

Common psychiatric problems encountered in general practice*

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Curriculum vitae

Dr Angelo John Lasich qualified MBChB, (Wits) in 1958. He obtained higher qualifications DPM (Wits) and FF Psych (SA) in 1963. He has been a practising psychiatrist for the past 22 years. He was in specialist private practice for 15 years (1966-1981), and has been on the teaching staff in the Department of Psychiatry at Medical School University of Natal since 1968. During 1966-1981 Dr Lasich served as consultant psychiatrist to King George V, Addington and King Edward VIII Hospitals. He is currently deputy head of department and clinical head King Edward VIII Hospital, Durban.

Studies have shown that psychiatric morbidity is widespread in the community and psychological illness contributes substantially to the workload of the practitioner. Most cases of psychiatric morbidity are dealt with at primary care level and a comparatively small number are dealt with by psychiatrists.

*This article is based on a talk given to the Natal Midland Branch of the Academy in November 1987.

Summary

Most psychiatric disorders are dealt with at primary care level. In this continuing medical education article, the most common psychiatric disorders the GP can expect, are explained and their classification, clinical features and management given.

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KEYWORDS: Psychiatry; Physicians, Family.

A major problem in the running of a general practice is the shortage of consultation time. Psychiatric problems do take time to manage and it is impossible to explore a complaint of a psychological nature in the time it takes to diagnose and treat a physical condition eg sinusitis. It is therefore important to use to advantage the cumulative effect of repeated short consultations. It is in accessibility to the patient and a continuity of care that much of the potential for successful management of psychiatric problems in general practice lies.

COMMON PSYCHIATRIC DISORDERS

Anxiety Disorders

Surveys suggest that anxiety states are the commonest psychiatric disorders seen in general practice. Every person experiences some degree of anxiety at some time in their lives, varying from simple anticipation of an exciting venture, to an immobilising panic.

A moderate amount of anxiety constructively increases effort and alertness; in the pathological form, anxiety is the source of most emotional disorders. Anxiety state is possibly overdiagnosed due to the failure to carry out a proper history and failure to recognise symptomatic anxiety. This problem may account for the over-prescribing of anxiolytics in general practice.

Classification of Anxiety Disorders

- a) Generalised Anxiety Disorder (chronic moderately severe anxiety)
- b) Panic Disorder (acute attack)
- c) Adjustment Disorder with anxiety (Anxiety is the predominant disturbance in the above.)
- d) Phobic Disorders (Agoraphobia, Social phobia and Simple phobia).
- e) Obsessive-Compulsive Disorder (Anxiety arises in the above two conditions when attempts are made to master the symptoms.)

Most psychiatric problems are dealt with at primary care level.

Clinical Features

- a) Generalised Anxiety Disorder (Chronic illness)

General features: Persistent unprecipitated anxiety lasting at least 1 month without specific symptoms ie panic, phobias, obsessions and compulsions.

Specific features:-

Psychological — apprehensive expectation (worry), edginess, impatience, insomnia, distractibility and irritability

Autonomic — hyperactivity: sweating, upset bowel, frequency of micturition, dizziness

Motor — tension characterised by tremor, muscular aches, fatigue, inability to relax, restlessness

- b) Panic Disorder

Acute terrifying apprehension (extreme anxiety).

Palpitations and dyspnoea.

Tremor/shaking.

Precordial discomfort with choking sensation.

Paraesthesias, sweating.

Fear of dying or losing control during attack.

Patients bring problems rather than illness.

Key Points

- a) Consider the possibility of an underlying anxiety disorder when a patient requests a prescription for an anxiolytic/sedative.
- b) Attempt to find the cause of anxiety before prescribing medication.
- c) Remember that anxiety is a symptom found in many medical conditions — cardiovascular, respiratory, cerebral, metabolic, hormonal, nutri-

tional disorders and intoxication.

- d) Psychological factors precipitate acute panic attacks.
- e) Panic attacks are generally associated with feelings of ongoing anxiety between attacks.
- f) Many of the physical symptoms of panic disorder result from hyperventilation.
- g) Differentiate anxiety state from depression as patients suffering from both disorders commonly exhibit mixed symptomatology.

*Important: A patient who complains of anxiety but who also exhibits so-called endogenous features of depression viz, anorexia with weight loss, decreased libido, delayed insomnia, diminished energy, diurnal variation of mood (ie worse in mornings), psychomotor retardation/agitation, should be diagnosed as *depressed*.

Management

1. Encourage self-reliance and maintenance of productive activity.
2. Provide supportive psychotherapy.
3. Train patient in relaxation techniques.
4. Use benzodiazepines sparingly and for short periods only. Propanolol appears to be more specifically effective against physical manifestations of anxiety.
5. If condition is chronic — many have to learn to live with symptoms.

Many emotions such as depression, frustration, anxiety are natural responses to stress; do not medicalise normality by eg inappropriate prescription of drugs.

Indications for Psychiatric Referral

1. Those who fail to respond to treatment after 3 months.
2. The physician is unable to identify the source of patient's anxiety.
3. The patient's personality makes management difficult.
4. The patients who request more intensive psychotherapy.
5. Those patients with a phobic or obsessive-compulsive disorder.

Depressive disorders

Depressive illnesses are common and it is estimated that almost 7% of the population show evidence of clinically significant depressive symptomatology at any

given time. The presence of depression with anxiety features often trick the unwary general practitioner into misdiagnosis. It accounts for the overdiagnosis of anxiety and the under-recognition of depression. Psychiatric symptoms usually overlap and diagnosis is arrived at on a hierarchical basis, certain symptoms taking precedence diagnostically, over others.

Anxiety states are the commonest psychiatric disorders seen in general practice.

Classification of Affective Disorders

(Depressive illnesses are included in this category.)

- a) Major Affective Disorders
 - Major Depression
 - Bipolar Disorder (manic-depressive)
- b) Other Specific Affective Disorders
 - Dysthymic disorder (Minor Chronic Depression)
 - Cyclothymic disorder (mood swings less severe than the bipolar)
- c) Uncomplicated Bereavement
- d) Adjustment Disorder with Depression

Note: Affective Disorders can be primary or secondary. Secondary types occur in relation to other psychiatric disorders, other physical disorders or drug use.

Clinical Features: Depression

A gradient exists between normal mood and clinical depression. To distinguish ordinary sadness, disappointment or discouragement from clinical depression, is dependent on the *intensity, duration* and *quality* of the features.

Milder degrees of depression are commonly missed due to the failure of the practitioner to recognise the difference between the mood of depression and the

Depression can occur at any age, even childhood; but mostly in middle and late middle age.

syndrome of a depressive illness. The diagnosis of depression is based on the following clinical findings:-

- a) *Psychological:*
 - mood — depressed, sad, inability to enjoy crying, diurnal variation, irritable with friction and often anxiety.
 - thought content — worthlessness, guilt, pessimism, hopelessness

- suicidal feelings and behaviour — suicidal thoughts, parasuicide, suicide

- b) *Physical:*

- Somatic — sleep and appetite change, constipation, hypochondriasis, loss of libido
- psychomotor — retardation/agitation

- c) *Social:*

- function and behaviour — loss of interest and energy, poor self-care, poor concentration, work impairment, social withdrawal

Minimum duration of symptoms — 2 weeks.

Key points

1. Depression can occur at any age (including childhood) but peak incidences occur at middle and late middle age.
2. Mood change can show diurnal variation.
3. Episodic alcohol abuse or impulsive antisocial behaviour may mask a depressive disorder.
4. Patients may fail to report an awareness of mood change and often complain of physical symptoms instead (therefore always enquire).
5. Patients with psychomotor retardation, slow thinking and indecisiveness may be misdiagnosed as having an organic brain syndrome.
6. Patients may present with critical hallucinations or delusions and may be misdiagnosed as schizophrenia (remember psychotic depression).

More than half of alcoholics, seen by physicians, go undiagnosed.

Management

- a) Do a thorough medical and mental state evaluation to rule out secondary depression.
- b) Always ask about somatic features.
- c) Evaluate suicidal potential — ask patient if he is thinking of killing himself; mention of the subject does not put ideas in the patient's head.
- d) Therapy: (i) *Physical* ie antidepressants
There are three major groups of antidepressants:
First generation: Tricyclics
Second generation: Non-Tricyclics
Other: Monoamine oxidase inhibitors

Always choose a drug well known to you. As tricyclic compounds have proved their worth, start treatment with such a drug.

Special problems eg cardiac patients, require specialist handling.

Decide whether you require a non-sedating, intermediate or sedative tricyclic antidepressant.

In the presence of:-

- i) Psychomotor retardation — use non sedating agent

- ii) Psychomotor agitation — use sedating agent
- iii) Anxiety with depression — use intermediate agent

Therapy: (ii) *Psychosocial* — supportive psychotherapy (be warm, empathic, understanding and optimistic).

Indications for Psychiatric Referral

- a) Suicidal patients
- b) Psychotically depressed patients
- c) Patients who fail to respond to treatment within 3 months
- d) Patients who are difficult to manage
- e) Depressed patients with a history of manic episodes
- f) Patients who request to see a psychiatrist.

Insomnia

Sleep disorders are extremely common; 10-20% of the population experience trouble sleeping during the course of any one year. As in the case of anxiety, insomnia, which can take various forms, is often symptomatic. Proper history taking is therefore essential before prescribing a hypnotic.

Insomnia has a multiplicity of causes and can be primary or secondary:

Primary

- Hyposomnia:* Sleep onset — Anxiety, Stimulants
Delayed — Depression
Chronic — Conditioned, sleep apnoea
- Hypersomnia:* Narcolepsy
Depression
- Dyssomnia:* Enuresis, somnambulism
Night terrors

Secondary

Pain, anxiety, anger, chronic hypnotic use, dyspnoea, impending psychosis.

General treatment of Insomnia

Doctor's role: Rule out or treat specific syndromes eg depression. Provide support and reassurance. Teach relaxation techniques. Use sedative-hypnotics for limited time only.

Advice to patient: Maintain a regular bedtime. Regular exercise during the day. Avoid vigorous mental activity late in evening. Avoid alcohol after supper.

Effective dose: 30 mg daily

10mg

1 mane

10mg

10mg

2 nocte

Dosage for elderly and sensitive patients: 15 mg daily

5mg

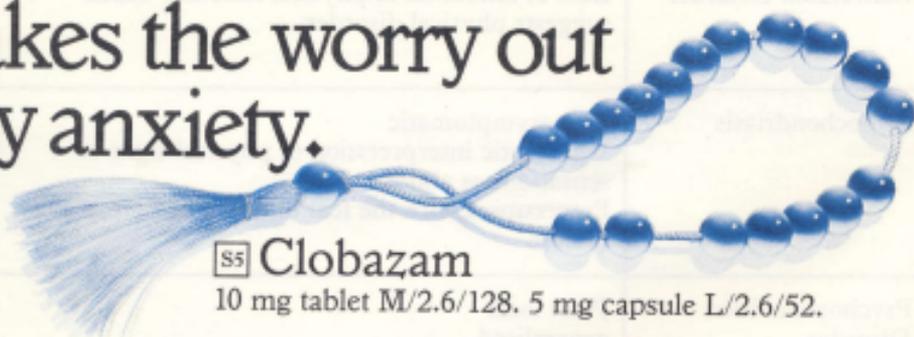
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Alcoholism

It has been suggested that general practitioners often do not have a sufficiently high index of suspicion. In respect of alcoholics, it has been estimated that more than half of those seen by physicians go undiagnosed. Alcoholics have an uncanny ability to conceal their problem and are usually convincing in their denial of the abuse of alcohol.

Be prepared to provide a steady and longstanding relationship with some patients.

Recognising the Alcoholic

Early recognition is important. The majority of alcoholics go unrecognised by physicians until their social and occupational life and their physical health have been significantly harmed.

Suspicion should be aroused when predominant complaints include:

1. chronic anxiety and tension
2. insomnia
3. chronic depression
4. headaches, blackouts
5. nausea and vomiting, vague gastrointestinal problems
6. tachycardia, palpitations
7. frequent falls or minor injuries.

The physician should enquire about the following:

1. absenteeism

2. job loss
3. financial difficulties
4. family trouble

Key points

1. The physician must maintain the courage of his convictions and confront the patient's denial head-on.
2. Be encouraging and non-judgemental.
3. Obtain specific information about quantities imbibed.
4. Interview relatives and friends whenever possible.

Management

1. Identify presence of alcoholism.
2. Develop a personal rapport with the patient.
3. Treat all medical complications of drinking.
4. Treat any complicating primary psychiatric illness.
5. Enlist family members in treatment.
6. Ensure abstinence by either Alcoholics Anonymous or disulfiram therapy. A combination of both programs is most effective.

Somatoform Disorders

The principle characteristic of somatoform disorders is physical complaints without demonstrable organic findings. The symptoms seem to be linked to psychological conflict. The conditions commonly encountered are Somatization Disorder, Conversion Disorder and Hypochondriasis. The symptoms are linked to psychological factors and the initiation of symptoms is not under voluntary control in all three.

Distinguishing Features of Somatoform Disorders

Condition	Clinical Features	Outcome
Somatization Disorder	Multiple somatic complaints. Presented in a dramatic and exaggerated form	Chronic Poor prognosis
Conversion Disorder	Loss of alteration of physical function which suggests physical disorder	Acute Favourable — good prognosis
Hypochondriasis	Monosymptomatic Unrealistic interpretation of physical signs or sensations as abnormal Preoccupied with the fear or belief of having a disease	Chronic Poor prognosis
Psychogenic Pain Disorder	Pain: local generalised	Chronic Poor prognosis

Key points

Somatoform disorders need to be positively identified as well as excluding organicity.

Management

1. In regard to the patient with somatization disorder or hypochondriasis, be prepared to provide a steady and longstanding relationship.
2. Prevent extensive examination, rehospitalisations and unnecessary medications.
3. Conversion Disorders are best treated by a psychiatrist.

Many patients with "crazy" behaviour may be suffering from a serious medical problem.

Acute Psychotic Reaction

Physicians should avoid believing that every patient with "crazy" behaviour requires only antipsychotic medication and admission to the state mental hospital. Many acutely psychotic patients may be suffering from a serious medical problem, such as meningitis, hypertensive encephalopathy, drug intoxication, subdural haematoma, hypoglycaemia.

Differential Diagnosis of Acute Psychosis

Syndrome	Characteristics
Schizophrenia	Loose association Flat affect Bizarre delusions Clear sensorium Orientation intact
Mania	Hyperactivity Pressured speech Elevated or irritable mood Orientation usually intact
Organic Brain Syndrome	Loss of intellectual abilities Poor memory Impaired orientation Possible hallucinations or delusions

Management

1. Exclude medical cause
2. Antipsychotic medication to control agitation
3. Refer patient for admission to a psychiatric unit and remember:-
4. Not every difficult/psychotic patient has a functional disorder

5. Practice extra care in the assessment of an uncooperative and difficult patient.

IN CONCLUSION

Many general practitioners would agree that patients bring problems rather than illnesses. It is important to remember that many emotions such as depression, anger, anxiety and frustration are natural responses to stress, and care should be taken therefore not to medicalise normality, usually by the inappropriate prescription of drugs.

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— From the Journals —

The Sequence of Panic Symptoms

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From the Department of Family Practice, The University of Texas Health Science Center at San Antonio, San Antonio, Texas. This paper was presented at the 14th Annual Meeting of the North American Primary Care Research Group (NAPCRG), Baltimore, Maryland, April 13-16, 1986. Requests for reprints should be addressed to Dr David A Katerndahl, Department of Family Practice, The University of Texas Health Science Center at San Antonio, 7703 Floyd Curi Drive, San Antonio, TX 78284.

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Abstract Although much research has focused on the pathophysiology of panic attacks, little work has been done to describe the phenomenon itself. Twenty-one patients with panic attacks were asked to sequence the panic-related symptoms during an attack in an attempt to clarify the phenomenon. Overall, panic symptoms could be grouped into three categories: early symptoms — consisting of dyspnea, palpitations, chest discomfort and hot flashes; intermediate symptoms — including shaking, choking, feelings of unreality, sweats, faintness, and dizziness; late symptoms — consisting of fear and paresthesias. Based on symptom clustering and temporal relationships, this study describes the panic phenomenon.

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