ANXIETY AND SOMATOFORM DISORDERS WORKBOOK

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CASE 1

Ms Mortimer is a thirty year old, unmarried, executive of a large financial firm. She is brought to an emergency room after she has suddenly felt extremely bad during an executive meeting. There was nothing unusual about the meeting itself.

She says that she suddenly felt very strange. It was as if everything was suddenly far away. She had a painful sensation in her chest. Her heart was racing. She had difficulty breathing. She broke out in a sweat, had hot and cold flushes, and felt faint. People around her wanted to know what was happening. She said she did not know, but was extremely scared. She thought she was having a heart attack. She was rushed to hospital where the whole event stopped; leaving her feeling weak and very worried. The whole episode lasted about 30 minutes.

There is no history of any previous medical condition, illnesses that run in the family, medication use, drug abuse, or previous psychiatric history. A mental status examination reveals no abnormalities. A medical examination proves normal. The ECG is normal. Emergency cardiac enzymes, a UK&E, and FBC are all normal. (Later results of a TSH and EEG are normal.)

Finding no medical reason for concern, the doctor takes time to find out more by taking a more elaborate history. She finds out that the Ms Mortimer has experienced similar episodes for about two months. They were not as bad as the last one, but still had prominent, intense anxiety, with difficulty breathing, paresthesias in her hands and feet, a feeling of dizziness, and hot flushes. She is worried about her heart, even though doctors told her that her heart is fine. Ms Mortimer acknowledged that lately she dreads going to supermarkets, because she fears getting an attack there with no one able to help her. She avoids it where possible, but still goes there with great distress.

1. What's going on here?

2. What helps you with an initial differential diagnosis?

3. What is stress?

4. Certain symptoms and signs in the vignette are striking:

5. **Is she psychotic?**

6. **Is it a mood disorder?**

7. **Is it an anxiety disorder?**

8. **Is it perhaps psychosomatic?**

9. **Is it somatisation?**

10. **Is it a somatoform disorder?**

11. Is it a dissociative disorder?

12. Is it a Factitious Disorder?

13. Is she malingering?

Classification of the DSM IV-TR Anxiety Disorders

Panic Disorder without Agoraphobia
Panic Disorder with Agoraphobia
Generalized Anxiety Disorder
Social Phobia / Social Anxiety Disorder
Specific Phobia
Agoraphobia without a History of Panic Disorder
Post Traumatic Stress Disorder.
Acute Stress Disorder
Obsessive Compulsive Disorder
Anxiety Disorder Due To a General Medical Condition
Substance Induced Anxiety Disorder

Panic Disorder with Agoraphobia

Recurrent, unexpected panic attacks with at least one month of either persistent concerns about further attacks, worry about the implications of the attacks, or significant behavioural change due to the attacks. There are also symptoms of Agoraphobia. It is not better accounted for by a substance, medical condition or other psychiatric condition.

What is a Panic Attack?

A circumscribed period of intense anxiety or discomfort, which develops suddenly, reaches maximum intensity quickly (within 10 minutes) and is accompanied by physical and psychological phenomena indicative of pronounced autonomic hyperactivity.

What is Agoraphobia?

Persistent fear of symptoms (limited symptom attacks) or panic attacks in situations where help will not be available, escape difficult or which will be embarrassing.

Panic Disorder without Agoraphobia

Recurrent, unexpected panic attacks with at least one month of either persistent concerns about further attacks, worry about the implications of the attacks, or significant behavioural change due to the attacks. There are no symptoms of Agoraphobia. Symptoms cannot be better accounted for by substances or a medical condition or another psychiatric disorder. It is not better accounted for by a substance, medical condition or other psychiatric condition.

Agoraphobia without History of Panic Disorder

Persistent fear of symptoms (limited symptom attacks) in situations where help will not be available, escape difficult or which will be embarrassing without a history of Panic Disorder. It is not better accounted for by a substance, or a medical condition.

Social Phobia / Social Anxiety Disorder

Persistent excessive and unreasonable fear of situations where the patient is exposed to people's scrutiny. Fear of embarrassment or humiliation. It is not better accounted for by a substance, medical condition or other psychiatric condition.

Specific Phobia

Persistent excessive and unreasonable fear of objects, events or situations other than those that are social or agoraphobic. It is not better accounted for by another psychiatric condition.

There are specified subtypes to account for all the "named" phobias (for example "acrophobia" would fall under Specific Phobia, natural environment type. Others are "animal type", "situational type", "blood injection-injury type", and "other type."

Posttraumatic Stress Disorder

There was exposure to an event with actual or threatened death or serious injury to self or others followed an intense distress. Thereafter there is at least one month of:

Persistent, distressing re-experiencing of the event
Persistent avoidance of stimuli associated with the event and numbing of general responsively
Persistent symptoms of increased arousal.

Acute Stress Disorder

See PTSD, but with more emphasis on the immediate reaction to the stressor and not less than 2 days and not more than 1 month. It is not better accounted for by a substance, medical condition or other psychiatric condition.

Anxiety Disorder Due to General Medical Condition

There is prominent anxiety, panic attacks, obsessions or compulsions that can be attributed to a

medical condition.

Substance Induced Anxiety Disorder

There is prominent anxiety, panic attacks, obsessions or compulsions that can be attributed to a substance.

Generalized Anxiety Disorder

At least 6 months of persistent, excessive anxiety and worry about a number of things which the patient finds difficult to control, and which is associated with physical and psychological phenomena of anxious, autonomic arousal. It is not better accounted for by a substance, medical condition or other psychiatric condition.

Obsessive Compulsive Disorder

The presence of either or both obsessions and compulsions, severe enough to cause distress or impair the patient's general functioning. It is not better accounted for by a substance, medical condition or other psychiatric condition.

What are Obsessions?

Recurrent, persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and cause marked anxiety or distress. The person attempts to ignore or suppress them, recognizing them as part of his or her own mind. They are not simply excessive, real life worries.

What are Compulsions?

Repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly. They are aimed at preventing or reducing distress or preventing some dreaded event or situation: however, they are unrealistic or excessive. The patient usually retains insight.

Out of the above it seems like Panic Disorder with Agoraphobia is the most likely diagnosis. One has to go to the diagnostic criteria at this stage to look as to whether everything fits.
But a Somatoform Disorder was also considered. Therefore, look at the Somatoform Disorders:

Classification of the DSM IV TR Somatoform Disorders:

Somatization Disorder.
Undifferentiated Somatoform Disorder.
Hypochondriasis.
Pain Disorder.
Conversion Disorder.
Body Dysmorphic Disorder.

Somatization Disorder

A polysymptomatic disorder that begins before the age of 30 yr, extends over years, and is characterized by a combination of multiple symptoms involving pain, the gastrointestinal system, sexual organs and pseudoneurological phenomena. It cannot be fully explained by a medical condition, substance or other psychiatric disorder.

Undifferentiated Somatoform Disorder

The presence of one or more unexplained physical complaints for more than six months that is not extensive enough to be explained by somatization disorder. It cannot be fully explained by a medical condition, substance or other psychiatric disorder.

Hypochondriasis

The preoccupation with the fear of having, or the idea that one has a serious physical disease. It is based on misinterpretations of body symptoms of functions. It cannot be fully explained by a medical condition, substance or other psychiatric disorder.

Pain Disorder

The preoccupation with pain where psychological factors are judged to have an important role in its onset, maintenance, exacerbation and severity. It cannot be fully explained by a medical condition, substance or other psychiatric disorder.

Conversion Disorder

Unexplained symptoms or deficits affecting voluntary motor or sensory function that looks like a neurological or other medical condition. Psychological factors are judged to be associated with the symptoms or deficits. It cannot be fully explained by a medical condition, substance or other psychiatric disorder.

Body Dysmorphic Disorder

The preoccupation with an imagined or exaggerated defect in physical appearance. It cannot be fully explained by a medical condition, substance or other psychiatric disorder.

Difference between the Somatoform Disorders and Factitious Disorder, and Malingering by using Hypochondriasis as an example.

	Hypochondriasis	**Factitious Disorder**	**Malingering**
Fear of having serious disease.	Much fear. Based on self-evaluated signs and symptoms.	None.	None.
Symptoms produced intentionally.	No.	Yes.	Yes.
Motivated by sick role.	No.	Yes.	No.
External incentives.	No.	No.	Yes, like getting boarded.
Unconscious factors.	Yes.	Reasons for wanting to play the sick are unconscious.	None.

14. Back to Ms Mortimer. Should we consider (it does not mean we will diagnose it) a somatoform disorder?

15. How should Ms Mortimer be managed?

CASE 2

Mr Palalane is a 25-year-old unmarried man who woks as a clerk in a commercial bank. He lives with his parents where he contributes substantially to the income and financial welfare of the family. He asks for a pill that will calm him down before he gets into a taxi that takes him to work and back. Before he gets into the taxi and while in the taxi he feels terrible. He says that he feels very scared. He is so anxious that he feels nauseous and dizzy. His heart also beats fast and he has difficulty breathing. When he gets out of the taxi he quickly recovers.

He gives a history of having survived a taxi accident 3 months earlier. He surprisingly did not sustain any serious injuries, but 3 people who were in the taxi died and two others were badly injured. He was horrified by the experience. He remembers seeing how the taxi was going to hit a lorry and about feeling very frightened and helpless. He remembers the taxi hitting the lorry, the people screaming, the taxi rolling a few times and finally coming to a stop lying on its roof. He was lying on the inside of the roof. He was surprised at himself not being injured. A woman was lying dead over his legs, her head twisted in a strange way. There was a lot of blood, but he can't remember the details of where on whom etc. He lost track of what happened. The next thing he remembers is standing outside the taxi with a blanket over him and an ambulance man asking his name. His current symptoms started directly after this episode.

He sleeps well, eats well, and does not suffer any intrusive recollections or depression. He is however irritable and "jumpy" – he startles easily. These phenomena were not there before the accident. He avoids motor vehicles where possible. He does not like to talk about the accident. Other than the foregoing information there is nothing of note. He abuses no substances and is medically healthy.

The physical examination is normal.

1. How do you know that anxiety is abnormal?

2. What is the differential diagnosis?

3. What is the final diagnosis?

4. How will you manage the patient as a general practitioner?

CASE 3

Mrs Surev is a 25-year-old married housewife and mother of 3 small children. She belongs to a family of devout Muslims, a faith she also follows. She presents with distress due to recurrent thoughts that she finds difficult to suppress. Initially she does not want to say what these thoughts are, but later says that for about 8 years now she repeatedly experiences thoughts blaspheming God. She is not willing to state exactly what the thoughts are. To help her to control these thoughts and the accompanying distress, she continuously repeats a few consecutive verses of the Koran in her mind, while having the blasphemous thoughts. She does it to the point where she would neglect what she is busy with.

Mrs Surev is seeking help now, because while having the thoughts, she experiences intense anxiety, starts shaking, perspiring, has palpitations, and feels as if she is going to go of her mind. These episodes of intense anxiety occur as regularly as the distressing thoughts, but never at other times. There is no other aspect of the history of note, including no psychoactive substance abuse, and no change in vegetative functions. The mental status examination reveals a woman of normal appearance and dress, a clear sensorium, good contact and communication, normal thought form, normal perception, no other problems with thought content except that which is already stated, normal cognitive functions, but slightly depressed. Her drive and concentration are normal. There are no thoughts related to suicide.

The physical examination is normal. The relevant laboratory tests and ECG is normal.

1. What *psychopathology* does Mrs Surev have?

2. What is the diagnosis?

3. How would you manage her as a general practitioner?

CASE 4

Mr Polkov is a 45 yr old, married machine operator. He complains of difficulty sleeping. This difficulty has been going on for many years intermittently, but lately became worse. He says it is affecting his concentration. It also worsens his anxiety. He says that he was anxious all his life, although it varies in intensity. He always feels edgy. His muscles, especially around the shoulders and neck always feel tense and uncomfortable. He tends to unnecessarily worry about small things, but he cannot help it. He also tends to be irritable, especially when more anxious. This also troubles him, since he does not like being this way.

At work and at home things are going satisfactory, although he worries about his work, since he has concentration difficulties. However, he still manages and does not have a problem in performing his job. He does not abuse any substances, has no history of medical problems, and has never been treated psychiatrically. He is on no medication.

The mental status examination reveals anxiety, no depression, no psychotic features, an intact sensorium and normal cognitive functions. The medical examination is normal.

1. What is the diagnosis?

2. How would you manage Mr Polkov as a general practitioner?

CASE 5

The 20-year-old Ms Carlisle complains to her friend that she cannot tolerate groups of people, especially strangers. She keeps to herself or her few known friends. She avoids strangers because she feels very uncomfortable between them. She is afraid that she will say something silly or make a fool of herself. Consequently she is anxious between people and it feels to her as if she is blushing all the time. She would like to mingle more, but she is simply too afraid. Her friend advises her to see a doctor, because there may be help for these things.

You evaluate her, and over and above the history given, finds nothing else of note.

1. What is the diagnosis?

2. How will you manage Mrs Carlisle as a general practitioner?

CASE 6

Mr Musak is a 26 yr old unmarried man working as an office assistant. He has been seeking help for several years at surgeons to change the size of his nose, which he considered excessively big. A plastic surgeon operated, but Mr Musak's satisfaction did not last very long. Thereafter one surgeon after the other told him that his nose is of normal appearance. He has been very embarrassed by the appearance of his nose and wanted it changed. He sometimes wonder if he is not overly concerned, but once he looks at himself in the mirror, he is once again struck by the size of his nose. The last surgeon he visited advised him to go back to his general practitioner to discuss the problem, after he refused to see a psychiatrist or psychologist.

The general practitioner agrees with the surgeon that Mr Musak's nose is normal. He does a psychiatric history and mental status examination, which reveals nothing of note except for Mr Musak's preoccupation with the size of his very normal looking nose.

1. What is the diagnosis?

2. How will you manage Mr Musak as a general practitioner?

CASE 7

Mr Viviers is 45 years old. He is married and has grown-up children. He has had a steady job for many years as an administrative officer at a private firm. He has been preoccupied with scaling skin on his forearms for many years. He has been seeking help for skin cancer, which he believes is his skin condition. This has been going on for about 2 years. Time and again he was told that he simply has dry skin, with a little resulting eczema. He had an appointment with a dermatologist who made the same diagnosis. He gave in to Mr Viviers' pressure to take a skin biopsy. The biopsy confirmed that there were no malignant cells, but mild inflammatory changes consistent with eczema. Mr Viviers was relieved and gladly took the prescribed UEA. However, the reassurance never did not last long. The skin biopsy was so small. The cancer could easily have been missed. The dermatologist refused to take another biopsy arguing that the skin looks the same all over the forearm, that there is no break in continuity of the skin and no changes consistent with any form of cancer. Mr Viviers could not keep himself from being worried. He eventually consults you, another general practitioner in a long line of general practitioners.
You confirm the previous doctors' diagnosis. The following is of note from the psychiatric history and mental status examination other than the already stated information: his family is fed-up with his incessant talking about skin cancer and his marriage is under strain. For the past 10 months he has difficulties sleeping, has difficulties to concentrate, often has muscle tension and feels on edge. He is excessively anxious and worries about little things.

1. What laboratory investigations would you request?

2. What is the diagnosis?

3. How would you manage the patient as a general practitioner?

This kind of patient needs a special approach. There is no cure and there is not proven drug.

1. Form a good doctor-patient relationship. This is a crucial part of the management.

2. Schedule regular follow-up appointments to avoid visits as needed.

3. Do appropriate physical examinations and side-room investigations like Hb, ESR,

urine microscopy etc.

4. Avoid doing special investigations, especially intrusive investigations except if objectively indicated.

5. Do not ridicule the patient.

6. Do not say "Nothing is wrong" (something is wrong: the patients do have symptoms even though we cannot explain them biologically at this stage. More useful is: "I could not find anything wrong during the physical examination (or special investigations if those were done). Yet you have these upsetting symptoms. Unexplained symptoms are relatively common in medicine. What I can say is that we can be pretty sure that there is not something dangerous lurking behind your symptom. Now let's discuss how we can manage it..."

7. Motivate the patient to lead as productive and fulfilling a life as is possible despite the symptoms (this principal is of value with any chronic illness).

8. Make use of harmless methods where applicable: physiotherapy, occupational therapy, warm water bags, relaxation training, gradual activities / exercise.

9. Avoid habit forming drugs: e.g. benzodiazepines, narcotic analgesics.

10. Amitriptyline (25 –50 mg, sometimes higher) and SSRI's may be very helpful for chronic pain of any origin.

11. SSRI's are helpful for Body Dysmorphic Disorder

12. Suspect and treat any comorbid anxiety and depressive disorder actively.

13. If the patient shows an interest to be referred to a clinical psychologist or psychiatrist, refer.

CASE 8

A woman came from a northern African country with the following story:

> "My problem started when I heard that my 12-year old daughter has bone cancer in her legs. I love my daughter. She is beautiful and such a lively girl. They told me she might have to lose her leg. I could not bear the thought. I thought that I would not be able to bear looking at her then. Ever since then my eye sight started getting worse and finally I became completely blind. I have been blind now for 2 years. The doctors in my country could not find out what is wrong with my eyes. So they send me to South Africa to see an eye specialist. The eye specialist is also puzzled that I am unable to see. He is words were something like, 'Your eyes have normal anatomy and reaction to light.' He said something about physical tests being perfectly normal. Now it seems to me people think that I am making it up. Why would I make this all up? I always enjoyed my vision. Now I cannot read, watch TV and so on. I know that everyone thinks I am faking it, Doctor, because the eye specialist cannot find anything wrong."

The doctor notices that although she can't see and walks carefully and slowly she nevertheless manages to walk without bumping into furniture. She also keeps her head level and not extended as is common in the blind.

The patient's vision returned under hypnosis.

1. What is the diagnosis?

2. How should a GP manage such a case?