforcing positive responses and ignoring negative ones; relaxation approaches, rewards systems, and breathing techniques can be used for the patient's benefit.

Many of these psychotherapeutic modalities can be used in a group setting. This approach provides significant support to groups of patients dealing with serious general medical conditions, smoking cessation, and stress disorders.

SUMMARY

1. Consider the use of supportive psychotherapy in any condition, recognizing the biopsychosocial model of illness.
2. Consider the increased efficacy of treating depressive disorders with a combination of SSRIs and cognitive psychotherapy.
3. Although formal CBT is generally conducted for a period of 15 to 25 weeks in weekly sessions, family physicians can make effective interventions during brief visits.
4. Some studies indicate significant cost-effectiveness of psychotherapy relative to other interventions.
5. Therapeutic intervention in family medicine is a skill that can be acquired with some additional training.
6. A referral to a qualified mental health professional is indicated when long-standing and complex problems are uncovered.
7. Supportive psychotherapy and CBT are the two most appropriate psychotherapeutic approaches for use in a family physician's practice.

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