COMMON PSYCHIATRIC PROBLEMS IN GENERAL PRACTICE

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By The end of session Students will be able to:

- 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.

Etiology of somatic symptom disorder

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
3. 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.

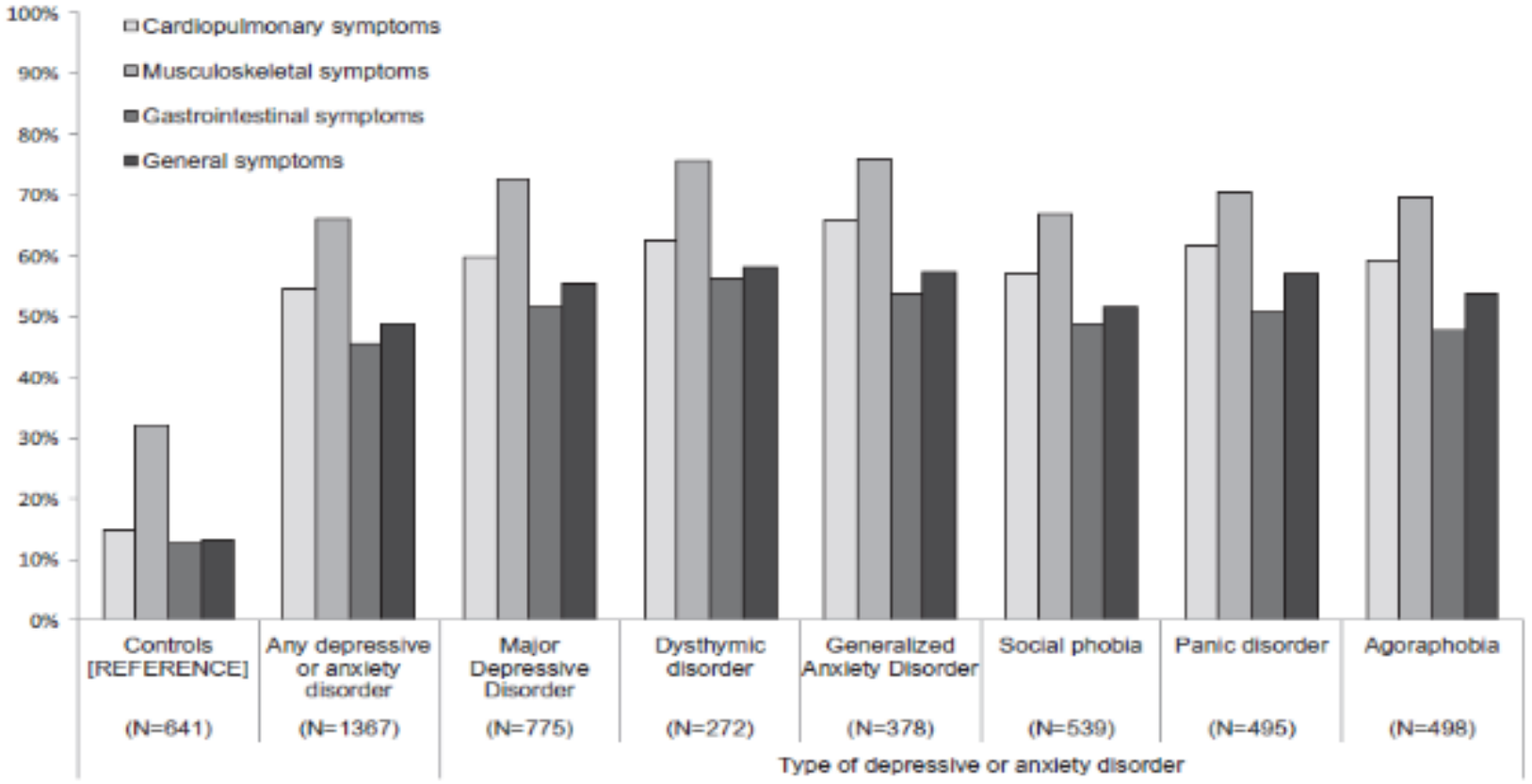

Fig. 1. Prevalence of clusters of somatic symptoms across controls and patients with a depressive and/or anxiety disorder.

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. https://doi.org/10.1016/j.jpsychores.2014.11.007

Becker, S.M. Detection of somatization and depression in primary care in Saudi Arabia. *Soc Psychiatry Psychiatr Epidemiol* **39,** 962–966 (2004). https://doi.org/10.1007/s00127-004-0835-4

- The study sample consists of 431 male and female primary care patients who completed the PHQ (Patient Health Questionnaire)
- The prevalence of the 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 were made on individual patients, particularly by male physicians who tended to overestimate somatization and slightly underestimate depression in their patients.

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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.

Female to male ratio of 10:1

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.

Somatization is also thought by some to be a defense mechanism.

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 pseudo neurologic 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,

Table 1. Somatic Symptom Disorder

Diagnostic criteria:

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

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

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

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

Specify if:

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

Specify if:

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

Specify current severity:

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

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

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

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

Somatic Symptom Disorder. www.aafp.org/afp *Volume 93, Number 1 ◆ January 1, 2016*

Table 2. Subsets of Somatic Symptom Disorder

Subset	*Description*
Conversion disorder	One or more symptoms of altered voluntary motor or sensory function inconsistent with a known condition
Factitious disorder	Falsification of physical or psychological symptoms, or induced injury or disease; can be with regard to self or imposed on others, although not for personal gain (as with malingering)
Illness anxiety disorder	Preoccupation with getting or having a serious medical disorder; the two types include care-seeking and care-avoidant; previously included in hypochondriasis
Psychological factors affecting other medical conditions	A medical condition must exist and psychological factors must negatively affect the condition
Other specified somatic symptom and related disorders	Symptoms consistent with somatic symptom disorder are present, but do not meet full criteria for any of the above disorders
Unspecified somatic symptom and related disorders	Symptoms consistent with somatic symptom disorder are present, but do not meet criteria for any of the above disorders; should be used only when there is insufficient information to make a more specific diagnosis

Somatic Symptom Disorder. www.aafp.org/afp *Volume 93, Number 1 ◆ January 1, 2016*

Clinical presentation

Symptoms a patient may present with include:

- Muscle and joint pain
- Low back pain
- Tension headache
- Chronic fatique
- 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

10 MINUTES QUIZ

Etiology of somatic symptom disorder

KEY POINTS

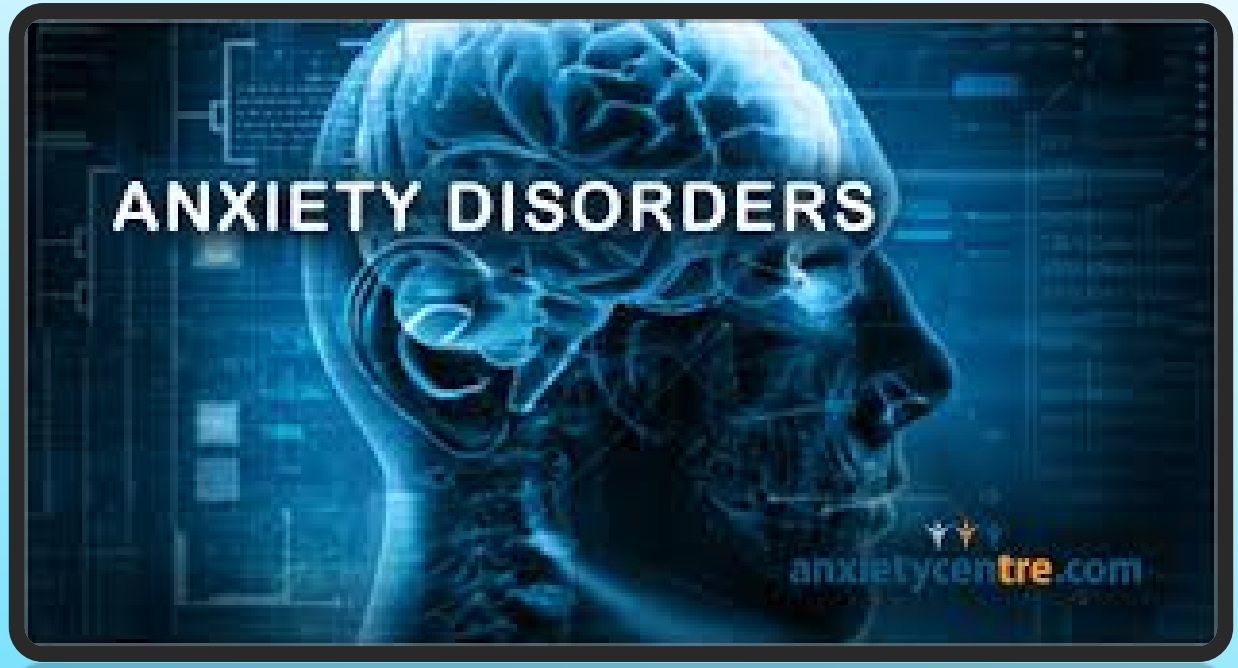
- Somatization is defined as emotional or psychological distress that is experienced and expressed as physical complaints.

- 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.


ANXIETY DISORDERS
anxietycentre.com

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

- 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

Medical conditions that mimic anxiety

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 disorder

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.

Diagnostic Criteria for Generalized Anxiety Disorder (1)

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

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

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

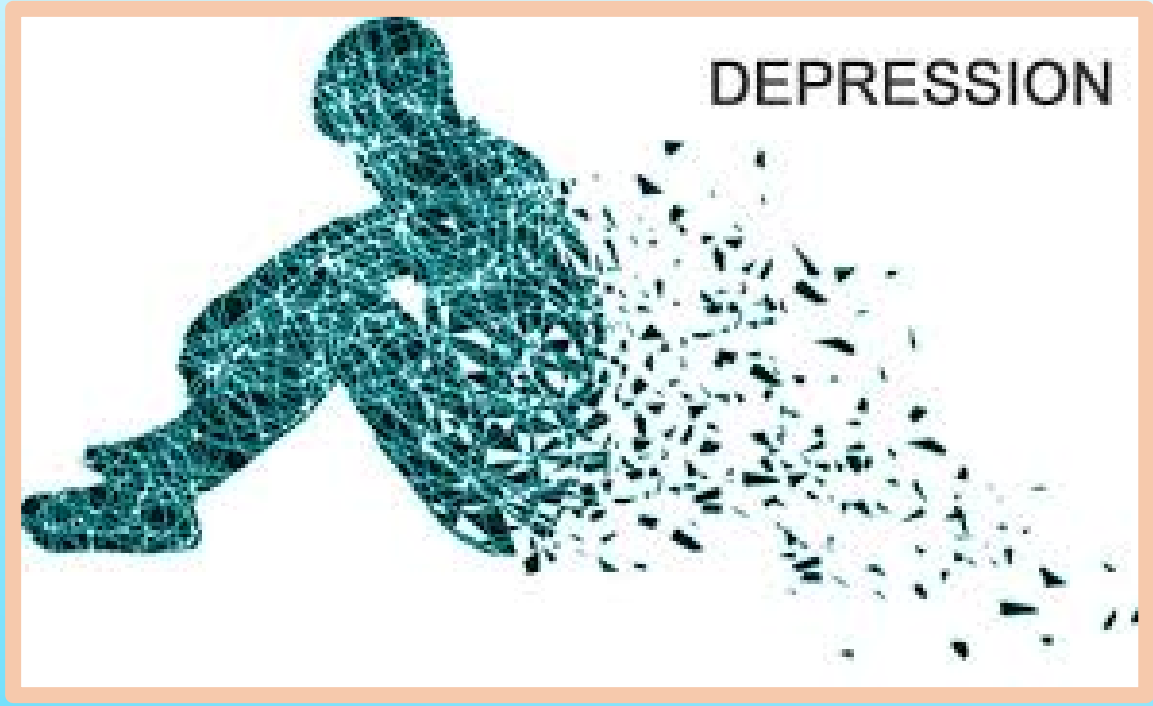
Note: Only one item is required in children.
1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

Diagnostic Criteria for Generalized Anxiety Disorder (2)

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

E. The disturbance is not attributable to the physiological effects of a substance (e. g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

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


DEPRESSION

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

Depression

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

Red Flag	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

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.	**CLINICAL CASE MANAGEMENT** **PROBLEM 2** Describe the basic diagnostic features of bipolar disorder: manic episode
CLINICAL CASE MANAGEMENT **PROBLEM 3** Describe the basic diagnostic features of bipolar disorder: hypomanic episode.	**CLINICAL CASE MANAGEMENT** **PROBLEM 4** List four groups of symptoms that may be manifested in the presentation of anxiety.
CLINICAL CASE MANAGEMENT **PROBLEM 5** List five common obsessions and five common compulsions associated with OCD.	**CLINICAL CASE MANAGEMENT** **PROBLEM 6** Describe the forms of psychotherapy that are useful in the family practice setting

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: (a) grandiosity, (b) decreased need for sleep, (c) hyperverbal or pressured speech, (d) flight of ideas or racing thoughts, (e) distractibility,
(f) increase in goal-directed activity or psychomotor agitation, and
(g) 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 nondepressed 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: (a) inflated self-esteem or grandiosity; (b) decreased need for sleep; (c) more talkative than usual; (d) flight of ideas or racing thoughts; (e) distractibility; (f) increase in goal-directed activity or psychomotor agitation; and (g) 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 (7) 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 (7) 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.

SOLUTION TO THE CLINICAL CASE MANAGEMENT PROBLEM 6

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) aimsto 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.

THANKS