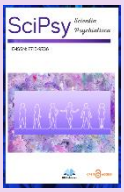

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Psychodinamic Aspect in Mixed Anxiety and Depression Disorder: A Case Reports

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ABSTRACT

Introduction: According to the ICD-10 criteria, mixed anxiety disorders and depression (MADD) are characterized by symptoms of anxiety and subsyndromal depression that occur together, but nothing dominates. A mixture of anxiety and depression disorders have various risk factors that underlie the occurrences. This case report aims to discuss the mixture of anxiety and depression disorders and their background. **Case Presentation:** A man, 23 years old, college student, single, middle down the socio-economic background, lived in a rural area in Yogyakarta, came to consult a psychiatrist at the psychiatric clinic Dr. Sardjito general hospital with complaints felt excessive anxiety and depressed because they were unable to do the thesis. From the psychiatric examination, it was found that men according to age, good self-care, thin body posture, many bowed, often moving his hands, looking nervous, cooperative, intonation and small voice volume, clear articulation, depressed mood, depressed mood, inappropriate affect, realistic thought, worried, worried about moving house, worried about the future, worried about people's assumptions about patients for fear of being blamed, sinful ideas, low self- esteem ideas, ideas of reference, ambivalence, a progression of coherent thought, relevance, good orientation, good memory, mental relations can, there are disturbances in concentration and attention, good impulse control. The patient realizes that what he is thinking is not real and only exists in his mind. **Conclusion:** Psychodynamic aspects have a role in anxiety disorders and depression

1. Introduction

According to the ICD-10 criteria, mixed anxiety disorders and depression (MADD) are characterized by symptoms of anxiety and subsyndromal depression that occur together, but nothing dominates. MADD seems to be very common, especially in primary care, although prevalence estimates vary, often depending on the diagnostic criteria applied.[1] The disease is associated with disruption of daily living activities, and a decrease in the quality of life associated with health like depression and full anxiety syndrome. Although about half of patients get remission in one year, patients who do not experience remission are at high risk for switching to wholly psychiatric disorders.[2,3]

A mixture of anxiety and depression disorders have various risk factors that underlie the occurrences. This case report aims to discuss the mixture of anxiety and depression disorders and their background.

2. Methods

Mr. H, a man, 23 years old, college student, single, middle down the socio-economic background, lived in a rural area in Yogyakarta, came to consult a psychiatrist at the psychiatric clinic Dr. Sardjito general hospital with complaints felt excessive anxiety and despair because they were unable to do the thesis. From auto-anamnesis obtained two years ago (when patients were semester 8), patients began to prepare presentations for their thesis research proposals. At this time, patients begin to experience changes in behavior that make it difficult to sleep, and sleep often awakes, feeling restless, anxious, and worried about the proposal. So that when presenting a proposal, the

patient feels a failure. When guidance, the patient becomes sleepy and has a headache, aches, and difficulty concentrating. Eight months earlier, the twin of patients studying in the Department of HI (International Relations) in the same class as the patient was declared graduated earlier than the patient.

The patient had consulted with a neurologist and was diagnosed as clinically severe insomnia. The patient then gets zolpidem ½ tablet / 24 hours and is given TMS (Trans Magnetic Simulation) treatment. After taking the drug and undergoing two TMS therapy sessions, the patient feels that he is starting to experience improvement and stops the therapy session himself with a neurologist.

The patient is the youngest and has a twin brother. The patient's grandmother was the primary caregiver when he was a child because the mother worked outside the home. Since childhood, patients have always been in the same class as their twin siblings, but he admitted that the patient's twin achievements were higher than what the patient could achieve. He is also often bullied by his classmates because his body is weaker and often sick.

From the psychiatric examination, it was found that men according to age, good self-care, thin body posture, many bowed, often moving his hands, looking nervous, cooperative, intonation and small voice volume, clear articulation, depressed mood, depressed mood, inappropriate affect, realistic thought, worried, worried about moving house, worried about the future, worried about people's assumptions about patients for fear of being blamed, Sinful ideas, low self-esteem ideas, ideas of reference, ambivalence, a progression of coherent thought, relevance, good orientation, good memory, there are disturbances in concentration and attention, good impulse control. The patient realizes that what he is thinking is not real and only exists in his mind.

Investigations using Hamilton Depression Rating Scales (HDRS) indicate moderate depression, Hamilton Anxiety Rating Scales (HARS) indicate moderate anxiety, MMPI-2 (Minnesota Multiphasic Personality Inventory-2) shows symptoms of clinical symptoms of depression, excessive paranoia, negative-emotions excessive.

Management of these patients is pharmacotherapy and psychotherapy. Pharmacotherapy given is fluoxetine 20 mg / 24 hours, and clobazam 5 mg / 24 hours. Fluoxetine is given for three months and will be re-evaluated every month. The use of clobazam is given during the first two weeks and will be tapered off after the anxiety symptoms subside and psychotherapy begins.

Psychotherapy is provided in the form of cognitive behavior therapy, relaxation exercises, and supportive psychotherapy. CBT is given to change the thinking of patients who are not right and find a better perspective of the problem. CBT is carried out for 12 sessions and is accompanied by relaxation exercises to relieve patient anxiety. After ten sessions of CBT, the patient felt calmer and the feeling of being unable to gradually begin to change into enthusiasm to struggle to finish his studies. The patient also admitted that he was able to concentrate better on lectures and his final assignment. The patient can accept that he and his twin are separate individuals, and each has advantages and disadvantages.

3. Discussion

According to Freud, every human being experiences a stage of psychosexual development consisting of oral, anal, and oedipal phases. In the development of these stages, never develop perfectly, there is always the possibility of failure or fixation in each of these phases. The failure will appear as symptoms of psychiatric disorders that appear later in life. Freud views neurotics as a regression response to a person's conflict in his environment.[4]

In patients, the possibility of fixation in the oral phase (0-1 years). In this phase, the mouth becomes the main source of pleasure for the child. Satisfaction in the mouth is obtained by inserting, holding, biting, spitting, and closing. Fixation in this phase will result in greed (greedy) and a sense of wanting to have a high (possessiveness) or verbal aggression. This fixation is

because the patient's mother has returned to work since the patient was three months old. The patient and his twin brother were cared for by his grandmother. The symptoms then appear when the patient starts school, where the patient and her twin sister must be attended to in class by his grandmother until the patient sits in grade 2 elementary school.[4]

In the phallic or oedipal phase (ages 3-6 years), libido is transferred to the genital zone. In this phase, boys are often afraid of losing their penis (Castration Anxiety). In this case, the penis is a symbol of power, strength, masculinity, and dominance. Then the child experiences the Oedipus complex, which is described as a triangular relationship between the child- mother-father. Since birth, the mother has become the object of love for children, while the father is a barrier to the relationship between mother and child. The father is considered a rival by the child, but he is unable to compete with his father. Then the child will admire the father through the process of identification. Then the child will do introjection or merge the traits of his father into him. The father then became a model for sorting out good and bad behavior, which later developed into a superego. The possibility of patients experiencing incomplete Oedipus-Complex where the patient is too close to his mother, because the father is less involved in patient care, so then the patient's relationship with his father becomes less familiar in his adult life.[5]

The trigger factor for mental disorders in these patients is educational problems, namely difficulties in working on the thesis, while his twin brother has graduated earlier than the patient. The possibility of the patient using a defense mechanism: repression, isolation (isolation, being alone when there is a stressor), somatization (diverting the situation he faces to physical complaints that include the body or the whole body), schizoid fantasy and partial regression to the fixation phase of the patient, the phase oral and anal. This frustration will cause tension and anxiety that manifests in sleep disorders, inability to control affection, cognition, and psychomotor.

As a treatment, pharmacotherapy is given in the form of fluoxetine and clobazam. Fluoxetine is an SSRI antidepressant (Selective Serotonin Re-uptake Inhibitor). It is currently the first-line therapy for treating mixed anxiety disorders and depression because it has anxiolytic effects. The onset of SSRI is slower than benzodiazepines (ranging from 2-4 weeks) but does not cause withdrawal symptoms, and the possibility of abuse is little. This drug works by increasing serotonin levels by blocking the serotonin reuptake pump. Besides, fluoxetine also increases levels of norepinephrine (NE) and dopamine (DA) through its work as a 5HT2C receptor antagonist. Benzodiazepines used in these patients are clobazam, an adjuvant therapy drug for the treatment of depressive disorders. Clobazam has anticonvulsant, anxiolytic, sedative, and muscle relaxation effects.[6,7]

The psychotherapy given to these patients is cognitive behavior therapy. The goal of therapy is to eliminate depression and prevent recurrence by inviting patients to identify faulty, distorted, or unproductive thinking patterns (cognitive distortions), developing a new mindset that is more adaptive to replace the less precise mindset. Exercises to repeat new thought patterns to create new behavioral responses that are more adaptive.[8-9]

4. Conclusion

Psychodynamic aspects have a role in anxiety disorders and depression.

5. References

1. Kaplan HI, Saddock BJ, Greb JA, 2010, Synopsis of Psychiatric Sciences in Clinical Psychiatric Behavior, Volume I, Binarupa Aksara Publisher
2. Amir N, et al., 2012, National Guidelines for Mental Medicine / Psychiatry Services, PP PDSKJI
3. Ministry of Health Republic of Indonesia Directorate General of Medical Services, 1993, Guidelines on Classification and Diagnosis of

Mental Disorders III (PPDGJ III), Jakarta, Ministry of Health Republic of Indonesia
4. Kaplan HI, Sadock BJ, Sadock VA, 2009, Comprehensive Textbook of Psychiatry, 9th, Philadelphia, Lippincott Williams and Wilkins
5. Lieberman JA, Tasman A, 2006, Handbook of Psychiatric Drugs, John Wiley & Sons, Ltd., pp. 41-82
6. Amir N, 2005, Depression of Neurobiological Aspects of Diagnosis and Management, FK UI Publisher Institute, Jakarta
7. Stahl SM, 2005, Essential Psychopharmacology the Prescriber's Guide, New York, Cambridge University Press, pp. 91- 96; 175-180
8. Wilding C, Milne A, 2013, Cognitive Behavioral Therapy, PT Index, pp. 253-257
9. Stein MB, Kirk P, Prabhu V, Grott M, Terepa M. 1995. Mixed Anxiety Depression in a primary- care clinic. Journal of Affective Disorders. p79- 84.