Introduction

Case Study
Ms H is a 42-year-old woman with fatigue, headaches, and insomnia. She also has a history of "anxiety and depression." Her physical exam and initial medical work-up are essentially benign. A selective serotonin reuptake inhibitor (SSRI) was initiated and increased, but she is minimally improved.

- Is her "depression" a significant mood disorder such as major depression or dysthymia?
- Is her "anxiety" an anxiety disorder—such as generalized anxiety disorder (GAD), panic disorder (PD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), or a phobia—or is it a manifestation of another illness?
- Was an SSRI the proper treatment choice?
- Was the SSRI given in the correct dose for an adequate length of time?
- What evidence supports these decisions?
- Does the clinician have comparable and adequate knowledge and skills to efficiently evaluate this patient’s psychiatric symptoms as he or she would with another patient without nonpsychiatric symptoms?

The Problems
Situations like this are occurring more frequently every day. Most patients with a psychiatric disorder who seek treatment turn to the general medical sector (e.g., primary care), not the specialty mental health sector, for care of their psychiatric disorders. In the primary care setting, however, their psychiatric disorders are frequently poorly recognized and ineffectively treated (1).

Studies consistently report that approximately 25% of primary care patients have a psychiatric disorder. Yet between 54% and 77% of these disorders will go unrecognized and untreated. Of those disorders recognized, only half will be adequately treated. Economic pressures (e.g., managed care and further deinstitutionalization of patients with chronic mental illnesses) combined with the introduction of new medications to treat psychiatric disorders have brought even more patients with psychiatric illnesses to the primary care setting. However, the clinician’s time with patients is shrinking, and compensation for the work effort has diminished, while the expectation that psychiatric illnesses will be managed in the primary care setting has grown.
The Solutions

Scholars and practitioners alike have advocated a range of solutions that promote change in 3 broad areas: the medical system as a whole, patients' behaviors, and clinicians' clinical practice behaviors. We argue that for any changes to be effective, the clinicians' clinical practice behaviors will need to be addressed first.

Specifically, general clinicians will be required to effectively recognize, diagnose, and treat the most common mental illnesses seen in the primary care setting. If general clinicians are not proficient at these tasks, more specialized sectors of the medical care system will not function optimally and efficiently. However, many general clinicians have inadequate knowledge of psychiatric disorders, underdeveloped skills in handling them, and negative attitudes toward the treatment of patients with psychiatric disorders. Even general clinicians who have interest and significant knowledge of psychiatry, still often have gaps in their knowledge and skills. These shortcomings are problematic whether the general clinician alone treats the patient or whether he or she, in the case of more severe disorders, collaborates with a psychiatrist.

This mismatch of increased demand and insufficient psychiatric knowledge and skills has occurred in large measure because preparation during medical training has not kept pace with advances in psychiatric knowledge.

This book is designed to bring the general nonpsychiatric clinician's psychiatric knowledge and skills to the necessary level to manage psychiatric disorders in nonpsychiatric settings (e.g., primary care) efficiently and effectively. The fundamentals or essentials of psychiatry are organized and presented in this book so that the general clinician can assess and hone his or her knowledge of psychiatric disorders and their treatments. This book is not intended to make a general clinician into a psychiatrist nor is it intended for psychiatrists. Rather, it is intended to increase a general clinician's competency and efficiency in recognizing, diagnosing, and treating the psychiatric symptoms and disorders of his or her patients in the “de facto mental health system.”

Goals of the Book

*Psychiatry Essentials for Primary Care* is designed to provide a structured overview of the most common and basic topics relevant to clinicians who see patients with psychiatric disorders in primary care settings. The following are the broad goals set forth in this book.

*To enable clinicians to effectively and efficiently recognize, diagnose, and treat psychiatric illness in the primary care setting.* This book is written from the point of view of the clinician in the general medical sector,
particularly in primary care, who sees patients with psychiatric disorders of varying severity. For many of the patients, the clinician can properly provide treatment in the primary care setting. For some, however, referral to the specialty mental health sector and collaboration with a psychiatrist or other mental health provider will be required. This book provides guidance for both situations.

To bring the psychiatric knowledge and skills of clinicians on par with their knowledge and skills of other medical specialties. Just as a general clinician is conversant in medical specialties such as cardiology, so should he or she be conversant in psychiatry. In the case of cardiology, the general clinician should have a working knowledge of the common forms of heart disease as well as how to recognize, diagnose, and treat them. However, some of the management will be referred to or shared with a cardiologist. The same is true with psychiatry. The clinician should be able to recognize, diagnose, and treat many psychiatric disorders while referring others for collaborative specialty care.

## Organization of the Book

The sections included in *Psychiatry Essentials for Primary Care* follow a progression from the general to the specific. In Chapter 1, we define psychiatric terms and set out the scope of the book. We review what we mean by “psychiatry” and how it pertains to primary care. Most importantly, we present an organizational matrix called **MAPSO**, designed to help organize psychiatric symptoms and disorders into an accessible and usable format.

**MAPSO** is an acronym that stands for **M**ood disorders, **A**nxiety disorders, **P**sychoses, **S**ubstance-induced disorders, and **O**rganic or other disorders. In Chapter 2, when and how to assess the potential for suicide are discussed from the general clinician’s point of view. Suicidality is conceptualized along a spectrum as opposed to a narrow focus on the relatively rare event of completed suicide.

The remainder of the book reviews specific psychiatric disorders and their treatments following the MAPSO format. The sections on mood disorders (Chapters 3 through 6) and anxiety disorders (Chapters 7 through 10) form the heart of the book. These are the psychiatric disorders most frequently seen in the primary care setting. The section on mood disorders is divided into 4 chapters that roughly follow the clinical process of recognizing, diagnosing, and then treating common mood disorders: Chapter 3, Depression: Evaluation and Case-Finding Strategies; Chapter 4, Treatment of Major Depression and Dysthymia: Initial Interventions; Chapter 5, Treatment of Major Depression and Dysthymia: What to Do When the Initial Intervention Fails; and Chapter 6, Bipolar Disorders.
The section on anxiety disorders (Chapters 7-10) is divided into 4 chapters that discuss the specific 5 anxiety disorders: Chapter 7, Panic Disorder and Generalized Anxiety Disorder; Chapter 8, Post-traumatic Stress Disorder; Chapter 9, The Phobias; and Chapter 10, Obsessive-Compulsive Disorder.

Chapter 11, The Psychoses, reviews the signs and symptoms of psychosis, the specific disorders seen by general clinicians in which psychosis is frequently present (e.g., schizophrenia, major depression, mania), and the use of antipsychotic medications.

Chapter 12, Substance Use and Psychiatric Disorders, sets forth basic concepts in addiction medicine but leaves this vast topic to other sources to cover in more detail (2). The chapter focuses on the effects and side effects of some commonly used medications or substances (e.g., corticosteroids and interferons) that can cause psychiatric disorders. Finally, we examine the interactions between comorbid substance use and psychiatric disorders, with particular focus on caffeine use, nicotine dependence, and depression.

The last section, Organic and Other Disorders, begins with Chapter 13, Cognitive (Organic) Disorders and Geropsychiatry, addresses the “3 D’s of Geropsychiatry” (i.e., Dementia, Delirium, and late-onset Depression) as well as age-related cognitive changes. It also includes Chapter 14, Medically Unexplained Symptoms in Patients with Psychiatric Disorders; Chapter 15, Personality Disorders, and a final chapter (Chapter 16) on other significant psychiatric topics (Adult ADD, Eating Disorders, and Women’s Mental Health) not covered elsewhere in the book.

The reader may notice several conspicuous omissions. There is no mention of childhood disorders, and neurobiology receives very little comment. Childhood disorders are mostly excluded, except for a brief discussion in the section on adult ADD, because they represent a narrow segment of general psychiatry that requires specialized knowledge and training. Neurobiology is not included because the focus of this book is clinical, and the sometimes speculative nature of neurobiology may be misleading or at least distracting from the central points of the book (3).

Each chapter in Psychiatry Essentials for Primary Care will reflect the following structure:

- [Name of Disorder] and the General Clinician
- Essential Concepts and Terms
- Screening or Case-Finding Strategies
- Treatment
- Key Points

[Name of Disorder] and the General Clinician

At the beginning of each chapter we attempt to capture its “theme” and the specific relevance of the topic to the general clinician. Since we have used unique approaches to some of the material, readers can use these initial
sections to orient themselves and hopefully understand our point of view and approach to the subsequent material.

**Essential Concepts and Terms**

These sections in each chapter include both the essential or enduring concepts and the basic terminology regarding the topic of the chapter. This section covers the essential background material for the focus of the chapter (e.g., epidemiology, comorbidities, risk for suicide). As clinicians, however, we not only need to grasp the basic or essential ideas but also need to know and understand the appropriate accepted diagnostic terminology (i.e., the terms in the *Diagnostic and Statistical Manual for Mental Disorders,* Fourth Edition [DSM-IV]). Our ability to understand advances in diagnosis or treatment will depend on the knowledge of the technical terms because the scientific evidence uses these terms.

**Screening or Case-Finding Strategies**

The Case-Finding Strategies section focuses on the practical approach to exploring these disorders in the clinical setting with patients. The words used in conversation with patients are different than the terms in our scientific literature. With medical patients, we try to avoid technical terms like neuropathy; instead, we ask about numbness or tingling. The same is true in psychiatry. Instead of asking if the patient feels “manic,” the clinician should ask the patient about a decreased need for sleep, feeling “hyper,” or having a change in personality. These sections contain the “how-to” basics required to recognize and diagnose the disorders in each ensuing chapter.

**Treatment**

Psychopharmacology and psychotherapy are the basic treatments used for psychiatric disorders. Each of the chapters devoted to specific disorders includes a relevant treatment section. Consistent with the purpose of the book, we approach treatment considerations as general clinicians working in primary care, rather than as psychiatrists. Our recommendations regarding treatment are evidence-based where there is sufficient and reliable evidence. Case examples are included for clarification and illustration of certain points.

**Key Concepts**

At the end of each chapter, we list the fundamental information covered in that section. “Key Concepts” is an idea borrowed from the ACP Key Diseases book series, and we continue it here.
Notes

1. In 1978, the Epidemiologic Catchment Area Study (ECA Study), sponsored by the President’s Commission on Mental Health, coined the term “de facto mental health system” in systematically documenting that most patients with a psychiatric disorder turn to the general medical sector, not the specialty mental health sector, for treatment.


Basic Concepts and Terminology in Psychiatry for Primary Care: MAPSO

Making Use of Psychiatric Terms and Concepts

Our goal is to enable general clinicians to be as efficient and adept at diagnosing psychiatric disorders as they are at diagnosing nonpsychiatric disorders. For example, within the first 5 minutes of most patient interactions, a practicing general clinician has usually generated a differential diagnosis and is zeroing in on the most likely cause of the symptoms. Accomplishing this degree of efficiency requires a detailed understanding of the terms and concepts needed to describe the likely disorders as well as an organizational construct for the material. This kind of thinking is an associative process (as compared to a linear or algorithmic one) that typically goes on outside the direct awareness of the clinician. During the interaction with the patient, a clinician generates a series of hypotheses (i.e., differential diagnoses) that seemingly “jump” into his or her mind while hearing the patient’s symptoms; subsequently, further questions are asked to rule in or rule out specific diagnoses. These cognitive processes are not random; they are learned, practiced, and ultimately performed with innate efficiency.

A 50-year-old woman presents with acute onset of chest pain and shortness of breath. The clinician should stop for a moment and notice his or her own internal cognitive process after this short description. The components of age (50 years), gender (female), onset (acute), and symptoms (chest pain, shortness of breath) are shuffled and sorted outside of the clinician’s awareness. He or she probably accesses some kind of organizational system. General categories are typically considered first, such as cardiac, pulmonary, gastrointestinal, musculoskeletal, and so on. Based on additional information from the patient, including severity, associated symptoms, or other medical conditions, the clinician will consider specific diagnoses (e.g., myocardial infarction, pulmonary embolus, esophageal reflux, intercostal muscle spasm). Then, to make a tentative diagnosis, he or she will ask very specific questions. Is it changed by exertion? Does eating affect it? Most clinicians are well versed in common diseases as well as in the terminology and questions required to separate one medical diagnosis from another. They can communicate about these diseases with a wide variety of patients in diverse situations by using various techniques that have evolved out of their cumulative practice experiences.

However, in clinical situations that warrant consideration of psychiatric diagnoses, most general clinicians do not have the same cognitive facility
that they have when considering general medical diagnoses. It seems that the basic terminology and organizational constructs necessary to make efficient psychiatric diagnoses are lacking, and instead of having an efficient clinical interaction with a patient, the clinician’s thought process stumbles along or is brought to a halt. The result is that psychiatric diagnoses are segregated instead of being integrated in a broad set of differential diagnoses. It is not uncommon to hear nonspecific language from clinicians, like nervous condition or psych problem, instead of specific terms, such as recurrent major depression or generalized anxiety disorder. The false dichotomy between medicine and psychiatry has lead to unfortunate statements to patients, like: “I can’t find anything wrong with you, so I think your condition is caused by stress and maybe you should see a psychiatrist.”

We are not suggesting that a general clinician must become a psychiatrist to evaluate psychiatric symptoms. Rather, general clinicians should be able to discuss common psychiatric disorders and their symptoms with patients with the same ease with which they discuss other medical conditions and have the technical language to obtain useful evidence from the literature. Most general clinicians already possess much psychiatric knowledge. However, there are gaps in their knowledge, and many of the psychiatric terms and concepts they use are nonspecific and incomplete. Further, clinicians often lack an organized, logical hierarchy of psychiatric terms and concepts. An organizational system is required to efficiently move through complex terminology and concepts in psychiatry just as in cardiology. Much like in Figure 1-1, the mind of the general clinician often has all of the terms mixed together. In “computer-speak,” he or she has “all files and no folders.”

The DSM-IV (Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition), which clinicians and researchers rely on as a psychiatric reference, offers a detailed and complex hierarchy of 18 diagnostic categories that includes over 6000 signs, symptoms, and inclusion criteria. Most of the current psychiatric research and evidence bases are communicated using the terms contained in the DSM-IV. This makes sense because the DSM-IV was explicitly developed to improve communication between
researchers and clinicians by using a consistent diagnostic system built on a descriptive approach. This descriptive or phenomenological classification system is objective and has greatly improved the reliability of psychiatric diagnoses over previously utilized subjective, theoretical, and diagnostic classifications. To utilize the growing scientific evidence base, psychiatrists have developed cognitive structures that help organize this material, but general clinicians have different needs and training. Thus, general clinicians require an organizational matrix that meets their unique clinical situations and training.

**MAPSO: An Organizational System for Clinical Decision Making**

We have developed the acronym **MAPSO** (Mood, Anxiety, Psychoses, Substance-induced, and Organic and other disorders) to provide an organizational matrix to aid the general clinician (see Figure 1-2). MAPSO represents an integration of competing organizational concepts: major symptom categories, important etiologies, and the most common categories of psychiatric disorders seen in the general medical setting. Why 5 domains? Because the human brain cannot easily carry 18 diagnostic categories, but it can typically hold at least 5 (1,2). By using MAPSO, the general clinician has a hierarchy to organize all of those “files” of psychiatric terms and concepts into “folders” or domains with the headings mood, anxiety, psychoses, substance-induced, and organic/other. With an organizational system such as MAPSO, general clinicians can cognitively approach psychiatric disorders much as they would medical disorders (see Table 1-1).

MAPSO is a broad organizational structure of psychiatric information that is useful in clinical decision making for clinicians working in general medical settings. It is not a good system for psychiatrists working in specialty mental health settings because its resolution is too coarse. Accordingly, MAPSO may break down if used by a psychiatrist or mental health specialist for patients in the specialty mental health setting because it does not encompass all of the psychiatric knowledge needed for this specialized setting.

Most general clinicians cannot organize and access information in terms of 18 categories of equal “weight” arranged sequentially in a catalogue like the DSM-IV. Psychiatrists use psychiatric knowledge and concepts every day, so they develop their own unique recursive problem-solving strategies to efficiently consider the clinical possibilities in the 18 DSM-IV categories. However, the general medical clinician does not normally think about the full range of psychiatric information and diagnostic categories like a psychiatrist.

| Mood | Anxiety | Psychoses | Substance-Induced | Organic and Other |

Figure 1-2
Table 1-1 MAPSO Psychiatric Organizational Matrix

<table>
<thead>
<tr>
<th>Mood</th>
<th>Anxiety</th>
<th>Psychoses</th>
<th>Substance-Induced</th>
<th>Organic and Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression</td>
<td>Generalized Anxiety Disorder (GAD)</td>
<td>Schizophrenia</td>
<td>ALL Psychoactive Substances:</td>
<td>Organic (due to general medical condition)</td>
</tr>
<tr>
<td>Single episode vs Recurrent episodes</td>
<td>Panic Disorder</td>
<td>Schizoaffective disorder</td>
<td>Over-the-counter drugs</td>
<td>Medications</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>Post-traumatic Stress Disorder (PTSD)</td>
<td>Bipolar I (Mania)</td>
<td>Prescription drugs</td>
<td>Dementias</td>
</tr>
<tr>
<td>Minor Depression for 2 years</td>
<td>Obsessive-Compulsive Disorder (OCD)</td>
<td>Psychotic depression</td>
<td>Herbal Supplements</td>
<td>HIV</td>
</tr>
<tr>
<td>Bipolar Disorders</td>
<td>Phobias</td>
<td>Dementias</td>
<td>Caffeine</td>
<td>Traumatic brain injury</td>
</tr>
<tr>
<td>Bipolar I</td>
<td></td>
<td>“Organic” psychoses (delirium)</td>
<td>Nicotine</td>
<td>Other Psychiatric Illness</td>
</tr>
<tr>
<td>Bipolar II</td>
<td></td>
<td></td>
<td>Alcohol</td>
<td>Personality disorder</td>
</tr>
<tr>
<td>Cyclothymia</td>
<td></td>
<td></td>
<td>Cannabis</td>
<td>Somatization disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cocaine</td>
<td>Eating disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Opioids</td>
<td>ADHD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Stimulants</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intoxication</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Side effect</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Withdrawal</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Long-term effect</td>
<td></td>
</tr>
</tbody>
</table>

Sample only. Not for distribution.
does, in part because a general clinician is juggling multiple diagnostic strategies and categories other than psychiatric ones. In any case, the DSM-IV is a useful resource, but it was not intended to be a rigidly applied diagnostic “bible” and was definitely not intended to be used directly as a clinical tool guiding patient interactions.

Discussing Psychiatric Symptoms with Patients

There is a myth that patients do not wish to discuss psychiatric symptoms with general clinicians. The World Health Organization (WHO) conducted a multinational, multisite study and concluded that patients were just as likely to discuss their psychiatric symptoms as their physical ones—if asked. Patients typically present to their general clinicians with medical symptoms (as opposed to psychiatric symptoms) because this is the patient’s expectation of a typical interaction in a medical setting (3). Just because patients “typically” interact this way does not mean the patient has a latent resistance to discussing psychiatric symptoms. Perhaps it is the clinician, not the patient, who is reluctant to discuss psychiatric symptoms. Not surprisingly, the study also found that the better the relationship between the patient and general clinician, the more likely they were to discuss all symptoms, medical and psychiatric.

MAPSO provides an important cognitive tool by organizing psychiatric terms for the general clinician. This in turn makes these concepts more readily available in the clinician’s working memory when addressing patients’ psychiatric symptoms in a general medical setting.

What Is a Psychiatric Disorder?

A psychiatric disorder is a cluster of abnormal symptoms that persist over time and result in significant dysfunction in multiple spheres, such as personal, occupational, and social roles. The diagnostic process does not stop here; a clinical judgment is then made regarding whether or not this constellation of symptoms is in fact a psychiatric disorder. The DSM-IV is a complete listing of all psychiatric disorders and the inclusion criteria or symptoms for each disorder. The DSM-IV is an excellent system for the study of psychiatric disorders, but it has significant limitations when used to make psychiatric diagnoses in a general medical setting. First, almost all psychiatric disorders occur across a clinical spectrum as opposed to within strict categories; the DSM-IV is a catalog of categorically defined disorders. Second, the DSM-IV lists inclusion criteria and symptoms, not screening questions. The DSM-IV’s clinical utility is in providing a consistent and reliable language for the study of these disorders. It is important to recall that
psychiatric disorders are not diseases with clear phenotypic boundaries, and they are not defined by etiology. Medical disorders like hypertension and migraine are more analogous to psychiatric disorders than are medical diseases with clear phenotypic boundaries, like pneumococcal pneumonia or Hodgkin lymphoma.

MAPSO, in contrast to the DSM-IV, is a clinical tool that focuses on the basic symptom categories (e.g., mood/affect, anxiety, psychoses) while simultaneously addressing important etiological considerations (e.g., whether it is substance induced, “organic,” or due to a general medical condition). Also, by limiting the domains to 5, clinicians can more easily hold these general domains in their “working memories” while interviewing their patients. This approach is similar to considering “organ system” etiologies (i.e., cardiac, pulmonary, gastrointestinal, musculoskeletal) with a patient complaining of chest pain.

A common mistake among both psychiatric and nonpsychiatric clinicians is the belief that if a patient has the signs and symptoms that meet DSM-IV diagnostic inclusion criteria for a particular psychiatric disorder, then the patient must have that psychiatric disorder. For example, a woman who is experiencing mood swings, tearfulness, decreased energy, weight gain, poor sleep, worry, and difficulty going to work each day may have major depression, but she may also be pregnant, perimenopausal, hypothyroid, or none of these. When a diagnosis of a psychiatric disorder is made, the patient should have the necessary inclusion criteria for that disorder. The patient seldom has all of the signs and symptoms of the disorder listed in the DSM-IV for that disorder, but the patient should exhibit the minimum signs and symptoms to meet the inclusion criteria for that disorder. The correlation between the patient’s signs and symptoms and the DSM-IV criteria for a psychiatric disorder allows clinicians to more accurately apply the evidence from the psychiatric literature. A psychiatric diagnosis is ultimately a complex clinical judgment that occurs after a clinician assesses a patient’s symptoms, the severity of the symptoms, and the degree of the patient’s functional impairment. A diagnosis should always be based on the clinician’s judgment, never a symptom checklist alone. This clinical judgment is primarily informed by the information obtained in an interview with the patient.

### Screening Questions

Screening instruments such PRIME MD exist, but they are algorithmic and can be cumbersome when used in the context of a clinical interview. DSM-IV criteria are sometimes misused as screening questions, leading to jargon-laden questions such as, Are you anhedonic? or Have you experienced agoraphobia? In this book, we suggest basic screening questions for the categories of symptoms and the major psychiatric disorders contained in MAPSO. For example, the question, Are you depressed? is about
90% sensitive but only 57% specific for detecting a current major mood disorder (e.g., major depression, dysthymia). However, if the clinician then adds an additional question to the screening strategy about anhedonia such as, *Have you lost interest in doing pleasurable things?* then the sensitivity reaches 95%, and the specificity increases to 90%.

**General Characteristics of Good Screening Questions**

Discussing specific symptoms with patients requires special language and skills. To use a medical analogy, people do not intuitively know how to discuss diarrhea with other people. Clinicians learn about the disorders (e.g., diarrhea secondary to malabsorption), find valid screening processes, then develop these skills. The clinician becomes skilled at asking questions that may seem uncomfortable or unnatural to discuss, such as asking a patient with diarrhea if it awakens him at night, if it is particularly malodorous, and if is there something that looks like an oily substance in the commode (a sign of fat malabsorption). Whether discussing diarrhea or depression, some general themes arise.

- Use plain language and avoid jargon.
  - *What do you do for fun or pleasure?* (screening for anhedonia)

- Be specific and quantify symptoms when possible.
  - *Let’s go through a typical night. What time do you start trying to go to sleep?* (exploring insomnia)

- Have a nonjudgmental stance.
  - *When was your last drink of beer, wine, or liquor?* (instead of *Do you drink too much?*)

- Balance between open and closed questions.
  - *How has the depression changed things for you?* (instead of either extreme: *How have you been?* or *Has the depression affected your sleep, appetite, concentration, sex drive, or willingness to be with others?*)

- Explain and then inquire.
  - *Some people who have major depression also experience the opposite of depression, where they have racing thoughts and feel full of energy. Have you?* (screening for mania)

**Screening for Psychiatric Disorders and Predictive Values**

General considerations for predictive values of screening strategies for psychiatric disorders are, not surprisingly, identical to those for medical disorders. Screening, or case-finding, questions are different than diagnostic questions or instruments. If a patient answers affirmatively when asked if he or she ever has chest pain after exertion, then more specific diagnostic tests would be performed subsequently. We would not move directly to treatment based on a simple symptom report of angina alone. The same is true when working with psychiatric disorders. The question, *Are you depressed?* is very sensitive but not specific. Treatment for major depression should not
be initiated with one positive screening question. A positive answer to a screening question requires further diagnostic questions, and only then should treatment be considered. The general rule is that the greater the number of symptoms present, the greater the likelihood of a disorder.

False positives to psychiatric screening questions for one psychiatric disorder may indicate that another psychiatric disorder is present. For example, a patient who answers “Yes” to Are you depressed? but does not have major depression (determined after asking more specific questions) may have an anxiety disorder (or another non-mood disorder), be in the early stages of a major depressive episode, or have a subsyndromal state of depression. When followed over time, patients who screen as false positives have greater impairment and utilize health care services more often than those who screen negative. The clinician should have a strategy for follow-up with patients who have false-positive screening for psychiatric disorders (4).

Screening for a Family History of a Psychiatric Disorder

Psychiatric illness in a patient’s biological relatives is a strong risk factor for many psychiatric disorders. Screening for a family history adds valuable information when determining if a set of symptoms is in fact a psychiatric disorder. The utility of this approach is similar to the value of a positive family history for coronary heart disease when assessing a patient with acute chest pain. However, unlike screening for coronary artery disease, a patient may falsely or incorrectly deny a family history of a psychiatric disorder because of stigma and embarrassment or because family members with psychiatric disorders never told anyone or never sought treatment.

Using a question like, Has any relative in your family ever had similar symptoms? can get around initial resistance to discussion of family psychiatric history. The clinical utility of a family history is that it increases the specificity of the clinician’s assessment. In other words, a positive response to screening for a psychiatric disorder in a relative of a patient increases the likelihood that a psychiatric disorder is the cause of the patient’s symptoms; however, a negative family history does not significantly decrease the likelihood.

**Key Points**

- Clinicians make clinical diagnoses quickly and accurately by recognizing patterns of symptoms and then generating hypotheses.
- This associative cognitive process often happens outside conscious awareness and requires the clinician to know and understand basic concepts and terminology involved in the disorders being considered.
MAPSO provides a matrix that organizes fundamental psychiatric terminology for nonpsychiatrists.
- When asked, most patients discuss psychiatric symptoms as readily as physical symptoms.
- Psychiatric screening questions have comparable sensitivities to other screening tests used in medicine.
- Fluid, practical screening and diagnostic questions are the keys in the diagnostic process.
- A psychiatric disorder is a cluster of abnormal symptoms that persist over time and result in significant dysfunction in multiple spheres (i.e., personal, occupational, and social roles).
- Ultimately, it requires a clinician’s judgment as to whether or not the patient’s symptoms represent a psychiatric disorder.

REFERENCES


KEY REFERENCES