Adult Mental Health Disorders Update

This edition of *FP Essentials™* will update family physicians on adult mental health disorders and will cover four sections: personality disorders, obsessive-compulsive disorder (including body dysmorphic disorder), posttraumatic stress disorder, and the primary care approach to counseling.

This edition of *FP Essentials* should be approximately 10,000 words in length, divided into four sections of approximately 2,500 words each (each with an abstract of 200 words or less) plus key practice recommendations, a maximum of 15 tables and figures, recommended reading, and approximately 100 references. This edition should focus on what is new in each topic and should answer the key questions listed for each section. Each section should begin with an illustrative case, similar to the examples provided, with modifications to emphasize key points; each case should have a conclusion that demonstrates resolution of the clinical situation. The references here include information that should be considered in preparation of this *FP Essentials*. However, these references are only a useful starting point that should be used to identify additional information to review.

**Needs assessment:** Family physicians provide mental health care to a significant portion of the US population. However, many patients with mental health issues remain undiagnosed or undertreated. In addition, family physicians can address the medical, social, and spiritual aspects of care that may directly affect and be affected by mental health conditions. A recent needs assessment of family physicians demonstrated they are uncomfortable addressing many basic mental health issues in their patients, and family physicians see a need for increased education in this area. In fact, American Academy of Family Physicians (AAFP) members ranked two of the topics covered in this edition of *FP Essentials*, posttraumatic stress disorder and personality disorders, in the top 4% and 7% conditions, respectively, for which there is a gap between the condition’s relevance to practice and their skill in dealing with the condition. This issue of *FP Essentials* is intended to help close that gap.
Section 1: Personality Disorders

Example case: Julie, a 33-year-old woman, comes to your office with multiple nonspecific physical complaints including fatigue, diffuse abdominal pain, and headaches. She reports that she has seen multiple physicians in the past, but they “didn’t understand her needs;” she felt that they abandoned her and did not help her. She says she has heard that “you are the best doctor in this place” and she is confident that you will solve all her problems.

Key questions to consider:

- What is the prevalence of personality disorders in the family medicine setting? Which personality disorders are most commonly seen in the family medicine setting?
- What behaviors or other factors should raise concern that a patient has a personality disorder?
- Are there risk factors for personality disorders? Can they be prevented or mitigated?
- What are the proposed models (biological, psychological, mixed) for the development of personality disorders?
- What are the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) (DSM-5) criteria for the following personality disorders:
  - Antisocial personality disorder
  - Avoidant personality disorder
  - Borderline personality disorder
  - Narcissistic personality disorder
  - Obsessive-compulsive personality disorder
  - Personality disorder trait specified
  - Schizotypal personality disorder
- How can personality disorders be differentiated from other mental health disorders such as bipolar disorder and obsessive-compulsive disorder? How does the use of alcohol and other substances affect the ability to diagnose a personality disorder?
- How often do personality disorders coexist with other mental health disorders? How does this affect the management of these disorders?
- How do personality disorders affect an individual’s overall health, including chronic diseases, utilization of health care, and life expectancy? What is the risk of suicide in borderline personality disorder and other personality disorders?
- Which patients should be screened for personality disorders? What tools are available for screening patients for personality disorders? Is one tool preferable?
- What counseling techniques are effective for the management of personality disorders?
- When is pharmacotherapy appropriate for the management of personality disorders? What drugs or combination of drugs are effective for the management of personality disorders?
- When is referral to a psychiatric subspecialist recommended? When is hospitalization indicated?

Initial references to consider:
- Perugula ML, Narang PD, Lippmann SB. The biological basis to personality disorders. Prim Care Companion CNS Disord. 2017;19(2).


• Pilkonis PA, Lawrence SM, Johnston KL, Dodds NE. Screening for personality disorders: a three-item screener from the Inventory of Interpersonal Problems (IIP-3). *J Pers Disord* [Epub ahead of print].

• Morey LC, Hopwood CJ. Expert preferences for categorical, dimensional, and mixed/hybrid approaches to personality disorder diagnosis. *J Pers Disord* [Epub ahead of print].

• Lewis KL, Fanaian M, Kotze B, Grenyer BFS. Mental health presentations to acute psychiatric services: 3-year study of prevalence and readmission risk for personality disorders compared with psychotic, affective, substance or other disorders. *BJPsych Open.* 2019;5(1):e1.


• Comtois KA, Carmel A. Borderline personality disorder and high utilization of inpatient psychiatric hospitalization: concordance between research and clinical diagnosis. *J Behav Health Serv Res.* 2016;43(2):272-280.


Section 2: Obsessive-Compulsive Disorder (including body dysmorphic disorder)

Example case: Andy, a 30-year-old man, is habitually late for appointments with you. When you ask him why he is always late, he tells you that he is concerned that someone is going to break into his house, and must check the lock on each door and window several times before he can leave his house. When questioned, he states that he knows that the chances of anyone breaking into his house are small, but he still needs to check each lock multiple times.

Key questions to consider:

- What is the prevalence of obsessive-compulsive disorder (OCD) in the family medicine setting? How does it typically present in the family medicine setting in children and adolescents versus adults?
- What are the current models that explain the development of OCD? What are the risk factors for developing it?
- What are the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) (DSM-5) diagnostic criteria for OCD?
- Should patients be screened for OCD? If so, which patients benefit most from screening? What is (are) the preferred screening test(s)?
- What effect does OCD have on overall health, coexisting chronic conditions, and other mental health conditions? What is the risk of suicide in individuals with OCD? How can a physician determine if OCD is harmful to a patient’s health and negatively affecting their life?
- What is the relationship between OCD and body dysmorphic disorder? Describe the similarities and differences in presentation, diagnosis, prognosis, and treatment strategies.
- What are the indications for treatment in OCD? What is the role for therapeutic lifestyle changes, including diet and exercise? What are the recommended psychological approaches?
- When is pharmacotherapy indicated? Which drugs and doses are the most effective? What management recommendations are different for children?
- What defines treatment resistance, and what is the recommended approach to treatment-resistant OCD? Describe therapies such as deep brain stimulation and neuroablation. How effective are they and what are their risks?
- When is referral to a psychiatric subspecialist recommended?

Initial references to consider:


• Ramos TD, de Brito MJA, Suzuki VY, Sabino Neto M, Ferreira LM. High prevalence of body dysmorphic disorder and moderate to severe appearance-related obsessive-compulsive symptoms among rhinoplasty candidates. *Aesthetic Plast Surg* [Epub ahead of print].


Section 3: Posttraumatic Stress Disorder

Example case: Henry, a longtime patient of yours, was involved in a motor vehicle crash and spent several weeks in the intensive care unit, followed by significant time in an inpatient rehabilitation facility. He is gradually improving physically. However, his wife tells you that he is increasingly moody and withdrawn. He startles easily at loud noises and says he will never drive again.

Key questions to consider:

• What is the prevalence of posttraumatic stress disorder (PTSD) in the family medicine setting? How does it typically present in children and adolescents versus adults?
• What are the current models that explain the development of PTSD? What are the risk factors for developing it?
• What are the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) (DSM-5) diagnostic criteria for posttraumatic stress disorder (PTSD)? When should patients be screened for PTSD in the family medicine setting? Are there any populations in which routine screening is recommended? When screening will be performed, are there any validated and effective screening tools for use in the family medicine? How accurate are these tools?
• What is the scope of PTSD in the family medicine setting? Describe common and uncommon traumatic events that may predispose a patient to PTSD (eg, major illness, traumatic brain injury, observing or experiencing a traumatic event). How common is PTSD among patients who survive the conditions for which they received care in the intensive care unit?
• Are there any conditions, other than the traumatic event, that predispose a patient to PTSD? If so, what are they and what can be done to mitigate them? Similarly, are there any conditions or factors that are protective against PTSD?
• What is the presentation of PTSD? Review the different types of symptoms (eg, psychological, behavioral, and physical) that may occur in PTSD. Is one cluster of symptoms more common than another?
• Do patients with PTSD require additional diagnostic assessments for other comorbid mental health conditions?
• What is the general therapeutic approach to patients who are diagnosed with PTSD? What are the indications for treatment?
• Are there effective counseling techniques for patients with PTSD? Are any of these techniques appropriate in the family medicine setting? If so, describe what they involve.
• What about therapies such as eye movement desensitization and reprocessing (EMDR)? What does it involve, for which patients is it indicated, and how effective is it?
• What are the indications for pharmacotherapy in patients with PTSD? Which drug(s) are preferred? What is the recommendation for combination therapy? How is treatment-resistant PTSD managed?
• Describe practice-wide or community-wide interventions that help in the prevention, identification, and management of PTSD.
• When is referral to a psychiatric subspecialist recommended?
Initial references to consider:


Section 4: Primary Care Approach to Mental Health Counseling

Example case: Ashley, a 27-year-old woman, reports feeling “down” for several weeks. Her patient health questionnaire-2 (PHQ-2) screen is positive and further evaluation with a PHQ-9 indicates mild to moderate depression. She has no active suicidal or homicidal ideation. She is adamant about not wanting pharmacotherapy. She would be interested in counseling, but she does not have the transportation or resources to go to a different office.

Key questions to consider:

• What is the role of family physicians in providing office-based counseling, and how is it explicitly defined? That is, how does it differ from talking with patients about their mental health conditions and their nonmental health conditions (eg, lifestyle modification).
• What conditions and behaviors are amenable to office-based counseling?
• What are the limitations of office-based counseling? What are the benefits?
• What is the transtheoretical (stages of change) model, and how is it applicable in the family medicine setting?
• What are the different counseling methods that can be used in a family medicine? Do they require specialized training? Provide an overview of the most commonly used techniques – including what they involve, how physicians might administer them, and which condition(s) benefit most from each of the various approaches. Discuss FRAMES (Feedback, Responsibility of patient, Advice to change, Menu of options, Empathy, Self-efficacy enhancement), 5 As (Ask, Advise, Assess, Assist, Arrange), BATHE (Background, Affect, Troubles, Handling, and Empathy), cognitive behavioral therapy (CBT), and other strategies, as applicable.
• How effective overall are brief interventions in the family medicine setting?
• Are there benefits to having a mental health subspecialist as part of the family medicine office? How is this individual integrated into normal workflow and patient care?
• How is billing handled? How can family physicians bill for counseling services or for counseling provided by mental health subspecialists in their practice?
• When should referral to a mental health clinician be considered, rather than in-office counseling in a family medicine practice?

Initial references to consider:


