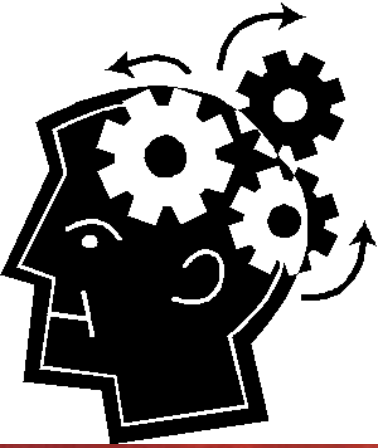
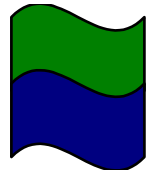




# Common Psychological problems in General Practice



Tony Dowell



Department of Primary Health Care and General Practice  
University of Otago - Wellington - New Zealand

# Today

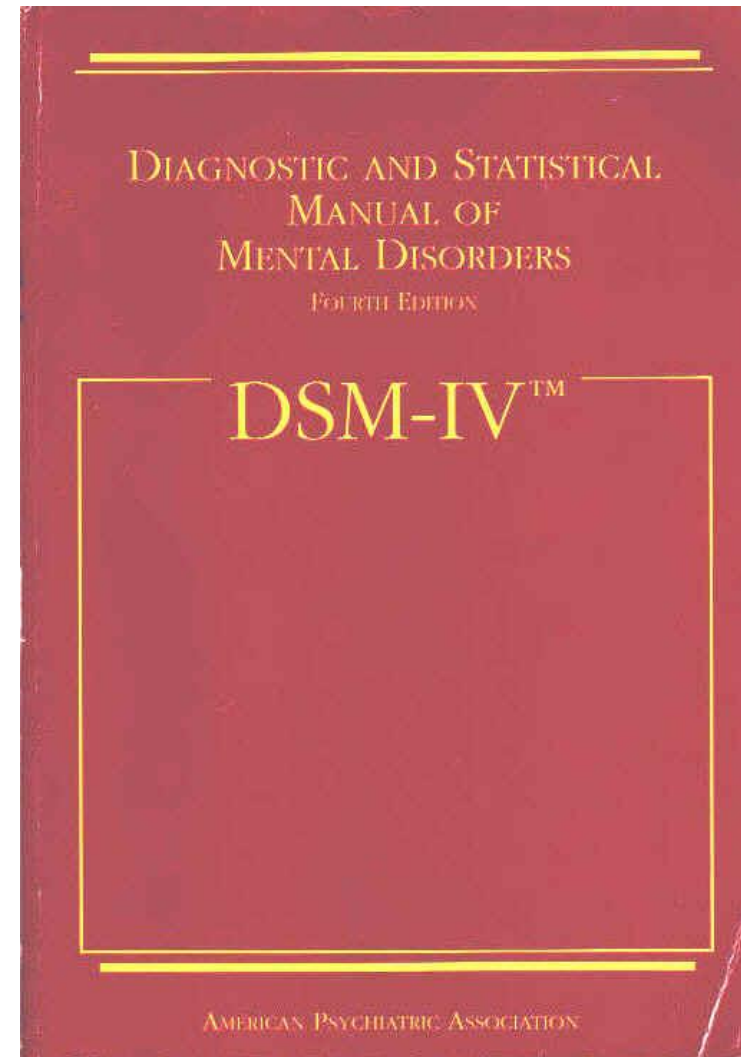
- Overview of common psychological problems
- Anxiety and Depression
- Bipolar
- Medically unexplained symptoms
- Psychosis audit
- Focus on childhood disorder
- Psychological therapies

# Psychological problems

- We don't know aetiology
  - We don't know anatomy
  - We don't know physiology
  - But we will
- 
- Neuro-developmental studies
  - Epigenetics
  - Cohort studies
  - Gene studies

# The nature of common psychological problems in GP

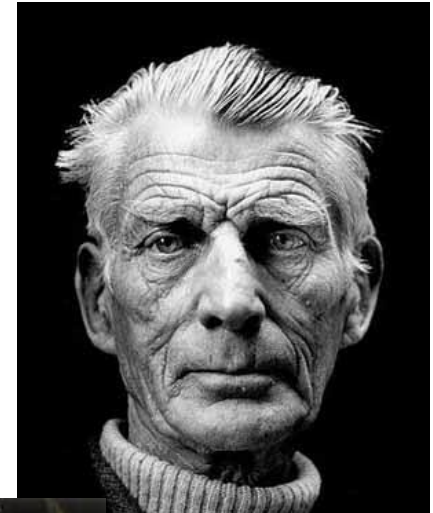
- Madness 1776
  - Melancholy madness
  - Maniacal , raving madness
  - Canine madness



# Real world perspectives

*“We are all born mad, some remain so”*

- *Samuel Beckett. ( Waiting for Godot.)*



*“Acting funny but I don’t know why”*

*Jimi Hendrix. ( Purple Haze)*

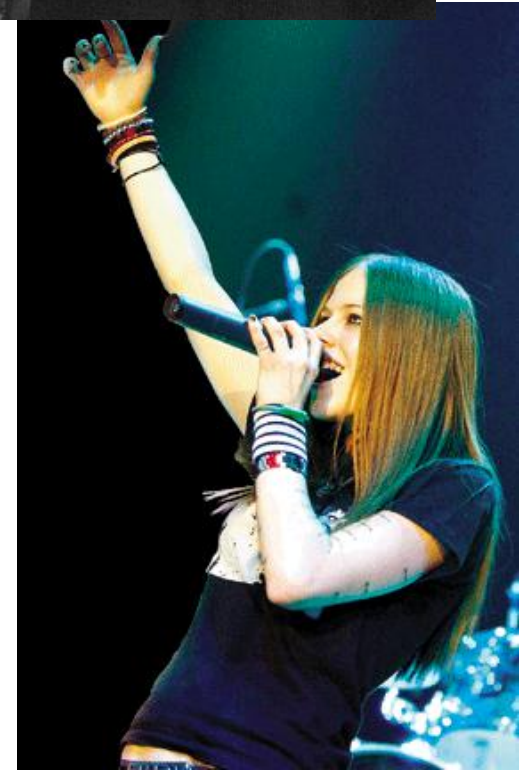


# They said it ...

‘Out of intense complexities, intense  
simplicities emerge’. Churchill  
W S



‘Why’d you have to go and make  
things so complicated.  
Life’s like this: you fall and you crawl,  
and you break and you take’  
Lavigne Avril et al. - Let go.



# Do we know what we do?



- Talking about mental health issues in the consultation

Example: Talking about drugs – we don't



# Alcohol use ?

**Compare:**

*have you stopped smoking yet?*

**With:** *And so in terms of other things at the moment for you with your blood pressure and and so on um [clears throat] has the alcohol side of things is that still drinking regularly and*

# Other Drugs – AOD

After smoking and alcohol

“ Do you take (do ) any other recreational drugs”

Not uncommon replies

No – Never have

Do a bit of Dak

Used to do a lot of stuff .....

- Never had refusal or concern over the question

# Controversially doing the right thing?

- GP: anything that runs in your family
- PT: um depression runs in the fam//ily but\
- GP: /right okay\\ and do you smoke or drink a lot of alcohol

# Same consultation

- GP: um how were you feeling then
- PT: um + still just ever since i've started work  
i've been just + quite tired a lot of the time
- GP: yeah okay ((inhales)) and have you been  
feeling anxious or low //or tearful\ or
- PT: /mm i\\ do get quite anxious about work  
like if i find it really hard to leave work at work  
i
- GP: yeah

- she's in a home permanently //and\ she wasn't that happy=
- GP: /right\\
- PT: = and wanted to come home all the time  
//((laughs)) *i'd dread visiting her*
- GP: /sure\\ yeah yeah
- PT: um but i don't know if that's just it but i just kinda like i felt kind of um (2) just kind of the old depression (i think) ((mumbles)) //(())\
- GP: /right\\ sure tell me more about it
- PT: about
- GP: about how you've been feeling and so on

# GP as Psychological specialists

- With current resources and consultation structure a lot of the time GP's Practice Nurses and the primary care team are doing a bloody good job
- We still shy away from a lot of 'difficult ' conversation areas
- We often don't close the psychological consultation with clear goals and objectives

参观由此向前

Visit to the former



当心绊倒

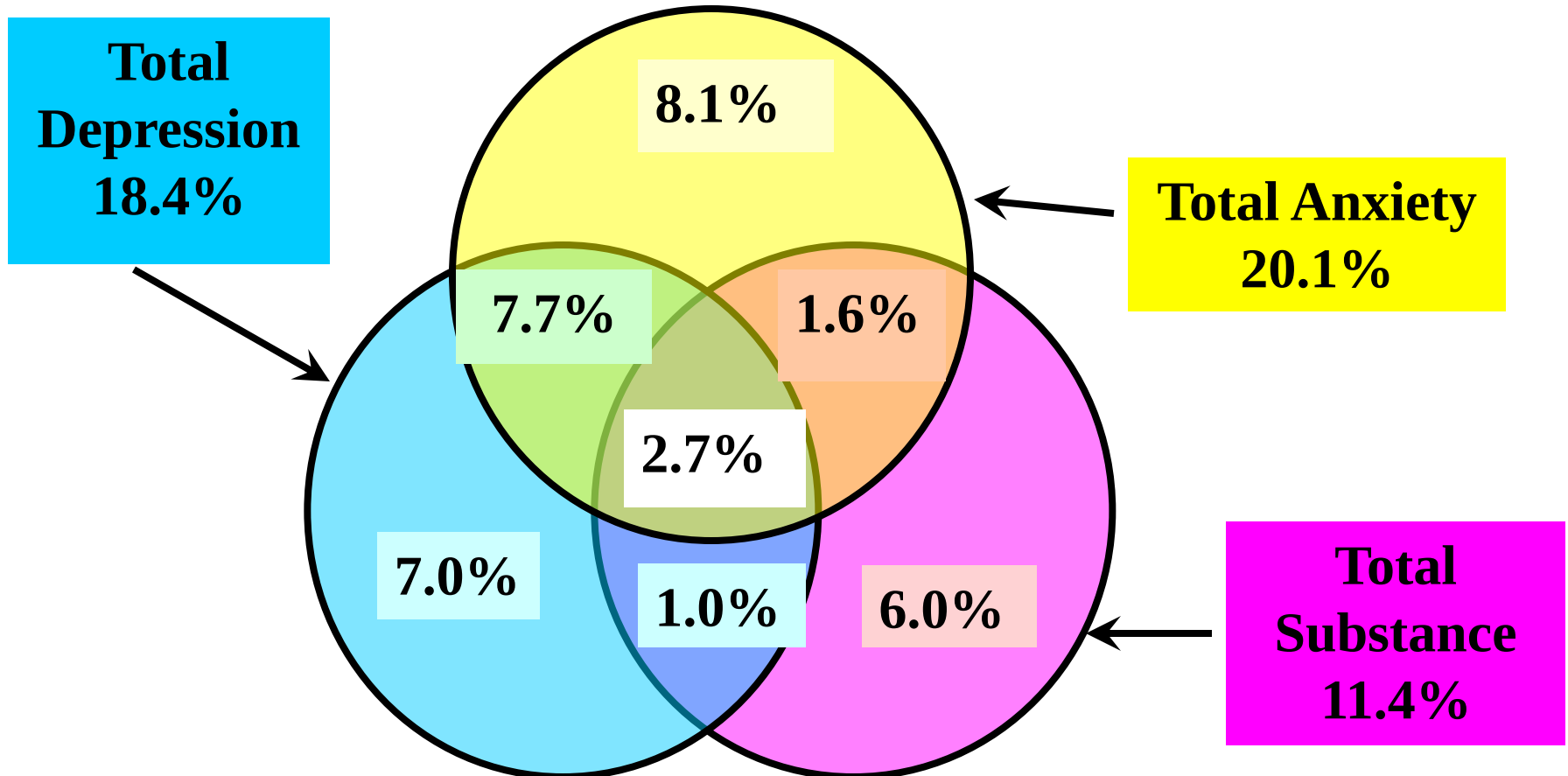
Mind tripped

# Anxiety and Depression

- There is no such thing as Depression
- **OMG !!**
- Or Anxiety
- DSM 1 – 4
- ICD 1 – 10
- There is a spectrum of Anxious Depression

# Anxiety, Depression and Substance use disorders in General Practice:

(12 months)



# Who cares ?

## **GP's and the primary health care team.**

- They very rarely (never) appear in a pure form
- And we very rarely see them
- Assessment and treatment are largely the same
- Generic rating scales 'always ' pick up symptoms of both e.g HAD / Kessler
- Anxiety currently under diagnosed and managed

# Who cares?

## Patients

- Anxiety symptoms ignored
- Less 'sympathy'

*I've had depression and I've anxiety ; depression is easy , anxiety is f\*\*\*ing awful*

- Patients missing out on treatment options

# What works

- Most things
- Psychological therapies ( see later)
- Drugs
- SSRI

1<sup>st</sup> Fluoxetine – response (63% ) , remission (60%)

- Sertraline best tolerability
- Citalopram better than paroxetine.

Baldwin D et al, Efficacy of drug treatments for generalised anxiety disorder: systematic review and meta-analysis [BMJ March 2011;342:d1199](#)doi:10.1136/bmj.d1199

# A solution

- Abolish Anxiety and Depression as separate entities.
- Replace with new term ?

# Dysphoria

**Dysphoria** (from Greek δύσφορος (dysphoros), from δυσ-, difficult, and φέρειν, to bear) is an unpleasant or uncomfortable mood, such as sadness (depressed mood), anxiety, irritability, or restlessness. Etymologically, it is the opposite of euphoria.

# Anxious depression

3 anxious and 3 depressive symptoms - **two weeks**:

*"anxiety symptoms"* :

- feeling nervous, anxious or on edge (S);
- not been able to control worrying (S);  
having trouble relaxing;  
so restless hard to keep still;; and  
afraid something awful might happen.

*"depression symptoms"*:

- persistent depressed mood (S);
- markedly diminished interest or pleasure (S);  
feelings of worthlessness or guilt;  
impaired concentration ; and  
recurrent thoughts of death or suicide.

# Bipolar disorder

- Up to 20% Bipolar Disorder missed as Depression?
- 3117 Primary care depression (UK) .
- Conservative' midestimate' = 9.6%
- Questions about primary care Bipolar?
- WHO – Is it a psychosis or 'emotional disorder'?



# Bipolar II



- Does it exist ?
- 1 hypomanic and 1 major depressive episode
- Depression > hypomania ? Suicide risk higher
- Hypomania = high functioning behaviour
- Hypomania - racing thoughts, irritability, anxiety, insomnia – Negative = depression?
- Rare to have hypomanic euphoria

# So

- Depression not getting better – consider Bipolar
- Sub threshold Bipolar common in Primary care settings.
- Adjuvant drug therapy might be helpful
- Established – Lithium / valproate
- Emerging – Atypical antipsychotics

# Long term mental health problems

*Primary mental health care has a role to play in supporting people with severe mental health and/or substance use disorders*

- Addressing access barriers
- Managing the physical and psychological care of people with stable conditions, or when new issues arise
- Long term conditions management programmes, so that health can be monitored eg: Care Plus
- Support for self management, healthy lifestyle
- Nurse led clinics
- Regular audits of care

# Health of people with severe mental illness

- Heart disease –death rate 2.2 times the rate of the general popn
- Influenza deaths – 5 times
- Cancer – Service users have a death rate 1.5 times
- Diabetes – death rate 3 times
- Respiratory illness deaths – 2.8 – 4 times
- 20% shorter life expectancy
- Substance and alcohol problems

# PHO Antipsychotic Practice Audit

440 patients 13 General Practices\*

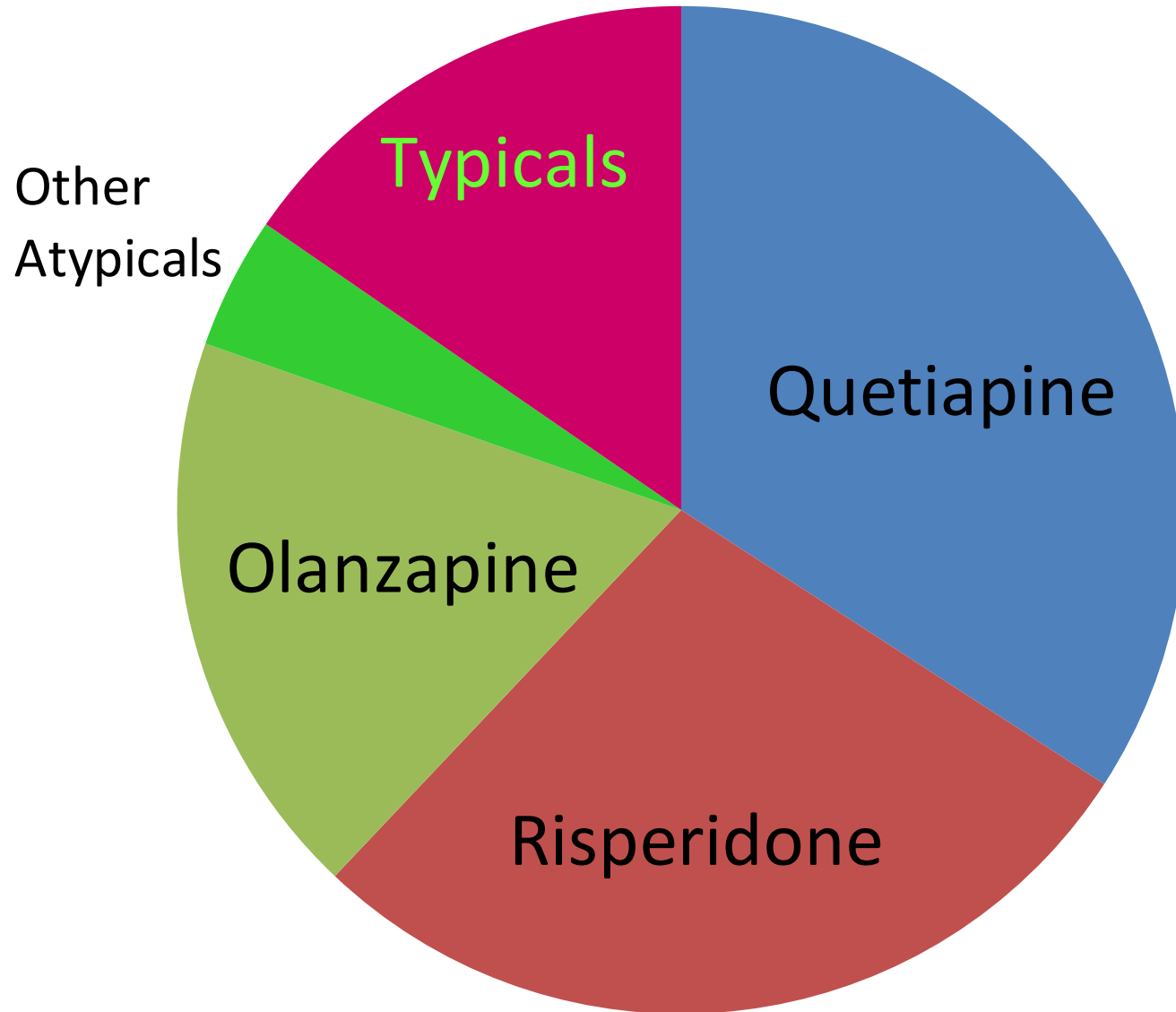
Patient Age 10 yrs – 98 yrs

448 antipsychotics prescribed

Atypical 379 (85%)

Typical 69 (15%)

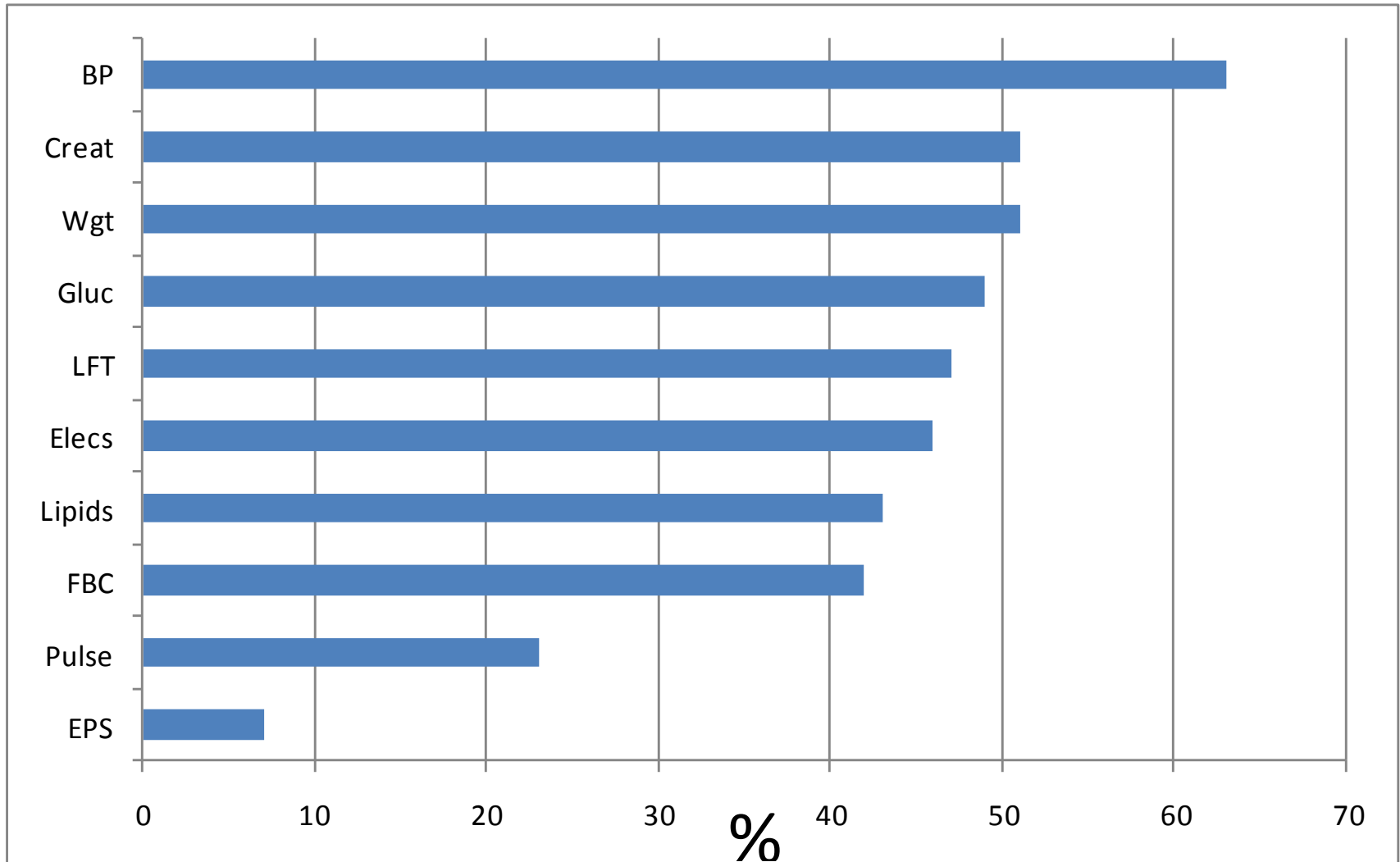
## Antipsychotics Prescribed



# Monitoring for Long Term Psychiatric conditions

| Parameter       | Baseline | Monthly                     | 3-monthly                                          | Annually |
|-----------------|----------|-----------------------------|----------------------------------------------------|----------|
| Weight/BMI      | ✓        | ✓                           |                                                    |          |
| Fasting glucose | ✓        | People at risk for 3 months | People at risk for one year, once for others       | ✓        |
| Lipids          | ✓        |                             | For one year for people on atypical antipsychotics | ✓        |

# Recommended tests for all Antipsychotics



# The Quest for the Medically Unexplained

- Converting Medically unexplained Symptoms (MUS) into
- Bodily Distress Syndrome (BDS)



# M.U.S

## Definition:

- Difficulty in explaining symptoms on basis of known pathology
- Frequent fliers
- Heart sink
- Fat folder
- Somatisers

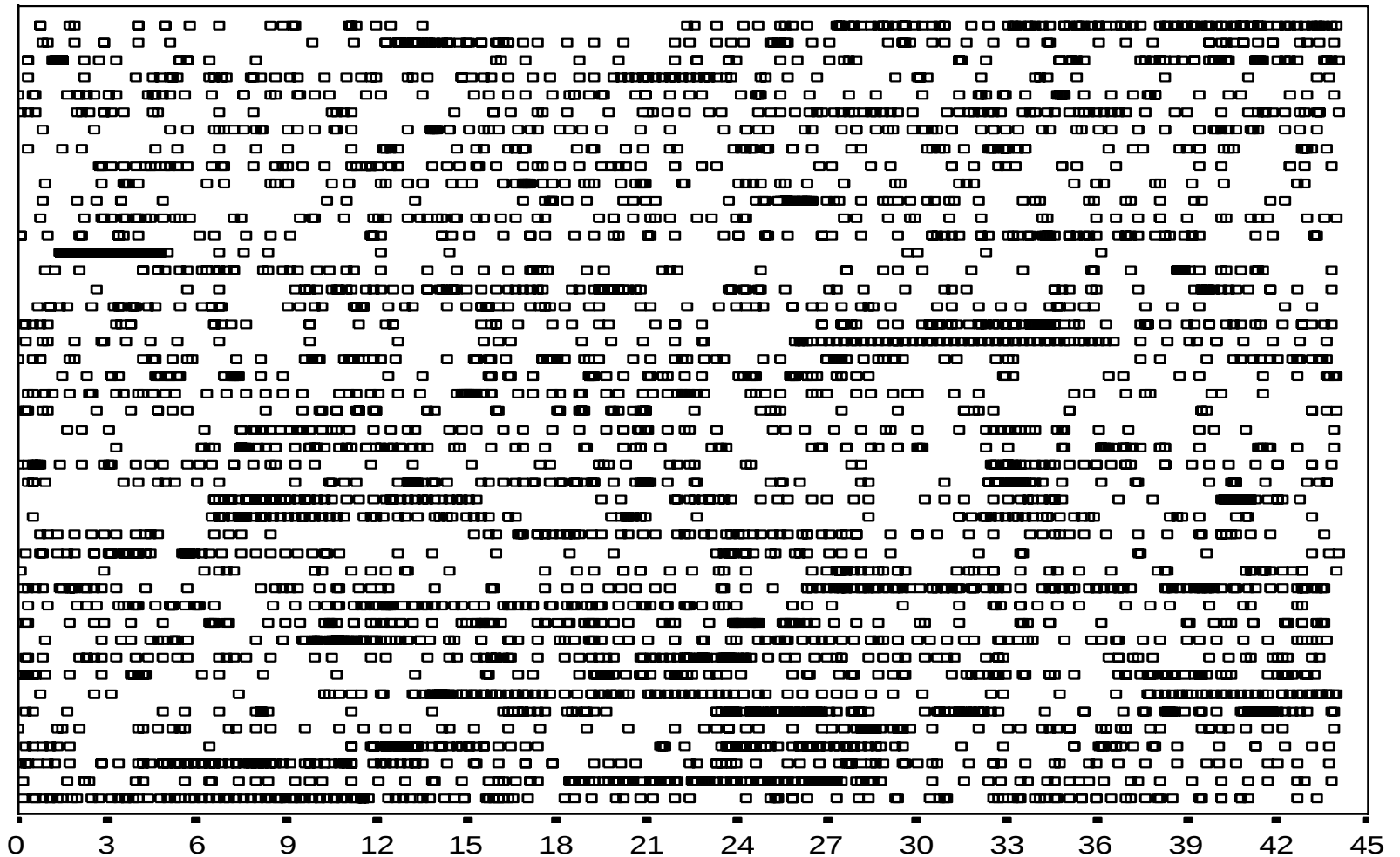
# Medically Unexplained Symptoms

- >25 % UK GP patients primary care patients in England have unexplained chronic pain, irritable bowel syndrome, or chronic fatigue
- 2ndary care 30% new neurological outpatients symptoms “not at all” or only “somewhat” explained by disease.

# Associated pathology

- Frequent attender studies = significantly greater GHQ scores
- 50% MUS in other studies had undetected psych ( anxiety / depression)

# WTF !



# What to do ?

- Classification conundrums
- Concern about Medically Unexplained Symptoms ( they often can be)
- Both medical (IBS ) and Psychological (somatoform disorder)
- Proposal – single new classification – neither psychological nor medical

**TABLE 1: FUNCTIONAL SOMATIC SYNDROMES ACCORDING TO MEDICAL SPECIALTY  
(MODIFIED AFTER WESSELY AND HENNINGSEN) (62;76)**

| <b>Medical specialty</b> | <b>Functional somatic syndrome</b>                             |
|--------------------------|----------------------------------------------------------------|
| Gastroenterology         | Irritable bowel syndrome (IBS), non-ulcer dyspepsia            |
| Gynaecology              | Pelvic arthropathy, premenstrual syndrome, chronic pelvic pain |
| Rheumatology             | Fibromyalgia, chronic lower back pain                          |
| Cardiology               | Atypical or non-cardiac chest pain                             |

|                      |                                                           |
|----------------------|-----------------------------------------------------------|
| Respiratory medicine | Hyperventilation syndrome                                 |
| Infectious diseases  | Chronic fatigue syndrome (CFS, ME)                        |
| Neurology            | Tension headache, pseudo-epileptic seizure                |
| Dentistry            | Temporomandibular joint dysfunction, atypical facial pain |
| Ear, nose and throat | Globus syndrome                                           |
| Allergy              | Multiple chemical sensitivity (MCS)                       |
| Orthopaedics         | WAD - whiplash ass. disorder                              |
| Anaesthesiology      | Chronic benign pain syndrome                              |
| Psychiatry           | Somatoform disorders, Neurasthenia, Conversion            |

# Bodily Distress Syndrome

- Patients suffer from various physical symptoms of bodily distress.
- Positive criteria - not a diagnosis of exclusion as the current somatoform disorders.

# Bodily Distress syndrome BDS

- Bodily distress syndrome – single-organ type
  - heart, respiratory and circulatory system
  - gastro-intestinal system
  - muscles and joints
  - general symptoms
- Bodily distress syndrome – multi-organ type
- Bodily distress syndrome - NOS

---

## Symptom groups

---

### **≥ 3 Cardiopulmonary/autonomic arousal**

Palpitations / heart pounding, precordial discomfort, breathlessness without exertion, hyperventilation, hot or cold sweats, trembling or shaking, dry mouth, churning in stomach / "butterflies", flushing or blushing

### **≥ 3 Gastrointestinal arousal**

Abdominal pains, frequent loose bowel movements, feeling bloated / full of gas / distended, regurgitations, constipation, diarrhea, nausea, vomiting, burning sensation in chest or epigastrium

### **≥ 3 Musculoskeletal tension**

Pains in arms or legs, muscular aches or pains, pains in the joints, feelings of paresis or localized weakness, back ache, pain moving from one place to another, unpleasant numbness or tingling sensations

### **≥ 3 General symptoms**

Concentration difficulties, impairment of memory, excessive fatigue, headache, dizziness

### **≥ 4 symptoms** from one of the above groups

---

# Changing history

plished in such a short period had, as usual, eroded his health. Despite suffering from bouts of “abdominal catarrh” he continued to push himself hard, turning out articles and working on a book to counter Bogdanov’s arguments, entitled *Materialism and Empirio-criticism*, before

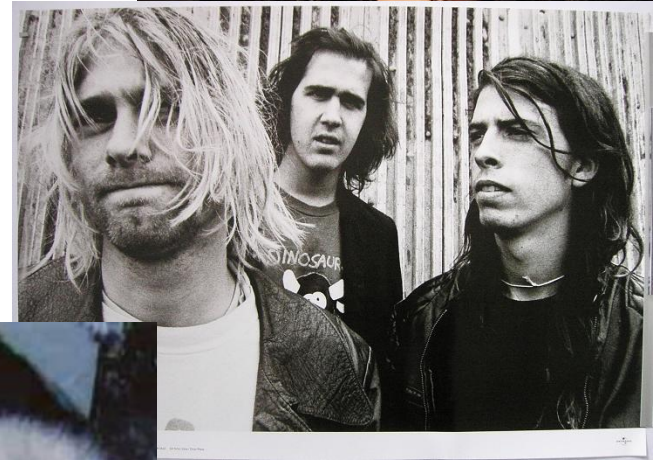


# Famous for IBS

- Cher (Also Tinnitus )
- Kurt Cobain

*“Come dowsed in mud, soaked in bleach, as I want you to be”*

- Adolf Hilter



# Bodily Distress Syndrome in History

## Neurasthenia

- [Lancet Volume 182, Issue 4708, 22 November 1913, Pages 1469-1472. Proceedings from the London Medical Society](#)
- " Those in the room who were students in Edinburgh 25 years ago or more would remember how often in the medical wards there were, as patients, men from the Orkney and Shetland Isles. They were usually physically sound, of characteristic Norse appearance, yet acutely miserable in negative kind of way, and in spite of their profound religiousness without God and without hope in the world. They had no energy, they were full of vague discomforts, and they imagined all kinds of visceral micro-anomalies- that food did them no good because it remained for days in the stomach. "

# Neurasthenia

- **John Buchans 'Domestic Medicine' in 1785 – The dangers of being ‘studious’**
- PERPETUAL thinkers, as they are called, seldom think long. In a few years they generally become quite stupid, and exhibit a melancholy proof of how readily the greatest blessings may be abused. Thinking, like every thing else, when carried to extreme, becomes a vice:

# Management

- Enjoy the challenge
- Explain symptoms in a way that makes sense
- Remove 'blame' and 'there's nothing wrong'
- Generate ideas about how to manage symptoms
- Encourage talk about psycho-social issues
- Lifestyle – avoid inactivity
- Modified mini-CBT

# Going back to the beginning



# The origin of mental health problems

Any disorder –

Any disorder pre-  
adolescence = 18%

Late adolescence = 42%



## ‘Jack’ - 9 Years

- Father in jail
- 2 siblings, further sibling drowned aged 3 yrs
- Mother 29: medical condition, unable to sustain a job though trying – in and out of jobs
- Overweight
- Learning difficulties at school
- Bullying in the playground

## Medical history:

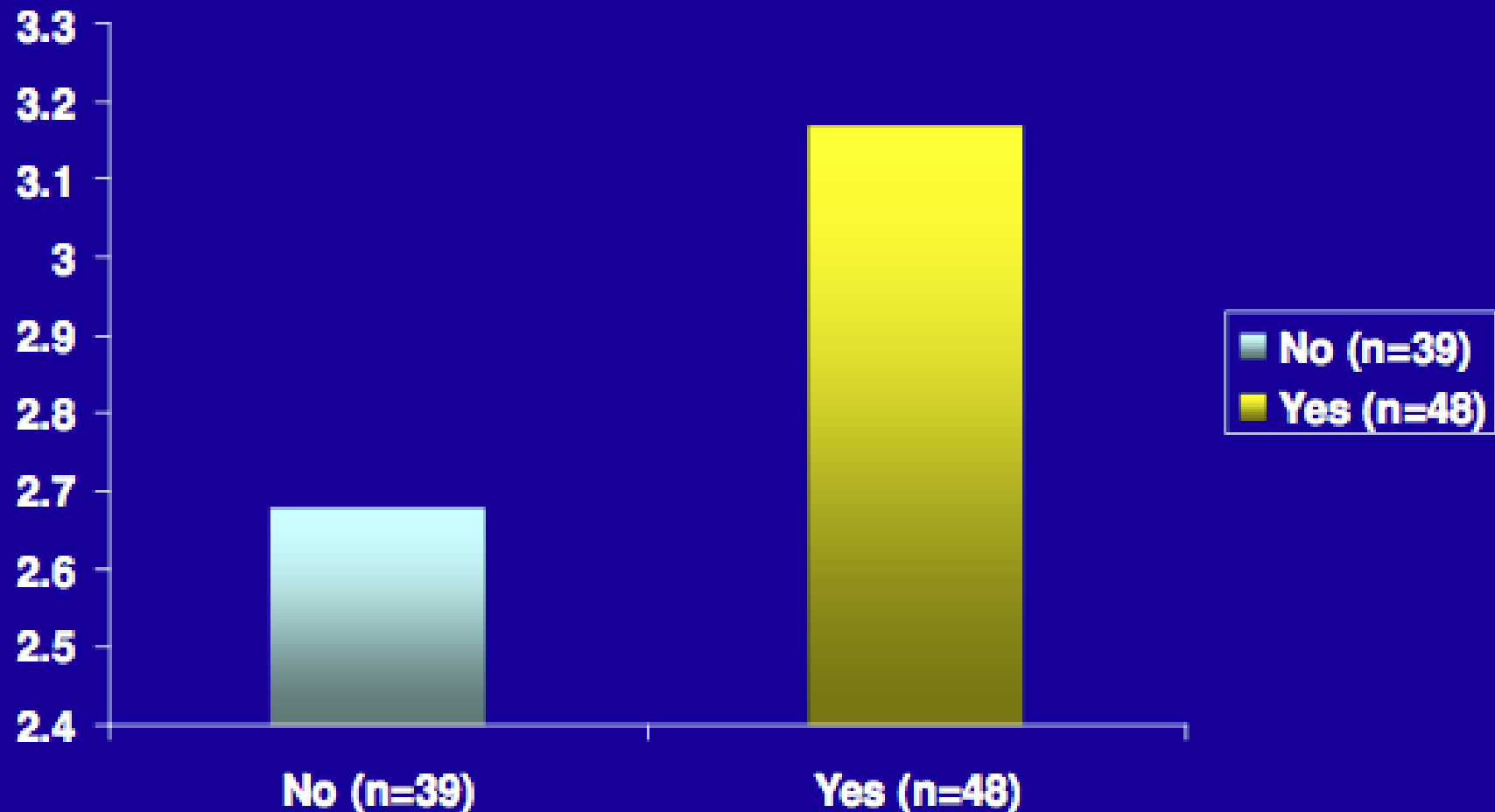
– Multiple visits to GP and A +M

Asthma, eczema, chest infections, skin infections, injuries, 10 hospital admissions – bronchitis (baby x2) asthma (x3), broken leg, head injury, cellulitis (x2), dental abscess

## Jack's future.....

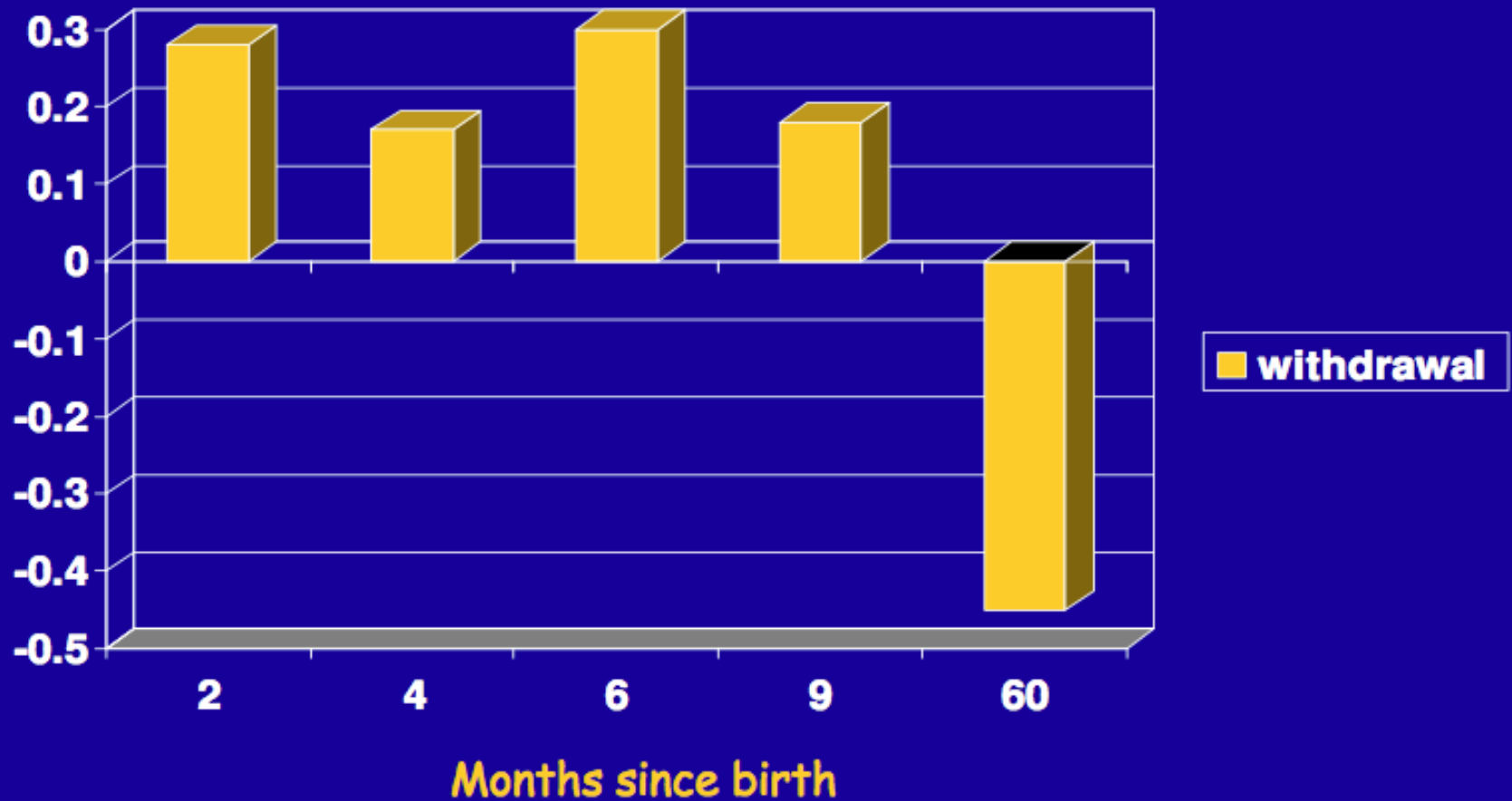
- Poor health lifelong
- Obesity
- Drug and alcohol abuse
- School failure, limited occupational options
- Criminality
- Broken relationships
- Shorter life expectancy

# Post-natal Depression And Mean Cortisol 08.00hrs At 13 Years



Infant exposure to postnatal depression

# Morning cortisol at 13 years and Maternal withdrawal during the 1<sup>st</sup> year and at 5 years of age (n=49 total)



# Assessing young children - HEARTS

- Home: conduct, general behaviour, 'manageability'
- Education : behaviour / progress
- Activities : attention span, ability to finish tasks, friendships.
- Relationships with peers / parents: any changes in the family
- Temper : mood
- Size: weight gain , appetite
- Get information from both child and adult

# CMD in Antenatal/postnatal

- No evidence that prevalence is higher in this population
- BUT missed disorder could result in:
  - poor antenatal self-care
  - obstetric and perinatal problems
  - poor mother-child interaction
  - relationship difficulties
  - developmental problems in offspring
  - child/fetal neglect/abuse
  - maternal self-harm

# Maternal Mental health disorders

- Characteristics of most mental disorders are similar in pregnancy and the postnatal period to those experienced at other times.
- Psychotic disorders may develop more rapidly and be more severe
- Childbirth can trigger a severe bipolar episode
- Suicide rare,- leading cause of maternal death

# Depression

- Antenatal = 13% of women have an episode of major or minor depression
- Postnatal = 19% - 3/12 post-partum
- Triggers
- Mother's level of social support, life events and
- psychiatric history
- Depressed mood or anxiety during pregnancy predicts PND
- PND in NZ - no identifiable risk factors, such as poor social support or partner relationship problems.

# Post Natal Depression

- Postnatal depression is inadequately recognised and treated in New Zealand
- Screening of high risk groups recommended
- EPDS / PHQ-9 / HADS
- 22% of women PND onset > 6 weeks after childbirth.

# Screening questions for depression

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by little interest or pleasure in doing things?
- Help question (below)
- Is this something with which you would like help?
- Options: no / yes, but not now / yes



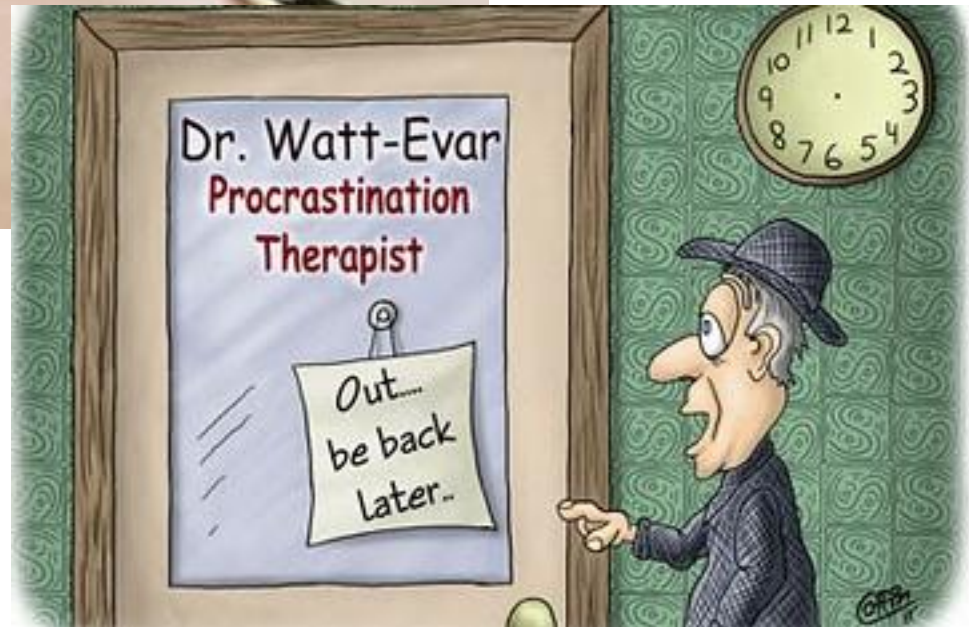
**Therapy  
Has Taught  
Me That  
It's All  
Your Fault**

**“ Psychological therapies – do they work and is there any difference between them”?**



An advertisement for 'Subliminal MP3s'. At the top left is a logo featuring a green power button symbol inside a blue circle, with musical notes floating to its right. Below the logo is the text 'Subliminal MP3s'. To the right of the logo is a red starburst graphic with the text 'ACT TODAY' in white. The background of the advertisement is a photograph of a smiling woman with blonde hair wearing large white headphones. Overlaid on the right side of the image is the text 'FREE SUBLIMINAL MESSAGES' in large, bold, green capital letters. At the bottom, in white italicized text, it says 'Download 3 FREE Subliminal MP3s Worth \$44.91!'.

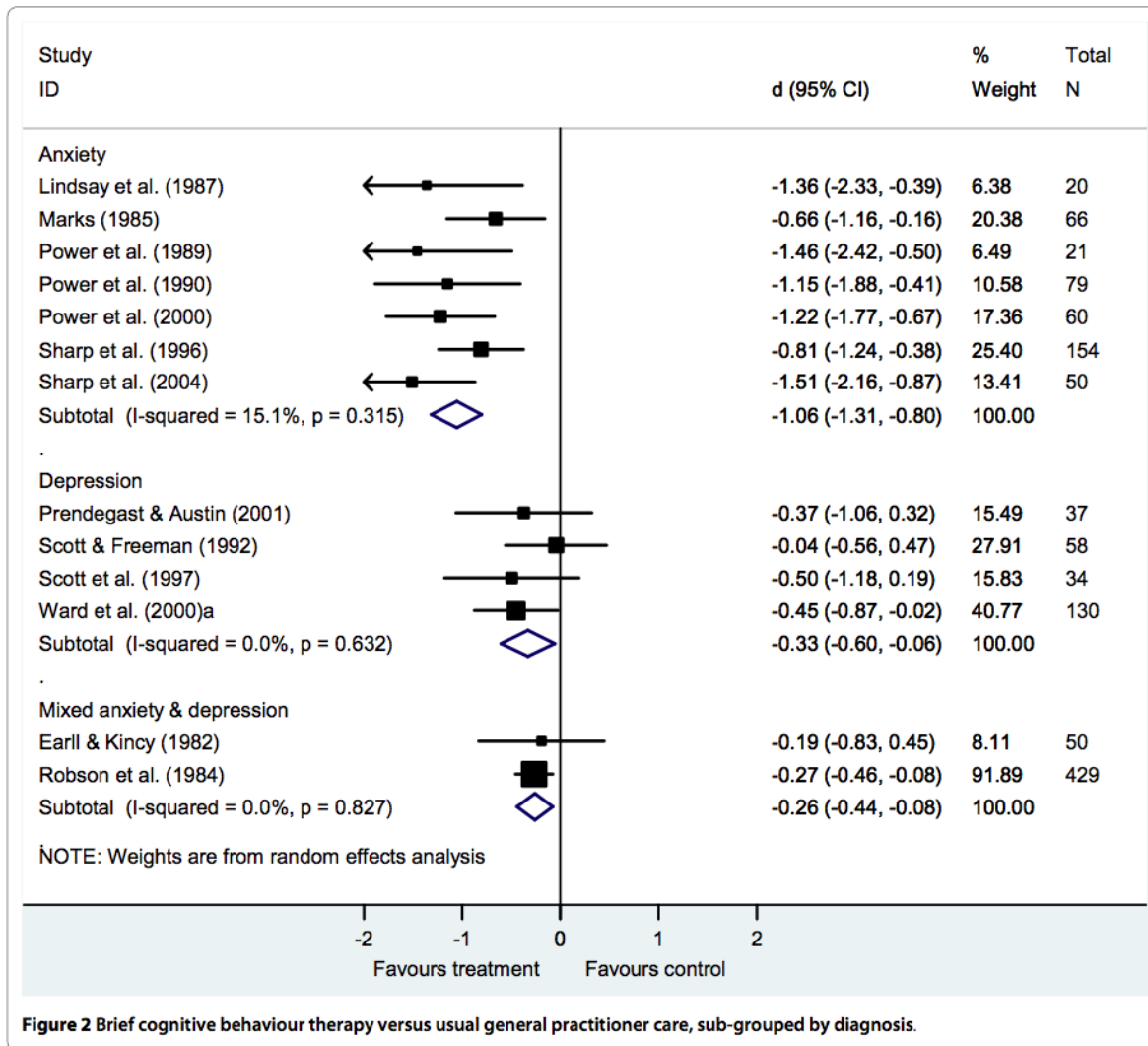
# Yes – they do work



# Effectiveness of brief psychological therapies

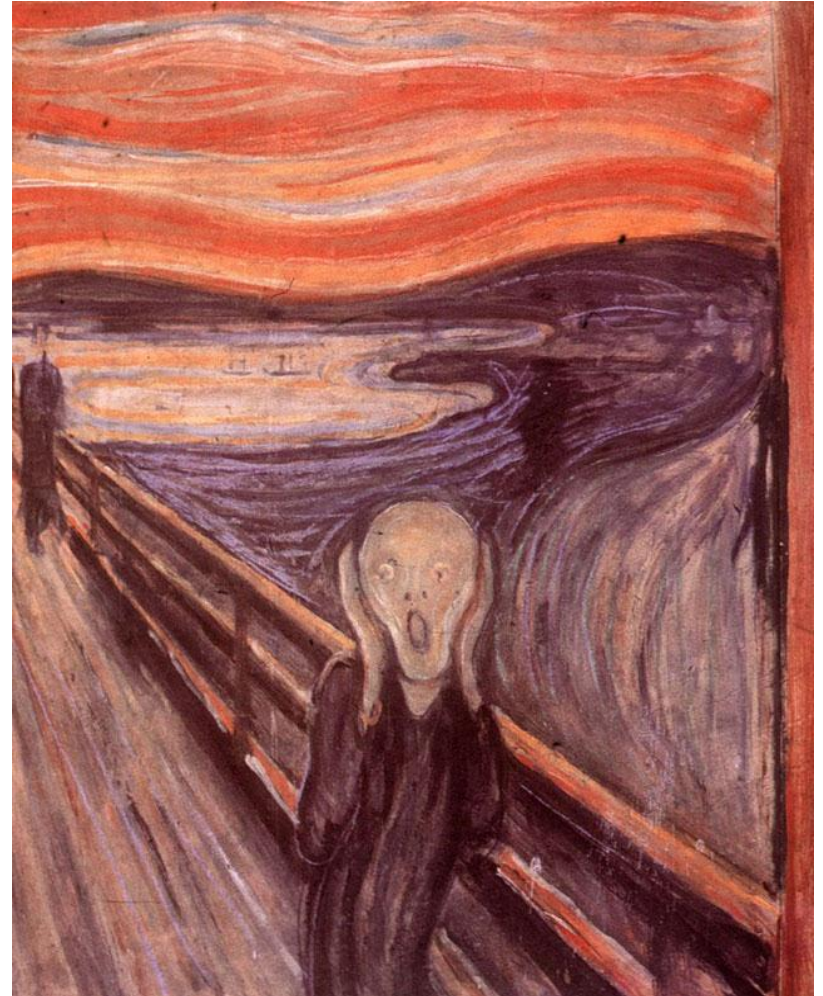
- 34 studies
- CBT > PST / counseling

Cape et al. Brief psychological therapies for anxiety and depression in primary care: meta-analysis and meta-regression. *BMC Medicine* 2010, 8:38  
<http://www.biomedcentral.com/1741-7015/8/38>



# New Zealand: Eclectic use of talking therapies

- Assessment
- Therapy according to the problem
- Problem identification
- Setting goals and objectives
- Cognitive underpinning
- Equivalent outcomes

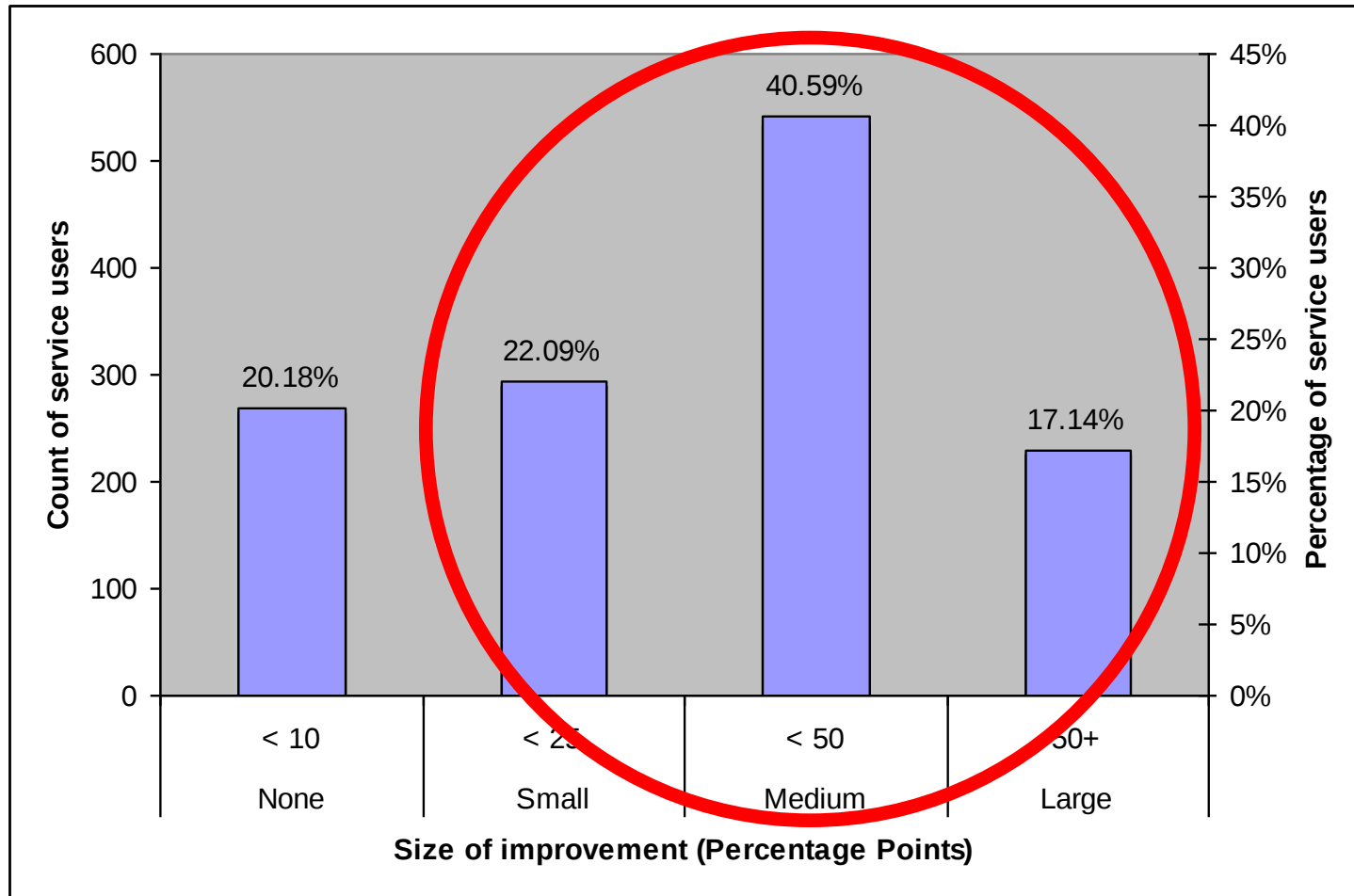


# Therapy type

|                                 |
|---------------------------------|
| Analytical Psychology (Jungian) |
| Art therapy                     |
| Behavioural/Cognitive           |
| Bioenergetic                    |
| Body Therapists/body work       |
| Cognitive Analytic              |
| Dialectical Behaviour Therapy   |
| Existential                     |
| Family Therapy                  |
| Gestalt                         |
| Group Analytic                  |
| Humanistic                      |
| Hypnotherapy                    |
| Integrative                     |

|                              |
|------------------------------|
| Interpersonal                |
| Music Therapy                |
| Neuro Linguistic Programming |
| Object Relations             |
| Person Centered              |
| Personal Construct Theory    |
| Play Therapy                 |
| Problem Solving              |
| Psychoanalysis               |
| Psychoeducation              |
| Psychosynthesis              |
| Self-psychology              |
| Systemic                     |
| Transactional Analysis       |
| Transpersonal                |

# What happened - % change in outcome measures



## Effect Size (95% CI)

## Meta-analysis across all initiatives

1.72 (1.62, 1.82)

1.18 (0.89, 1.47)

2.33 (1.73, 2.94)

1.78 (1.41, 2.16)

1.32 (1.20, 1.45)

1.65 (1.47, 1.83)

1.68 (1.19, 2.17)

0.14 (0.03, 0.25)

2.69 (2.23, 3.15)

1.17 (0.89, 1.46)

0.55 (0.42, 0.67)

1.24 (0.76, 1.71)

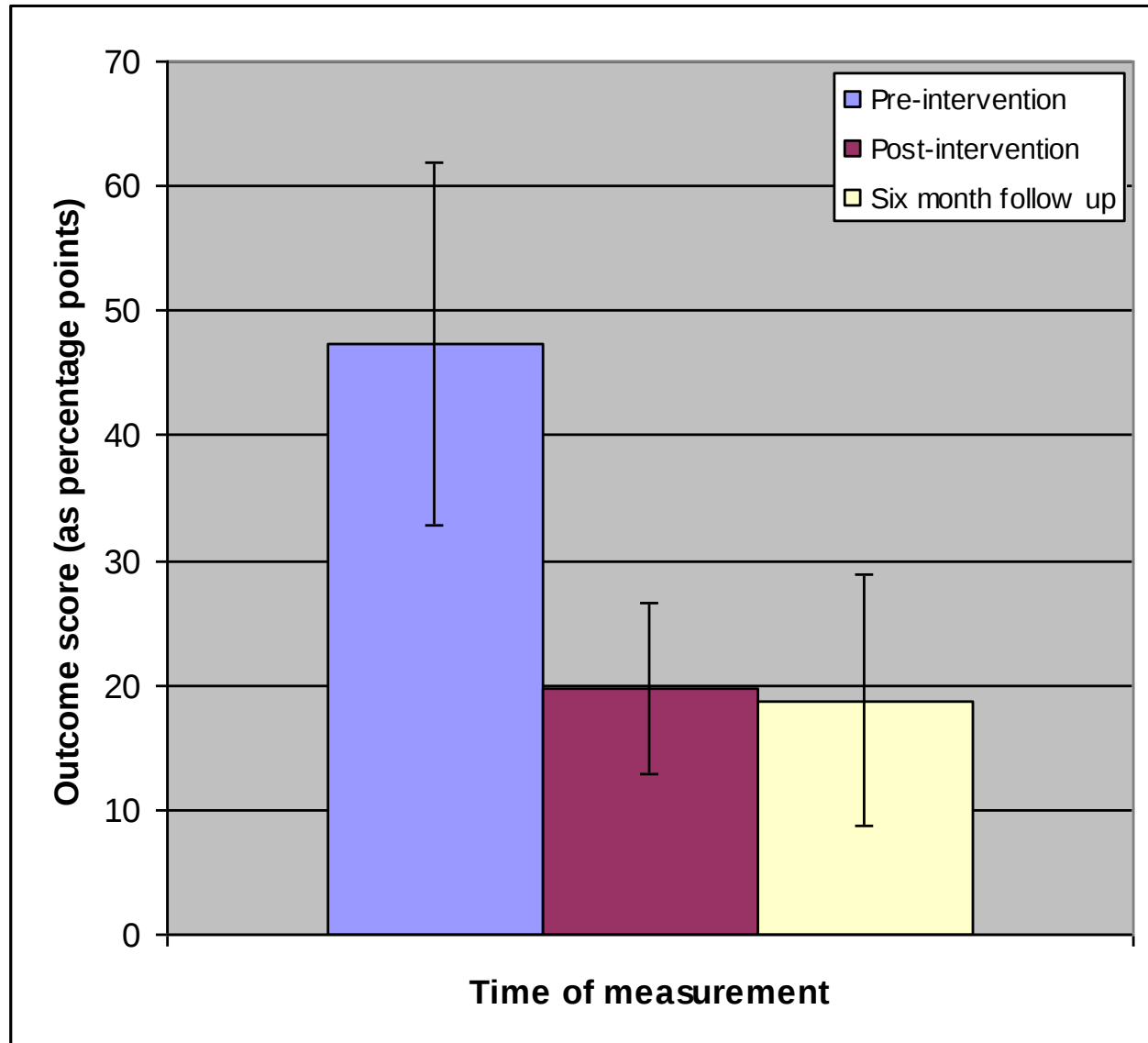
1.46 (1.30, 1.63)

1.27 (1.13, 1.42)

1.42 (1.07, 1.77)

Effect Size

# Six Month Follow-up (n =110)



# 3 - 10 minute psychological therapy

A – Identifying '**A**ctive  
'problem

B – What **B**eliefs does that  
produce

C – What Consequences –  
depression etc

D – **D**ispute the thoughts /  
belief

E – Find **E**ffective thinking

F – Reframe into new  
**F**eeling

- Identify Problems
- Prioritise Problems
- Choose 1
- Make a work plan to address it
- Review
- Choose another problem

# E – therapies

- <http://www.calm.auckland.ac.nz/>
- <http://www.beyondblue.org.au/index.aspx?>
- <http://www.depression.org.nz>
- <http://www.thelowdown.co.nz>

## CALM - Computer Assisted Learning for the Mind

Site map | Downloads | Your feedback | Conditions of use | Further help | Computer requirements

Homepage

Mental resilience

Managing stress, anxiety & depression

Healthy relationships

Finding meaning in life

Feature Resource: NDI

Welcome to the **CALM** Website, **C**omputer **A**ssisted Learning for the **M**ind.

All of us want to have a happy life. No one wakes up in the morning thinking "I hope I will be miserable today". Many of us think that happiness is dependent on external situations like possessions, status and pleasures. Though these things can be good, often the satisfaction they bring is short term.



Scientific studies on what makes people truly and genuinely happy show the importance of four main things:

1. **Mental resilience**
2. **Managing stress, anxiety and depression**
3. **Healthy relationships**
4. **Finding meaning in life**

Please take a moment to familiarise yourself with the content of at least the first two tabs below. Either click each tab individually, or use the NEXT TAB link:

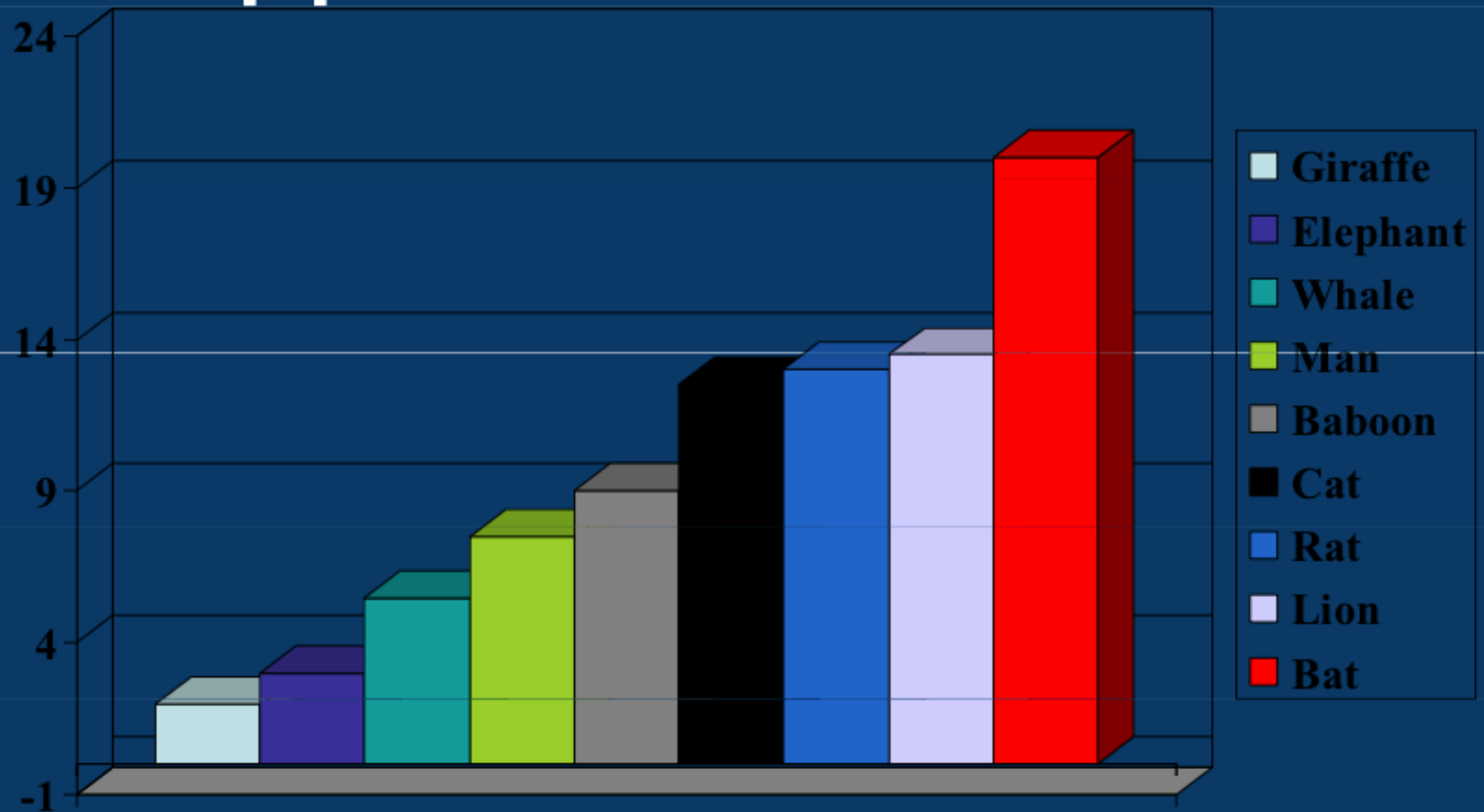
Orientation | Audio files | Feedback | Credits | Copyright

### Orientation to other parts of the website

Some of the sections include audio files with exercises and information you can download, as well as links to relevant websites that provide additional information and resources. Please take a moment to orientate yourself to the structure of this website:

1. **Homepage**

# Sleep per 24 Hours

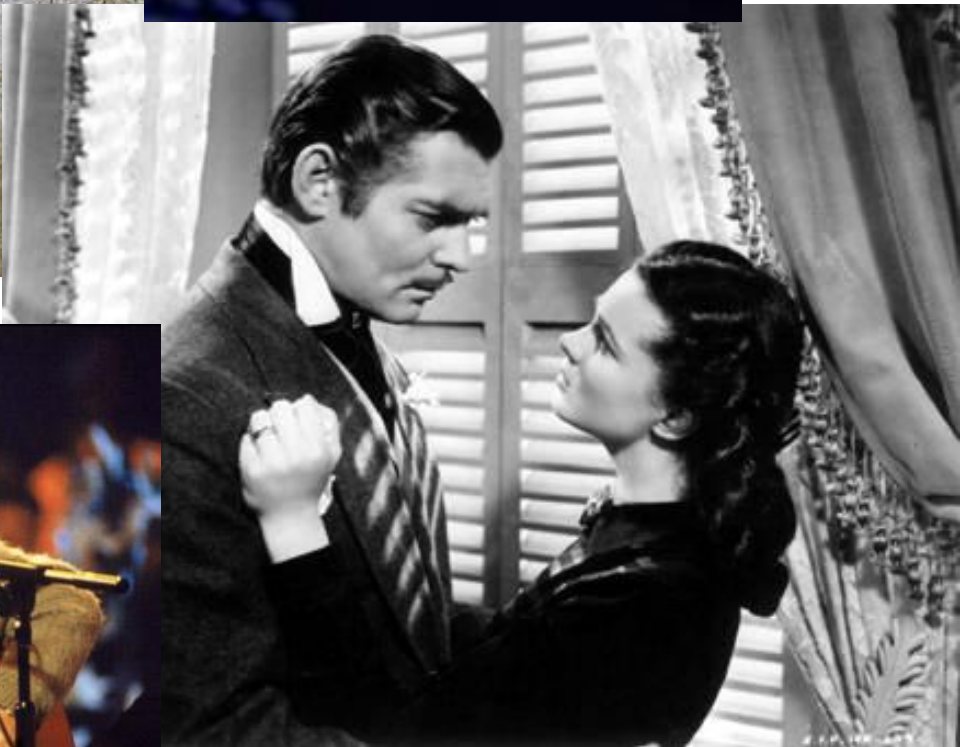


# Sleep disorders

- Not everything is a circadian rhythm disorder
- Anxiety and Depression are potent sleep disturbers
- Light and exercise are good
- Don't stay in bed when awake (exceptions apply)

The last challenge: is mental disorder an evolutionary advantage or disadvantage



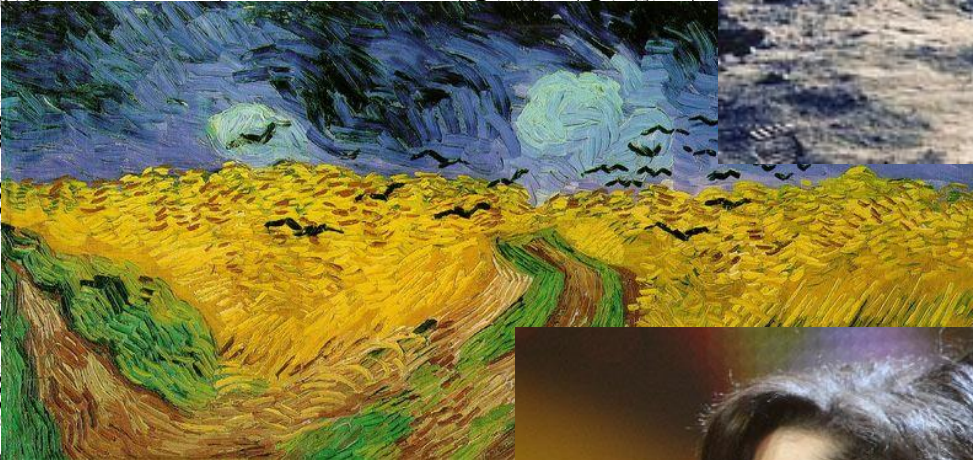


# Piano Concerto

in B $\flat$  minor Op. 23 No. 1  
for piano and orchestra

P.Tchaikovsky (1840-1893)

Andante non troppo e molto maestoso



**Therapy Cat**



**is concerned**



Thank you for listening