



A SOURCE OF MENTAL HEALTH INFORMATION FOR GENERAL PRACTITIONERS

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In the next issue

- **Bipolar Affective Disorder**
- **Borderline personality disorder**

What is Hypochondriasis

The core features of hypochondriasis are disease phobia, disease conviction and preoccupation with the disease that persists despite medical investigations and reassurance. The recent literature has preferred the less offensive term "health anxiety" as patients often take hypochondriasis as an accusation rather than a diagnosis. Sufferers are often preoccupied with intrusive thoughts around the themes of having an actual disease or fear of developing actual disease. Misinterpretation of normal sensations is extremely common as is a tendency to self examine. Any body areas may be involved, although symptoms relating to the chest abdomen, head and neck are particularly common. Physical and psychiatric disorder may coexist and inevitably patients with hypochondriasis will at some point develop physical disorder.

Doctors commonly become angry and frustrated in their dealings with these patients. If patients are simply told that there is nothing wrong with them, they will usually react with fury and merely seek alternative

opinions. It is important that you reassure the patient that his/ her symptoms are real and that you accept the reality of their suffering.



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Management of Hypochondriasis

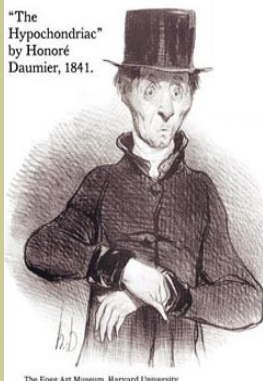
Management starts with comprehensive assessment that has medical, psychiatric and social aspects. It is important that, from the outset one doctor preferably patient's general practitioner takes control of the patient's management, as these patients are likely to cause splitting of healthcare professionals. After a thorough medical assessment and all appropriate investigations the doctor should give results to the patients in a clear and unambiguous way. Mainstay of treatment of hypochondriasis is psychosocial. Doctor should avoid telling the patient that his symptoms are not real or are imaginary. He

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The doctor should accept that symptoms are real to patient and cause suffering.

Evidence shows that a course of CBT is effective in this disorder.

should accept that patient is experiencing those symptoms are those are causing him/her considerable suffering. One should avoid repeated reassurance especially any premature reassurance. The evidence of pharmacological treatment of hypochondriasis is less strong. There is evidence that a course of cognitive behaviour therapy is effective in this disorder.



The Fogg Art Museum, Harvard University



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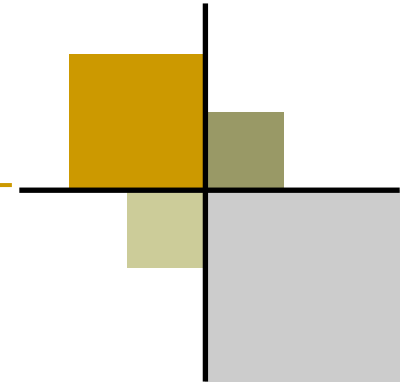


LPC BULLETIN

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Postnatal Depression; presentation and symptoms

- ◆ Half of women who give birth experience low mood at some point in their pregnancy and/or in the initial days or weeks following the birth. Symptoms include feeling tearful, overwhelmed and irritable, but these may pass with rest, support and reassurance.
- ◆ If, following the birth of the child, marked low mood persists for a prolonged period of time, the mother may be diagnosed with postnatal depression.
- ◆ Postnatal depression affects 15 to 20% of new mothers within 12 months of their child's birth.
- ◆ The illness may start straight after delivery, on 4th or 5th day or insidiously in 8th-12th weeks after delivery.
- ◆ Diagnostic features include irritability, fatigue, sleeplessness, lack of appetite, anxiety, poor mother–infant interaction (for example, lack of interest in the child), anxieties about the child (possibly including thoughts of harming the child), lack of motivation, panic attacks, feelings of isolation, a sense of being overwhelmed and physical signs of tension, such as headaches or gastrointestinal symptoms.
- ◆ The UK Confidential Enquiry into Maternal Deaths (CEMD) reports that psychiatric disorders contributed to 12% of all maternal deaths (10% of which were due to suicide).
- ◆ Midwives use screening questionnaire called Edinburgh Postnatal Depression Scale. EPDS has ten questions and score range from 0-30, with a score of 12 or above indicates a depressive illness.
- ◆ Thoughts of self-harm and suicide may also be present, which may or may not lead to self-harming behaviour. The development of mental disorders in pregnancy and postnatally may be associated with or aggravated by a number of factors. These include:
 - ◇ psychological factors, such as the demands and expectations of being a mother, in addition to the psychological effects of a traumatic delivery
 - ◇ social factors, including social isolation, economic status, ethnicity, cultural issues and housing
 - ◇ family factors, including the relationship with the child's father and the support received from family and friends
 - ◇ biological factors, including genetic factors and the hormonal changes that occur during pregnancy, childbirth and following childbirth
 - ◇ personal history (including drug and alcohol use, domestic violence, and childhood sexual and physical abuse), family history, past psychiatric history
 - ◇ and previous maternal history
 - ◇ the infant's general health.
- ◆ The rate of recurrence of postnatal depression after a subsequent birth is about 30%. The majority of cases of antenatal and postnatal depression and other disorders that arise in pregnancy and postnatally will be mild to moderate and managed in primary care.



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Treatment of Postnatal Depression

- ◆ In postnatal depression If untreated, women may remain depressed, sometimes for many years, with consequent negative impact, not only for the mother but also for other family members.
- ◆ One third improve with CBT. CBT can be given in group form though not every patient can attend groups.
- ◆ Severe illness needs pharmacotherapy. SSRI are used due to less side effects.
- ◆ In some cases, effective interventions may be non-pharmacological but, for a significant proportion of women with severe mental illness, medication may be an appropriate treatment.
- ◆ All antidepressants are secreted in breast milk.
- ◆ Often in severe illness patient cannot breastfeed.
- ◆ Recent reviews of antidepressants show that **Sertraline** is a choice of antidepressant in

breastfeeding mothers because it results in lowest levels in breast milk as compared to other SSRIs. *(During pregnancy Fluoxetine is relatively safer antidepressant). Prescriber needs to check latest information before prescription.*

