Rapid Diagnosis and Treatment of Anxiety and Depression in Primary Care: The Somatizing Patient

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The somatic presentations of anxiety, mixed anxiety and depression, and depressive disorders are commonly seen by primary care physicians, and several studies have indicated that patients who present with such psychiatric disorders in the primary care setting often do not have their disorders appropriately diagnosed. Underlying psychosocial problems often hide behind somatic screens. When physicians fail to relate the somatic symptoms to the feelings that motivated the visit, the subsequent negative workup or poor response to therapy can compromise the patient's recovery and level of satisfaction. Although not equivalent to an extensive clinical interview, the Goldberg depression screening scale and the author's SWIKIR anxiety screening scale can be used to substantially reduce the number of undiagnosed, readily treatable psychiatric disorders in the primary care population. Once an accurate diagnosis has been obtained, psychotropic medications can be used to safely and effectively manage anxious and depressed patients. Selective serotonin reuptake inhibitors have proved extremely effective in the treatment of major depression, and buspirone has excellent efficacy for the management of generalized anxiety disorder.

Key words. Anxiety; depression; somatoform disorders; antidepressive agents. (*J Fam Pract 1994; 39:373-378*)

The primary care office is a clearinghouse for ill-defined, vague patient complaints of uncertain origin. This situation contrasts sharply with a subspecialty practice, in which patients' illnesses are generally related to one particular organ system. Self-selection by the patient and physician referral strongly influence this stratification of symptom presentations.

Scientific advances of the past century have reinforced the reductionist belief that medical problems can be fully explained by abnormalities in biologic phenomena. This view largely ignores social and psychological variables.[1] When this reductionist approach is applied to the care of a patient whose physical symptoms stem primarily from an underlying psychological disorder, the result is usually a dissatisfied and unimproved patient. The lack of improvement despite a scientific workup and seemingly appropriate treatment of the somatic complaints often frustrates physicians, causing them to view such a patient as a chronic complainer or hypochondriac.[2]

In this dynamic, the patient and physician work at cross-purposes. Patients do not (and probably cannot) clearly differentiate the "purely physical" from the psychological, the patient interview being a product of both.[3] The physician is preoccupied with the objective disease while the patient is focused on the subjective illness.[4] From the patient's perspective, feeling well (ie, free of illness) is as important as being well (ie, free of disease). When somatic symptoms that have psychosocial (illness-oriented) origins are investigated and treated according to the disease-oriented model, the physician is likely to experience frustration and failure,[5] and because the physician is unable to relate an organic dysfunction to the feelings that motivated the patient's visit, the patient is no better. The soma is tested, while the source of the problem, the psyche, is ignored.

Prevalence of Psychiatric Disease Among Family Practice Patients

Studies have shown that the prevalence of psychiatric disease in family practice ranges from 5% to 34%,[6-8] and

Submitted, revised, March 16, 1994.

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ISSN 0094-3509

primary care physicians have been described as "the hidden mental health network." Schurman et al[9] reported that 77% of all mental health visits are to primary care physicians, almost half of whom are family physicians. Nearly 28% of all nonpsychiatrist visits had a psychiatric diagnosis, with anxiety (11%) and depression (6.3%) being the predominant disorders. Psychiatric disease is usually discovered while physical symptoms are being treated. Of all patient visits resulting in a psychiatric diagnosis, over one half present with somatic complaints while only one fifth present with psychological symptoms.[10]

Ormel and associates[11] recently evaluated the ability of primary care physicians to recognize and correctly classify psychiatric disease. Patients in this study were screened with the General Health Questionnaire and the Present State Examination (PSE), and by primary care physicians. The physicians failed to diagnose one half of the patients with psychiatric disease as identified by the PSE, typically assigning them nonspecific diagnoses. Physicians were more effective in recognizing depression than anxiety, and their detection rates for severe disorders were higher than for less severe psychiatric disease. Recognition was strongly associated with management and outcome: recognized cases were more likely to receive mental health interventions and had better outcomes with respect to both psychopathology and social functioning.

The difficulty of diagnosing psychiatric disease in a primary care setting is underscored by Goldberg and Blackwell's study,[12] in which a primary care physician who had been a psychiatrist failed to detect one third of the psychiatrically ill patients. Again, the primary reason for this failure was probably that the patients perceived their problems in somatic terms and thus presented with somatic rather than psychological complaints. The patients did not perceive themselves as emotionally disturbed.

Even though primary care offices provide treatment for nearly one half of the mental health visits in the United States, these visits represent only 2.4% of the primary care case load.[9] In relation to the much larger estimated prevalence of mental disorders in primary care settings, this underrecognition of mental illness remains a significant problem. The tendency of the physician to attend only to somatic symptoms, with limited awareness of the potential underlying psychosocial influences on the patient's illness, is a key factor in this problem.

Manifestations of Mood Disorders

The suffering associated with mood disorders is one of the most common reasons patients seek help, ostensibly for treatment of physical symptoms.[13,14] If they are to properly address these problems, primary care physicians need to know how to screen their patients for psychiatric origins of illness.

It is appropriate to define various psychiatric disorders according to criteria in the *Diagnostic and Statistical Manual for Mental Disorders,* revised, 4th edition (DSM-IV)[15] before describing screening tools that may help the generalist physician to identify patients with psychiatric disease.

Major depressive episode is defined as a change from previous functioning that includes at least five of the following symptoms occurring during a 2-week period: depressed mood, diminished interest or pleasure in most or all activities, significant weight loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or inappropriate guilt, diminished ability to think or concentrate, and recurrent thoughts of death. The symptoms must include either depressed mood or diminished interest in activities and cannot be substance induced.

Panic attack is a period of intense fear or discomfort associated with at least four of the following symptoms: shortness of breath, dizziness, tachycardia, trembling, sweating, choking, nausea, depersonalization or derealization, paresthesias, flushes or chills, chest pain, and fear of dying or loss of self-control. Panic disorder is defined as either four panic attacks within a 4-week period, or one or more attacks followed by at least a month of persistent fear of another attack.

Generalized anxiety disorder (GAD) is characterized by excessive anxiety and worry for at least 6 months. In this disorder, the intensity and duration of the worry are disproportionate to the likelihood or impact of the feared event. The worry is also pervasive, makes it difficult to focus on tasks at hand, and is associated with symptoms of autonomic hyperactivity, motor tension, or hyperarousal.

In considering these classic psychiatric definitions, the primary care physician, even when assisted by the screening devices described in the following section, is likely to provide relatively nonspecific diagnoses with respect to DSM criteria.[16] It is not clear whether this is because primary care patients present with mixed symptoms of depression and anxiety that are difficult to classify in DSM terms or because DSM criteria are not well suited for these patients.

When anxious feelings are present, a person must either adapt to or change the situation to avoid experiencing suffering. If prolonged, the mood disorder may be accompanied by symptoms and signs, often autonomic, including rapid pulse, elevated blood pressure, increased sweating, change in bowel function, trouble sleeping, or difficulty breathing. Endocrine and immunological imbalances can occur. In extreme situations, the mechanisms

and related symptoms of anxiety can even affect mortality.[13,14]

Somatization is the tendency to experience, conceptualize, and communicate mental states and personal distress as bodily complaints and medical symptoms. It is a general physiologic predisposition: a symptom rather than a disorder.[17] Multisystemic somatic complaints involving the gastrointestinal, genitourinary, cardiovascular, pulmonary, central nervous, or a combination of these systems drive psychosocially stressed patients to the physician's office.[18] In the primary care setting, somatization is commonly related to both anxiety and depression. These disorders seem to be inextricably woven together[19,20] and rarely present with an absolutely clear profile.[18,21]

Somatization, anxiety, and depression are very common. Somatizing depression, usually in the form of chronic pain, has been estimated to be present in 5% of all patients seeking a physician's care.[20] As noted, diagnostic criteria for panic disorder and GAD require the presence of multiple somatic symptoms.[15] These disorders are most easily differentiated in that the somatic symptoms of panic disorder occur during isolated paroxysmal episodes of intense anxiety, whereas GAD and its related somatic complaints are characterized by chronic and persistent anxiety of at least 6 months' duration. These anxiety disorders and depression are recognized as the more common and easily treatable disorders in the differential diagnosis of somatoform illnesses.[22,23]

Somatization may be a common means of entry into the medical system for patients with anxiety and related mood disorders, who commonly attend to their somatic symptoms instead of the accompanying psychological ones.[22] Patients quickly learn to express their feelings in physical terms, instead of as anger, fear, or depression. Many patients find these psychologically induced, stress-related somatic complaints, which Glasser[24] calls "symptom companions," more concrete and easier to express to a physician than the underlying emotions.

The somatization process thus might be characterized as one in which the "somatic ticket" gains entry to the office where the "symptom companions" are introduced. The key to diagnostic expertise starts with awareness that the cure for primary care somatizing patients centers on understanding the psychosocial causes of the patient's illness.

Diagnostic Issues

Family physicians generally are well suited to deal with the psychosomatic symptoms with which the primary care population so often present.[12] To treat appropriately, the differential diagnosis must identify the primary disorder.[18]

Table 1. Short Screening Scales for Anxiety and Depression

Anxiety Scale
(Score one point for each "Yes")
1. Have you felt keyed up, on edge?
2. Have you been worrying a lot?
3. Have you been irritable?
4. Have you had difficulty relaxing?

(If "Yes" to two of the above, go on to ask:)
5. Have you been sleeping poorly?
6. Have you had headaches or neck aches?
7. Have you had any of the following:
   trembling, tingling, dizzy spells, sweating, urinary frequency, diarrhea?
8. Have you been worried about your health?
9. Have you had difficulty falling asleep?

Depression Scale
(Score one point for each "Yes")
1. Have you had low energy?
2. Have you had loss of interests?
3. Have you lost confidence in yourself?
4. Have you felt hopeless?

(If "Yes" with ANY question, go on to ask:)
5. Have you had difficulty concentrating?
6. Have you lost weight (due to poor appetite)?
7. Have you been waking early?
8. Have you felt slowed up?
9. Have you tended to feel worse in the mornings?

Interpretation: Add the anxiety score. Add the depression score. Patients with anxiety scores of 5 or depression scores of 2 have a 50% chance of having a clinically important disturbance; above these scores the probability rises sharply.

From Goldberg D, Bridges K, Duncan-Jones P, Grayson D. Detecting anxiety and depression in general medical settings. BMJ 1988; 297:897–9. Reproduced with permission of BMJ Publishing Group.

Unfortunately, the standard, lengthy interview commonly used by psychiatrists to develop a diagnosis consistent with DSM criteria is impractical for the average primary care physician. A busy office practice demands systematic, efficient techniques for detection and diagnosis of the commonly somatizing anxiety and depressive disorders. Goldberg and associates[25] have developed short bedside screening scales for this purpose (Table 1). Although not capable of providing diagnoses that meet DSM standards, such questionnaires can substantially reduce the incidence of psychiatric cases typically missed by generalist physicians.[26]

In Goldberg's study, well over 80% of patients with anxiety or depressive disorders had high scores on the appropriate scale,[25] and relatively few cases of psychiatric illness were overlooked. Compared with research interviews by psychiatrists, the sensitivity and positive predictive value were 82% and 0.56 on the anxiety scale, and 85% and 0.85 on the depression scale, respectively. Overall specificity (ie, the percentage of patients without psychiatric disorders who scored low on both scales) was 91%. A patient with a score at the cutoff for either scale (5

Table 2. SWIKIR Anxiety Scale

Somatic complaints
Worries
Irritability
Keyed up, on edge
Initial insomnia
Relaxation difficulties

Interpretation: 1 point is scored for each item in the scale that applies to the patients. Patients with SWIKIR anxiety scale scores of at least 3 are assumed to have a significant probability of a clinically important anxiety disorder.

for anxiety, 2 for depression) has a 50% chance of having a clinically important disturbance. At higher scores, the probability rises sharply.[25]

It is important to emphasize, however, that this screening device has not been evaluated in prospective studies. These scales will not necessarily replace standardized rating instruments, such as the Zung or Hamilton anxiety and depression rating scales.[27–30] The Goldberg scales are designed to avoid lengthy interviews with patients who have a low probability of anxiety or depression. Patients who score above the cutoff on the Goldberg scales can complete one of the common self-rating instruments, such as the Zung scale, or have the Hamilton scale administered by a trained professional.

To further streamline the office interview process in applying the scales to the somatizing primary care patient, the SWIKIR anxiety scale (somatic complaints, worries, irritability, keyed up, initial insomnia, relaxation difficulties), which was developed by the author, involves asking the patient several overlapping questions to determine if he or she is experiencing any of the symptoms of anxiety included in the scale (Table 2). A patient who scores 3 or more on this scale should fill out an anxiety rating scale while the physician sees the next patient. In a busy practice office, these scales can rapidly identify patients who may benefit from treatment centered on the underlying psychiatric disorders rather than the somatic complaints with which they so often present. These scales, however, may be most important as screening tools to identify patients who warrant more refined diagnostic evaluation.

Treatment Issues

Primary care physicians provide a different "product" in psychiatric treatment from that of most psychiatrists,[9] treating less acute disorders that are frequently hidden behind physical symptoms.[31] The overlapping of anxious and depressive symptoms also confuses the diagnostic picture.[21] Nevertheless, when a case of hidden somatizing mental illness is detected and treated, the physical symptoms often improve greatly.[12] Drug treatment is clearly the therapy of choice for the majority of primary care physicians, who prescribe medications for patients with psychiatric diagnoses 50% more often than do psychiatrists.[9,32] This prescription frequency raises issues of medication choice and treatment duration.

Anxiety and Depression

Severe anxiety and depressive disorders require powerful interventions because of their highly significant associated morbidity and mortality. The appropriate use of antidepressants, benzodiazepines, and buspirone is the common strategy for the primary care physician.[9] The primary care physician is usually the only psychotherapist for patients with mild to moderate anxiety or depressive disorders.[21,31]

Depression

Several classes of psychotropic drugs are effective in the management of depressed patients. These include tricyclic and heterocyclic compounds, monoamine oxidase inhibitors (MAOIs), selective serotonin reuptake inhibitors (SSRIs), and bupropion.[33–36] The development of SSRIs, such as fluoxetine, sertraline, paroxetine, and the investigational agent nefazodone, has substantially enhanced the choices available for the treatment of major depression. These drugs generally are as effective as tricyclic antidepressants but are free from their potential toxicity.[34–36]

Anxiety

The key somatizing anxiety disorders are GAD and panic disorders.[15] The distinction between the two is based on Klein's observation that these conditions respond differently to pharmacologic treatment.[37] Generalized anxiety disorder has been judged to be fairly unresponsive to antidepressants that have proven efficacy in the treatment of panic disorder. Generally, this has remained true. Benzodiazepines, which are prescribed extensively to treat patients with anxiety disorders, are useful in a broad range of indications. In addition to their anxiolytic efficacy, benzodiazepines have sedative/hypnotic, anticonvulsant, muscle relaxant, and antistress effects.[38] These drugs also have a rapid onset of action. Because benzodiazepines have a relatively high potential for abuse, primary care prescriptions for this medication have declined in the past several years.[39]

Several studies have demonstrated that azapirones are effective in anxiety disorders. Buspirone, the first

member of this class to become available for this indication, acts at serotonin 5-HT_{1A} receptors on both presynaptic terminals and postsynaptic cells, where it has primarily agonist activity.[40]

Several clinical trials have demonstrated that buspirone may be particularly valuable in the management of patients with GAD. In an early study by Feighner and associates,[41] buspirone was significantly more effective than diazepam in outpatient therapy for GAD. Side effects such as sedation and drowsiness were also significantly less frequent and less severe with buspirone than with diazepam. In a recent comparison of buspirone and oxazepam in 230 patients with GAD, Strand et al[42] reported equivalent efficacy of the two agents. The average Hamilton Rating Scale for Anxiety (HAM-A) score was reduced from 23.9 to 10.6 with buspirone and from 23.9 to 11.5 with oxazepam.

Using meta-analysis, Gammans and coworkers[43] retrospectively evaluated pooled efficacy data for eight placebo-controlled studies of buspirone. This analysis demonstrated that, according to attending physician assessment, buspirone produced significantly greater improvements in HAM-A scores as well as significant global improvements as compared with placebo. Patients with GAD and coexisting depressive symptoms of at least moderate intensity also exhibited significantly greater improvement with buspirone than with placebo. This aspect of the drug's efficacy is important because 50% of patients with GAD have concomitant depressive symptoms.[44]

Rickels and Schweizer[45] have suggested that, because of its relatively slow onset of action, buspirone may be most helpful in anxious patients who do not demand rapid symptom relief that can be accomplished with benzodiazepines. The slower and more gradual onset of anxiety relief associated with buspirone, however, is balanced by increased safety and no potential for dependency.

A wide variety of medications are available for the treatment of panic disorder.[46] Heterocyclic depressants have been shown to reduce the frequency of panic attacks. Both MAOIs and alprazolam are also useful for this indication. Serotonergic agents, such as clomipramine and fluoxetine, may be beneficial in panic attacks but have not been studied extensively in panic disorder.

As these studies indicate, there now are useful alternatives to benzodiazepines for the management of patients with anxiety disorders. The choice of nonhabit-forming agents such as buspirone and selected antidepressants can substantially reduce the danger of chemical dependency and increase the potential for greatly improved quality of life in patients with mild to moderate somatizing anxiety depressive disorders.[47]

Conclusions

Primary care physicians should play a central role in the initial screening for psychiatric disorders, but better tools are needed to assist in this process. Although currently available screening devices, including the one proposed in this paper, cannot replace the clinical interview by an experienced diagnostician, they have reduced the incidence of undiagnosed psychiatric disorders in the primary care setting. Effective alternatives are available for the treatment of depressive and anxiety disorders. SSRIs have markedly changed the management of major depression, and psychotropic agents such as buspirone may be an attractive alternative treatment for anxiety disorders, especially GAD.

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