Fits, faints and funny turns

Could it be a mental disorder?

BACKGROUND Patients who present to primary care with symptoms of fainting and dizziness, for which there is no adequate physical explanation, are frequently suffering from an undiagnosed psychiatric disorder.

OBJECTIVE This article aims to improve the recognition of common mental disorders presenting as 'fits, faints and funny turns' (FFFTs) and to encourage general practitioners to view these disorders as a positive diagnosis in need of treatment.

DISCUSSION Psychiatric disorders, particularly panic attacks and depression, are common in the setting of FFFTs and should be a positive diagnosis rather than a diagnosis of exclusion. A detailed description of the episode, with corroborating information from a witness if possible, and psychiatric rating scales can assist in this process. Identifying a physical cause for the episode does not exclude a psychiatric diagnosis and vice versa. Specific psychological and pharmacological therapies are effective for anxiety and depression.

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'Fits, faints, and funny turns' (FFFTs) encompass a variety of symptom clusters that patients may present with, often in a dramatic manner. These presentations are frequently a diagnostic dilemma for the treating doctor. This is especially true in general practice, where the general practitioner straddles responsibility for the physical and psychological care of the patient.[1] Commonly, the physical diagnoses are pursued with extensive investigation, while the possibility of a mental disorder is relegated to a diagnosis of exclusion. This can lead to common mental disorders not being formally diagnosed, and therefore not being adequately treated. Apart from the disability for the individual patient whose mental disorder remains undiagnosed, the cost to the community of ongoing, unnecessary investigations and consultations is substantial.[2] In this article we argue that common mental disorders such as depression and anxiety should be considered in all patients presenting with FFFTs through full assessment with the aid of diagnostic questionnaires.[3]

Patients who present to primary care with symptoms of fainting and dizziness for which there is no physical explanation, may often be suffering from an undiagnosed psychiatric disorder.[4] For example, in one study of 1000 primary care patients, the presence of the symptom of fainting was associated with a 50% chance that the patient had an anxiety disorder, and a 62% chance that the patient was suffering from a mood disorder.[4] Dizziness, without adequate physical explanation was also associated with high rates of anxiety and mood disorders.[4] With significant rates of nondetection of common mental disorders in primary care,[5] the presence of FFFTs (which lack an adequate physical explanation), should be a prompt for GPs to consider the possibility of one of the high prevalence mental disorders such as depression or anxiety.

The clinical presentation of a mental disorder as a FFFT is an example of somatisation. The term somatisation has been defined as: '...the tendency to experience, conceptualise and communicate mental states and distress as physical symptoms or altered bodily function'.[6] Somatisation is perhaps the most common of the psychiatric phenomena seen in general practice[7] with the presentation of physical symptoms in the setting of a mental disorder being very common.[8] This is not surprising since throughout history and across cultures, the expression of psychological distress through physical symptoms has really been the norm.[9]

One of the challenging aspects of assessing a patient with a FFFT is that they may have both a combination of physical and psychological reasons for their symptoms. General practitioners are well placed to assess both the psychological and physi-

cal aspects of the patient's presentation to determine and manage the contributing factors.[1]

Part of the assessment involves understanding the patients' perception of the cause of their FFFTs, especially when no physical cause has been identified. Often patients are told 'there is nothing wrong' without having their fears addressed.[10] However, the evidence suggests that patients are often not reassured by simply being informed of normal diagnostic tests.[11] Many patients will need assistance to understand the link between their physical symptoms and their emotional state. One intervention that is effective in helping patients to make this link is to use the 'reattribution' approach. Reattribution uses a practical model for assessment, acknowledgment and management of functional somatic symptoms that patients present within primary care.[12]

In order to highlight the practical aspects of managing these patients we present three cases: a fit, a faint, and a 'funny turn' as they presented in general practice.

Case history 1 – a fit

Bill was a 27 year old personal trainer who lived with his wife and one year old son. He presented with problems controlling his anger, emotional lability, and a query as to whether he had been experiencing seizures.

Bill said that he had been experiencing increasing levels of distress related to the suicide of his father nine years earlier, the death of a former girlfriend a year after that, financial strain, and frustration with feeling unable to manage his anger. Over the past few months he said he had experienced 'seizures' (generally triggered by reminders of his father) where he felt completely overwhelmed by his emotions and feelings of grief. He experienced intense anger, headache, tingling in the hands and feet, tunnel vision, and felt absolutely miserable.

His past medical history included numerous sporting injuries that had also hampered his ability to enjoy exercise. He was a nonsmoker, drank little alcohol, but used marijuana occasionally. There was a family history of psychiatric illness (maternal grandfather also committed suicide and his aunt suffered from substance abuse). Premorbidly, he was a worrier, quite impulsive, engaged in risk taking behaviour; he was very sensitive to criticism and was very self critical.

At review, he was a pleasant man who developed good rapport. On a number of occasions he displayed dramatic behaviour by falling on to the floor and curling up in a ball and crying, and also standing up, kicking his chair and yelling. He was able to respond to directions to return to his chair and talk through his feelings. His mood was depressed and his affect labile. There was no evidence of psychotic features. He expressed suicidal ideation without plan or intent.

The SPHERE-12 rating scale symptom profile[17] suggested that he was highly likely to be psychologically depressed (Figure 1). On a Beck Depression Inventory[18] he scored 32, which suggested that he was significantly depressed.

He had a normal neurological examination and normal EEG and cerebral MRI scan. He had been assessed by a neurologist who diagnosed pseudoseizures (seizures that are deemed to be psychological rather than epileptiform).

Bill's initial diagnosis and management

The initial impression was that Bill was suffering from mixed depression and anxiety on a background of unresolved grief and an impulsive and interpersonally sensitive personality style and that his seizures were probably panic attacks.

A course of cognitive behavioural therapy (CBT)[15] was commenced to help him deal with his anger and grief in conjunction with treatment with a selective serotonin reuptake inhibitor (SSRI).

On further consultations with Bill and his wife, it became clearer that Bill had been experiencing quite classic complex partial seizure auras.[19] His wife described how he would become agitated at night, start smacking his lips, get up out of the bed in a trance-like state and start feeling clothes by the side of the bed. On a number of subsequent occasions, an ambulance was called and he was conveyed to hospital. Repeat EEGs were normal (a not uncommon finding in a patient with confirmed epilepsy). Later, he was observed in hospital to have a tonic clonic seizure.

Comment

The general lesson from this case is the importance of keeping an open mind to alternative diagnoses as the patient is followed up. There appeared to be a strong association with stress and the seizure episodes, which led to the initial diagnosis of pseudoseizures. It was important to obtain a corroborative history to identify a pattern consistent with aura, postictal confusion and emotional lability. Consequently, his management involved both treatment of his epilepsy and his mixed depression and anxiety.

SPHERE-12

Over the **past few weeks** have you been troubled by:

Psychological distress

	Never or some of the time	A good part of the time	Most of the time
1. Feeling nervous or tense?	[0]	[1]	[2]
2. Feeling unhappy and depressed?	[0]	[1]	[2]
3. Feeling constantly under strain?	[0]	[1]	[2]
4. Everything getting on top of you?	[0]	[1]	[2]
5. Losing confidence?	[0]	[1]	[2]
6. Unable to overcome difficulties?	[0]	[1]	[2]

Somatic physical distress

	Never or some of the time	A good part of the time	Most of the time
7. Muscle pain after activity?	[0]	[1]	[2]
8. Needing to sleep longer?	[0]	[1]	[2]
9. Prolonged tiredness after activity?	[0]	[1]	[2]
10. Poor sleep?	[0]	[1]	[2]
11. Poor concentration?	[0]	[1]	[2]
12. Tired muscles after activity?	[0]	[1]	[2]

Add up the numbers in the response circles to get a score for psychological distress (questions 1–6) and a score for physical distress (questions 7–12)

Total psychological symptom score: _____

What does the score mean?

0 or 1: **No psychological distress**

2 or more: **Possibly some psychological distress**

Total physical symptom score: _____

What does the score mean?

0 or 2: **No physical distress**

3 or more: **Possibly some physical distress**

SPHERE-12 classification

[ ] Level 1 (type 1): Patient is a case on both the psychological and physical subscales, ie. the patient reports both characteristic psychological and physical symptoms. These are the most symptomatic patients.

[ ] Level 2 (type 2): Patient is a case on the psychological subscale only, ie. the patient reports psychological symptoms only.

[ ] Level 2 (type 3): Patient is a case on the physical subscale only, ie. the patient reports physical symptoms only.

[ ] No symptoms: Patient reports insufficient psychological or physical symptoms to justify any mental disorder diagnosis.

Figure 1. The SPHERE-12 questionnaire

Question 1 In the past 4 weeks, about how often did you feel tired out for no good reason?	None of the time A little of the time Some of the time Most of the time All of the time	[1] [2] [3] [4] [5]
Question 2 In the past 4 weeks, about how often did you feel nervous?	None of the time A little of the time Some of the time Most of the time All of the time	[1] [2] [3] [4] [5]
Question 3 In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?	None of the time A little of the time Some of the time Most of the time All of the time	[1] [2] [3] [4] [5]
Question 4 In the past 4 weeks, about how often did you feel hopeless?	None of the time A little of the time Some of the time Most of the time All of the time	[1] [2] [3] [4] [5]
Question 5 In the past 4 weeks, about how often did you feel restless or fidgety?	None of the time A little of the time Some of the time Most of the time All of the time	[1] [2] [3] [4] [5]
Question 6 In the past 4 weeks, about how often did you feel so restless you could not sit still?	None of the time A little of the time Some of the time Most of the time All of the time	[1] [2] [3] [4] [5]
Question 7 In the past 4 weeks, about how often did you feel depressed?	None of the time A little of the time Some of the time Most of the time All of the time	[1] [2] [3] [4] [5]
Question 8 In the past 4 weeks, about how often did you feel that everything was an effort?	None of the time A little of the time Some of the time Most of the time All of the time	[1] [2] [3] [4] [5]
Question 9 In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?	None of the time A little of the time Some of the time Most of the time All of the time	[1] [2] [3] [4] [5]
Question 10 In the past 4 weeks, about how often did you feel worthless?	None of the time A little of the time Some of the time Most of the time All of the time	[1] [2] [3] [4] [5]
	Total of scores _____	

'Scores range from 10 to 50. People seen in primary care who score under 20 are likely to be well. People who score 20–24 are likely to have a mild mental disorder, people who score 25–29 a moderate mental disorder. People who score over 30 are likely to have a severe mental disorder. About 25% of people seen in primary care will score 20 and over'.
For more information see www.crufad.unsw.edu.au or www.gpcare.org

Figure 2. Kessler Psychological Distress K-10 Scale[13]

Case history 2 – a faint

Michael was a 35 year old married man who worked as an electrician for a large firm.
He presented with a history of a few months duration where he said he had been experiencing episodes of fainting and collapsing. On further questioning, it was clear that he had not in fact fainted or collapsed, but rather, he had a fear he was going to faint or collapse. This had become worse for him, particularly when he had to climb up ladders – he was worried that he would fall and hurt himself.

Over the past three months, one of his children had been diagnosed with a serious illness, and his employer had been downsizing. As a result, remaining staff were expected to become multiskilled and take on more work. When Michael was in his early 20s he had experienced a number of episodes of panic and avoided public transport for some months but forced himself to get back on buses and trains again and effectively overcame the panic and agoraphobia himself.

Physical examination was normal although he was slightly overweight. Relevant investigations were normal apart from raised serum cholesterol; ECG and Holter monitor were normal.

Michael's score on the Kessler Psychological Distress Scale (K10)[13] suggested that he was likely to have a moderately severe mental disorder (Figure 2). The Fear Questionnaire[14] indicated that he was anxious and agoraphobic.

Michael's initial diagnosis and management

Michael's diagnosis was panic disorder with mild agoraphobia that had developed in the setting of a number of stressors at work. The management approach consisted of:

- reassuring the patient using the normal tests to reinforce that he was physically healthy
- psychoeducation about panic symptoms and avoidance behaviours
- slow breathing technique, and
- CBT[15] particularly focussing on the interpretation of his physical symptoms.

Comment

Clarifying what the patient meant by his FFFT was important. He revealed that he had not actually fainted or collapsed, but rather, he felt dizzy and thought he may collapse. This distinction was important in determining his diagnosis and also important in treatment to assist with reattribution of his experience. A link between psychiatric dysfunction and the symptom of dizziness had been established.[16] It is unclear if this is a neuropsychological mechanism or if the relationship is a manifestation of self focussed attention and symptom interpretation.[16] One hypothesis is that the anxiety related arousal enhances the experience of minor neurological sensations[16] and perhaps this was the case in Michael's experience.

Case history 3 – a funny turn

Sarah was a 40 year old office manager who presented with a series of 'funny turns'. She described getting ready for a wedding when she felt 'all dizzy and nauseated and had to lie down'. She recovered, attended the wedding but left early, having experienced another turn standing in the church. The same thing happened the following Monday when she was getting ready to go to work; which resulted in her phoning in sick.

On further questioning, for the past 6–8 weeks she had become increasingly depressed and felt like 'hiding from the world'. She experienced marked anhedonia, sleep disturbance with early morning wakening and decreased appetite with weight loss. There was no past psychiatric history. She smoked 16 cigarettes a day, did not drink alcohol or use recreational drugs. There was no reported significant medical history. There was a family history of depression in both her mother and a sister. Premorbidly, she liked to be organised and was meticulous and perfectionistic.

At review, she was a pleasant woman who developed good rapport. Her mood was depressed and her affect reactive but restricted in range. There was no evidence of psychotic features. On a Beck Depression Inventory[18] she scored 39, which was suggestive of significant depression.

Sarah's initial diagnosis and management

Sarah was diagnosed with major depression with prominent anxiety and panic. She was initially commenced on moclobemide, 300 mg twice a day for 2–3 weeks, but her depressive symptoms did not improve during this time. She was changed over to venlafaxine but this exacerbated her nausea and anxiety.

She was advised to wait for three days before commencing an SSRI; half a tablet in the morning for seven days, then increase to a full tablet in the morning. For the following week she did experience some worsening of the nausea, however, this gradually subsided. She also commenced psychological treatment consisting primarily of CBT,[15] and reattribution about the cause of her nausea and dizziness, and made gradual improvement over a three month period.

Comment

The choice of antidepressant medication requires some consideration in the setting of a patient experiencing FFFTs, particularly balancing the risk of possible side effects that may worsen physical symptoms (Figure 3). In this case the initial choice of medication was probably not ideal according to current guidelines.[20] The commencement of an SSRI medication can be associated with the common side effect of nausea,[21] although in this patient's case, the nausea subsided after one week.

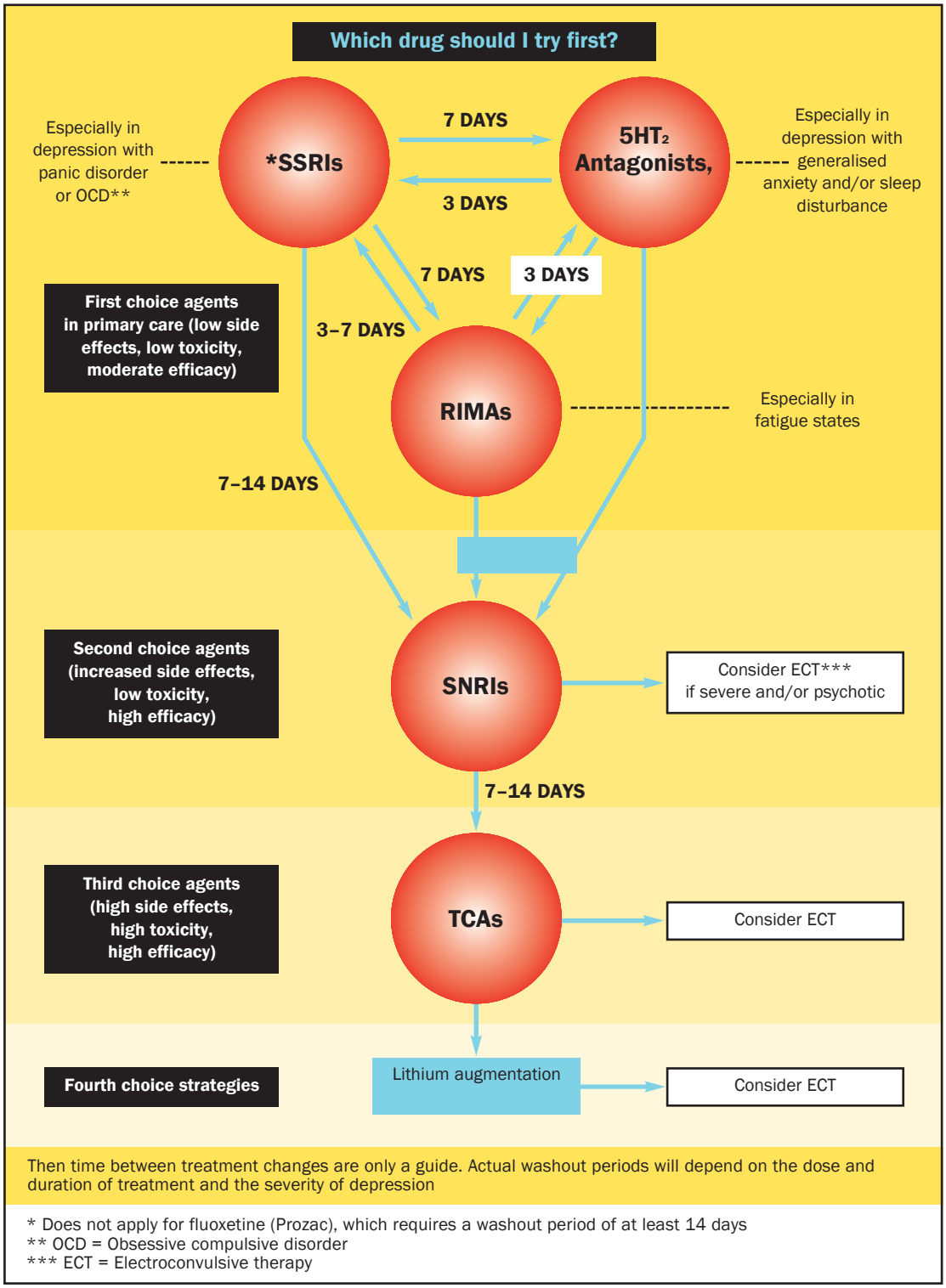

Figure 3. Flow diagram of rational antidepressant use[15]

Conclusion

A careful history is an important part of determining diagnosis. Clarifying what the patient means by their FFFT, examining the period before, during and after the 'turn' helps to be more specific about the presenting signs and symptoms.[22] Assessing specifically for depressive and anxiety symptoms should be a routine part of assessment in FFFTs as these are common underlying causes. Use of rating scales helps to quickly screen for the presence of depression and anxiety. It is also important to recognise that both a physical problem and a psychiatric problem may be contributing to the patient's FFFT. Once a positive diagnosis is made, it is just as important to treat the underlying psychiatric disorder as it is to treat an underlying physical condition. Effective treatments for depression and anxiety exist – these conditions should not be ignored.

SUMMARY OF IMPORTANT POINTS

- Common psychiatric causes of FFFTs include anxiety disorders (especially panic attacks) and depressive disorders.
- A detailed history of the FFFT is essential, preferably with corroborating information from a reliable witness.
- Common mental disorders in the setting of FFFTs should be a positive diagnosis rather than a diagnosis of exclusion - rating scales can assist.
- Identification of a physical cause for the FFFT does not exclude a coexisting mental disorder and visa versa. Comorbidity is common.
- Commencement of psychotropic medications in patients experiencing FFFTs requires consideration of the drug's side effect profile.

Conflict of interest: Dr Hugh Morgan and Dr Grant Blashki have developed and taught SPHERE programs sponsored by Pfizer.

References

1. McWhinney I R. A textbook of family medicine. 2nd edn. New York: Oxford University Press,1989.
2. Andrews G, Henderson S, eds. In: Unmet need in psychiatry: problems, resources, responses. Cambridge: Cambridge University Press, 2000.
3. Hickie I B, Andrews G, Davenport T A. Measuring outcomes in patients with depression or anxiety: an essential part of clinical practice. Med J Aust 2002; 177:205–207.
4. Kroenke K, Spitzer R L, Williams J B, et al. Physical symptoms in primary care. Predictors of psychiatric disorders and functional impairment. Arch Fam Med 1994; 3:774–779.
5. Goldberg D. Epidemiology of mental disorders in primary care settings. Epidemiol Rev 1995; 17:182–190.
6. Singh B S. Managing somatoform disorders. Med J Aust 1998; 168:572–577.
7. Clarke D, Smith G. Somatisation. Aust Fam Physician 2000; 29:109–113.
8. Simon G E, VonKorff M, Piccinelli M, Fullerton C, Ormel J. An international study of the relation between somatic symptoms and depression. N Engl J Med 1999; 341:1329–1335.
9. Kleinman A. Rethinking psychiatry from cultural category to personal experience. New York: The Free Press, 1988.
10. Fitzpatrick R. Telling patients there is nothing wrong: unless their true fears are addressed, diagnostic tests may leave them more anxious than before. Br Med J 1996; 313:311–312.
11. Sensky T. Causal attributions in physical illness. J Psychosom Res 1997; 43:565–573.
12. Gask L. Management in primary care. In: Mayou R, Bass C, Sharpe M, eds. Treatment of functional somatic symptoms. Oxford: Oxford University Press, 1995.
13. Andrews G, Slade T. Interpreting scores on the Kessler Psychological Distress Scale (K10). Aust N Z J Public Health 2001; 25:494–497.
14. Marks I M, Mathews A M. Brief standard self rating for phobic patients. Behav Res Ther 1979; 17:263–267.
15. Hickie I, Scott E, Morgan H, et al. A depression management program: incorporating cognitive behavioural strategies. Melbourne: Educational Health Solutions, 2000.
16. Moss-Morris R, Petrie K J. Link between psychiatric dysfunction and dizziness. Lancet 1999; 353:515–516.
17. Hickie I B, Davenport T A, Hadzi-Pavlovic D, et al. Development of a simple screening tool for common mental disorders in general practice. Med J Aust 2001; 175(Suppl):S10–S17.
18. Beck A T, Ward C H, Mendleson M, Mock J, Erbaugh J. An inventory for measuring depression. Arch Gen Psychiatry 1961; 4:561–571.
19. Kaufman D M. Clinical neurology for psychiatrists. 4th edn. Philadelphia: WB Saunders Company, 1995.
20. Ellis P M, Smith D A. Treating depression: the beyondblue guidelines for treating depression in primary care. Not so much what you do but that you keep doing it. Med J Aust 2002; 176(Suppl):S77–S83.
21. Hickie I B. Choosing antidepressant drugs in general practice. Aust Fam Physician 2001; 30:663–667.
22. Murtagh J. General Practice. 2nd edn. Sydney: McGraw Hill, 1998.

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