PRIMARY CARE
MED437

Common Psychiatric Problems

Objectives:

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

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References

- Doctor's slides and notes

Important *Notes* *Extra* *Golden*

Editing file link

Somatic symptom disorder

1. Somatization is broadly defined as emotional or psychological distress that is experienced and expressed as physical complaints.
2. Somatization can occur in the presence of physical illness, with symptoms, either unrelated to the illness or out of proportion to objective findings.

- Somatization is an important problem in family medicine.
- Approximately one-third of all family practice patients have ill defined, symptoms not attributable to physical disease, and 70% of those patients with emotional disorders present with a somatic complaint as the reason for their office visit.

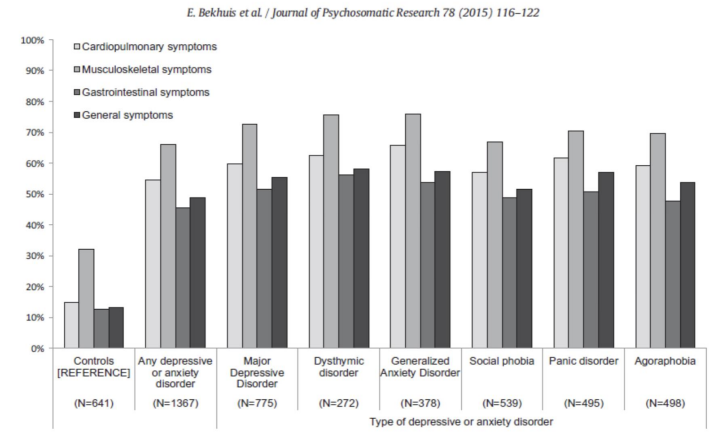
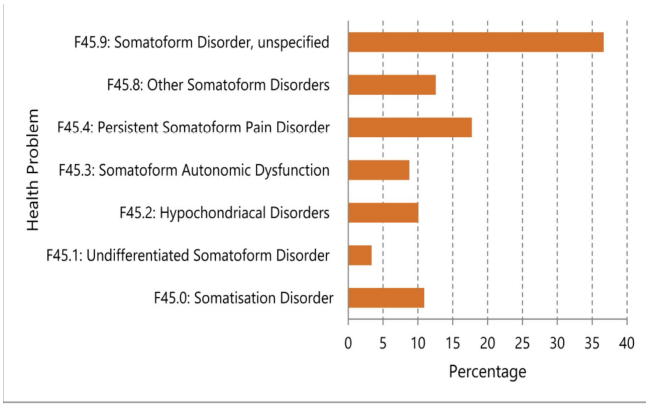


Fig. 1. Prevalence of clusters of somatic symptoms across controls and patients with a depressive and/or anxiety disorder.

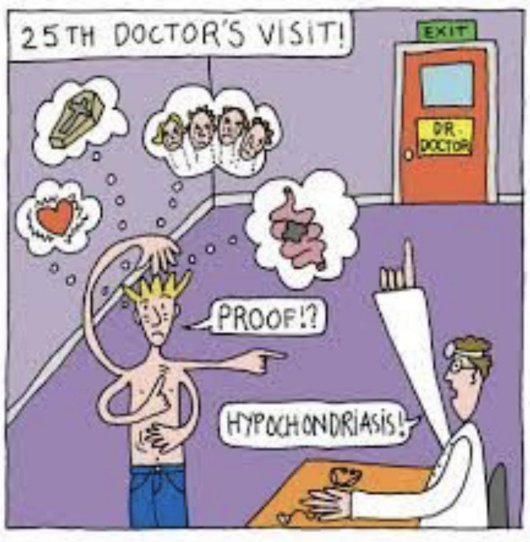


ig 1. Recorded somatoform disorders F45.

Cross-sectional data were derived from The Netherlands Study of Depression and Anxiety (NESDA). A total of 2008 persons (mean age: 41.6 years, 64.9% women) were included, consisting of 1367 patients with a past-month DSM-diagnosis (established with the Composite International Diagnostic Interview [CIDI]) of depressive disorder (major depressive disorder, dysthymic disorder) and/or anxiety disorder (generalized anxiety disorder, social phobia, panic disorder, agoraphobia), and 641 controls.

The data were initially made available for our study group in order to evaluate a comprehensive evaluation programme in German primary care, F45-Patients
(n = 350,528)

- The study sample consists of 431 male and female primary care patients who completed the PHQ
- The prevalence of somatoform disorder in the sample was 19.3% based on the PHQ and 35.7% using physician assessments.
- The PHQ identified 20% of the sample with depression and physicians identified 18.1%
- There were 38.9% of patients with a PHQ diagnosis of somatization who also had a PHQ diagnosis of depression.
- The high rate of comorbidity of these disorders supports the practice of simultaneously screening for somatization and depression in the sample.
- False negative and false positives made on individual patients particularly by male physicians who tended to overestimate somatization and slightly underestimate depression in their patients.



Etiology of somatic symptom disorder

- Genetic factors may play a role since somatization is much more common in females and familial patterns have been reported.
- CNS regulates sensory information abnormally, resulting in symptoms.
- Behavioral theories suggest that somatization is a learned behavior in which the environment reinforces the illness behavior.
  - Behavioral كل واحد يتعلم من الاخر
    A 12-year-old girl start having the same complaint as her mother (vaginal discharge)
- Somatization is also thought by some to be a defense mechanism.
  Paralysis of her hand when she is angry, resolve when she is happy

Somatic symptom disorder

- Characterized by multiple unexplained symptoms in multiple organs
- Beginning before age 30.
- DSM-IV criteria require the presence of four pain symptoms, two GI symptoms, one sexual symptom, and one pseudoneurologic symptom drawn from an extended list of symptoms.
- Other somatoform disorders include **hypochondriasis** and **conversion disorders**.
- The prevalence of somatization disorder is less than 0.2% in males, 2% in the general female population, 6% in the general medical clinical population.

Conversion disorders like paralysed hand and blindness.

Clinical presentation

Symptoms a patient may present with include:

•Muscle and joint pain
•Low back pain
•Tension headache
•Chronic fatigue
•Non-cardiac chest pain
•Palpitation
•Non-ulcer dyspepsia
•Irritable bowel
•Dizziness
•Insomnia

Clues to Somatization:

- Multiple and vague symptoms: description of symptoms can be inconsistent or bizarre
- Symptoms persist despite adequate medical treatment
- Illness begins with a stressful event
- The patient “doctor shops”
- History of numerous workups with insignificant findings
- The patient refuses to consider psychological factors or discuss issues other than medical concepts
- There is evidence of an associated psychiatric disorder
- The patient has a hysterical personality
- Demanding yet disparaging of the physician
- Unreasonable demands for treatment and drugs
- Dwelling on symptoms and proud of suffering

Etiology of somatic symptom disorder

- Somatization is defined as emotional or psychological distress that is experienced and expressed as physical complaints.
- A thorough history and physical examination are essential in order to eliminate the possibility of organic disease.
- Unless there is evidence suggesting a specific disorder, extensive testing should be avoided.
- An important step in management is to legitimize and acknowledge the complaints, share the patient’s frustrations, and express continued interest and hope.
- Pharmaceuticals can benefit patients with major depression or an anxiety disorder that presents with somatic symptoms.

- How can i decide if it was areal physical complaint or somatization ?

1. Multiple and vague symptoms
2. It can't be explained (Hypertensive you give medication when they know about the side effects they start thinking they have these symptoms)
3. Doctors shops frequent attenders each time they have new complaints.
4. They refuse to discuss mental illness.
5. Demands for treatment and drugs الله يخليك دكتورة عطيني اي شي
6. Dwelling and proud of suffering الدكاترة يقلبوني كأني ميته

Anxiety

Etiology of anxiety disorder

- Anxiety disorders occur in 19% of primary care patients.
- Recognition of anxiety disorders in primary care is low (23%); and, fewer than 30% of patients receive treatment.

Anxiety disorders in primary care

- Generalized anxiety disorder
- Panic disorder
- Posttraumatic stress disorder
- Obsessive compulsive disorder
- Acute stress disorder

Medical conditions that mimic anxiety

- Alcohol withdrawal
- Angina
- Asthma
- Attention deficit hyperactivity disorder
- Bipolar disorder
- Bulimia
- Cardiac arrhythmias
- Hyperthyroidism
- Medication side effects
- Menopause
- Neurologic disorders
- Stuttering
- Substance abuse
- Transient ischemic attacks

Clinical Red Flags Suggesting a Serious Additional Problem in Patients Presenting with a Suspected Anxiety Disorder

- Alcohol abuse
- Bulimia/anorexia
- Delusions
- Developmental delay
- Focal, persistent weakness
- Hallucinations (although reliving experiences in posttraumatic stress disorder can be very vivid)
- Neurologic physical exam findings
- Sexual/physical abuse
- Substance abuse
- Suicidality
- Syncope
- Weight loss

- Anxiety disorders, generalized anxiety disorder, panic disorder, posttraumatic stress disorder, obsessive compulsive disorder, and acute stress disorder are commonly encountered in primary care.
- An anxiety disorder should be considered in the differential diagnosis for insomnia, pain, or fatigue.
- Screening for anxiety disorders can be accomplished using one or two questions.
- Benzodiazepines may be needed to provide relief from anxiety symptoms in the short term, but most anxiety disorders can be managed over the long term with a selective serotonin reuptake inhibitor or cognitive behavioral therapy.

Depression

- Depression is highly prevalent within the general population.
- In 1 year, mood disorders will be experienced by 9.5% of adults, major depressive disorder (MDD) by 6.7% and bipolar disorders by 2.6% .

Depression is important in primary care not only because of its high prevalence, but also because primary care is often the only source of care for patients suffering from this condition

Red Flags Suggesting More Serious or Complex Disease in Patients Presenting with Depression

	Significance
• Personal or family history of mania, hypomania, or formal diagnosis of bipolar disorder	Consider a diagnosis of bipolar disorder
• Personal or family history substance abuse disorder	Screen for co-occurring of substance abuse
• Prominent anxiety symptoms	Consider co-occurring diagnosis of an anxiety disorder and/or management of anxiety symptoms as antidepressant is taking effect.

Depression is highly prevalent in family medicine patients and a frequent comorbid condition with other chronic medical illness.

- Treatment for depression in family medicine is based on a strong therapeutic alliance between the patient and clinician.
- Treatment of depression to remission rather than symptom improvement is the goal.
- Routine monitoring of depression treatment using a standardized questionnaire is feasible and essential for guiding treatment.

CLINICAL CASE MANAGEMENT PROBLEM 1

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

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.

CLINICAL CASE MANAGEMENT PROBLEM 2

- Describe the basic diagnostic features of bipolar disorder: manic episode.

SOLUTION TO THE CLINICAL CASE MANAGEMENT PROBLEM:

Manic Episode

1. A manic episode is a distinct period of abnormally and persistently elevated, expansive, or irritable mood lasting at least 1 week and of sufficient severity to cause marked impairment in social or occupational functioning.
2. During this period, at least three of the following symptoms are also present:grandiosity, decreased need for sleep, hyperverbal or pressured speech,flight of ideas or racing thoughts,distractibility,increase in goal-directed activity or psychomotor agitation, and excessive involvement in pleasurable activities that have a high potential for painful consequences.
3. There is no evidence of a physical or substance-induced cause or the presence of another major mental disorder to account for the patient's symptoms.

CLINICAL CASE MANAGEMENT PROBLEM 3

- Describe the basic diagnostic features of bipolar disorder: hypomanic episode.

SOLUTION TO THE CLINICAL CASE MANAGEMENT PROBLEM

Hypomanic Episode

1. During a hypomanic episode, there is a distinctly sustained elevated, expansive, or irritable mood lasting for at least 4 days that is clearly different from the individual's non-depressed mood but does not cause marked impairment in social or occupational functioning such as in acute mania.
2. During the mood disturbance, at least three of the following symptoms are also present to a significant degree: inflated self-esteem or grandiosity, decreased need for sleep, more talkative than usual, flight of ideas or racing thoughts, distractibility, increase in goal-directed activity or psychomotor agitation, and excessive involvement in pleasurable activities that have a high potential for painful consequences.
3. The episode is not physical or substance induced.

CLINICAL CASE MANAGEMENT PROBLEM 4

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

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.

CLINICAL CASE MANAGEMENT PROBLEM 5

- List five common obsessions and five common compulsions associated with OCD.

SOLUTION TO THE CLINICAL CASE MANAGEMENT PROBLEM

Some common obsessions are as follows:
(1) Contamination and illness
(2) fear of harming others or self
(3) perverse or forbidden sexual thoughts, images, or impulses
(4) violent images
(5) symmetry or exactness
(6) exaggerated health concerns and religious thoughts.

Some common compulsions include the following:
(1) checking things (e.g., doors, locks, and water taps)
(2) cleaning or washing
(3) counting objects of various types
(4) hoarding or collecting objects of various types
(5) ordering or arranging articles of various types
(6) repeating things (speech and tapping) and committing some unethical, immoral, or criminal acts.

CLINICAL CASE MANAGEMENT PROBLEM 6

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

SOLUTION TO THE CLINICAL CASE MANAGEMENT PROBLEM 6

- 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 re-establish 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.

Questions

1. A 40 years old lady came to clinic complaining of mental exhaustion, poor sleep, palpitation for the past year. She visited 4 doctors over the past 3 months with no improvement. People who consumed more health resources are those with?

A. Anxiety disorders
B. Depression disorders
C. Personality trait disorder
D. Somatization disorders

2. 52 years truck driver present to the clinic with low mood, loss of appetite, and feeling of guilt for losing his son 18 months ago for road traffic accident. He is on bisoprolol for his hypertension. Which of the following classes of antidepressants are associated with the side effects of anticholinergic effect?

A. Atypical antidepressants
B. MAOIs
C. TCAs
D. SSRIs

3. You are concerned about the potential for suicide in n 18-year-old patient you are treating for depression. Which of the following increases this patient's risk for suicide?

A. The patient is felt to have dysrhythmic disorders.
B. The patient is frequently asked if he has suicidal thoughts or plans
C. The patient has a moderate bout of depression that improves on SSRIs for 1 month.
D. The patient fulfils criteria for a major depressive episode.

Answers:
1.A
2.C
3.D

4. A 20-year-old female came to your clinic for refill of her treatment. She was diagnosed as obsessive-compulsive disorder and was started on SSRIs. SSRIs are a mainstay of treatment of obsessive-compulsive disorder (OCD) because:

A. Antipsychotic medications may be helpful adjuncts to SSRIs in treatment of OCD.
B. Buspirone, although useful as an adjunct to SSRIs in treatment of depression, is not helpful as an adjunct to SSRIs in OCD.
C. Response time for SSRIs in OCD is shorter than that for depression.
D. SSRIs may be used in doses lower than those employed in treatment of depression.

5.A 25-year-old male came to your clinic with uncomplicated panic attacks. You treated his panic attacks with some success. Which of the following pharmacological approaches would be most helpful as maintenance therapy?

A. Chlorpromazine (Thorazine) 25 mg daily
B. Propranolol (Inderal) 20 to 40 mg daily
C. Sertraline (Zoloft) 25 to 50 mg daily
D. Trazodone (Desyrel) 50 mg daily

6.A family physician sees 30 patients a day, 5 days per week. Included in his practice are both gender and all age groups. What percentage of the symptoms given by these patients will have no biomedical basis of explanation?

A. 1% to 10%
B. 11% to 20%
C. 21% to 40%
D. 41% to 60%

Answers:
4. A
5. C
6. B