466 Mental Disorders

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Mental disorders are common in medical practice and may present either as a primary disorder or as a comorbid condition. The prevalence of mental or substance use disorders in the United States is approximately 30%, but only one-third of affected individuals are currently receiving treatment. Global burden of disease statistics indicate that 4 of the 10 most important causes of morbidity and attendant health care costs worldwide are psychiatric in origin.

Changes in health care delivery underscore the need for primary care physicians to assume responsibility for the initial diagnosis and treatment of the most common mental disorders. Prompt diagnosis is essential to ensure that patients have access to appropriate medical services and to maximize the clinical outcome. Validated patient-based questionnaires have been developed that systematically probe for signs and symptoms associated with the most prevalent psychiatric diagnoses and guide the clinician into targeted assessment. The Primary Care Evaluation of Mental Disorders (PRIME-MD; and a self-report form, the Patient Health Questionnaire) and the Symptom-Driven Diagnostic System for Primary Care (SDDS-PC) are inventories that require only 10 min to complete and link patient responses to the formal diagnostic criteria of anxiety, mood, somatoform, and eating disorders and to alcohol abuse or dependence.

A physician who refers patients to a psychiatrist should know not only when doing so is appropriate but also how to refer, because societal misconceptions and the stigma of mental illness impede the process. Primary care physicians should base referrals to a psychiatrist on the presence of signs and symptoms of a mental disorder and not simply on the absence of a physical explanation for a patient's complaint. The physician should discuss with the patient the reasons for requesting the referral or consultation and provide reassurance that he or she will continue to provide medical care and work collaboratively with the mental health professional. Consultation with a psychiatrist or transfer of care is appropriate when physicians encounter evidence of psychotic symptoms, mania, severe depression, or anxiety; symptoms of posttraumatic stress disorder (PTSD); suicidal or homicidal preoccupation; or a failure to respond to first-order treatment. This chapter reviews the clinical assessment and treatment of some of the most common mental disorders presenting in primary care and is based on the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), the framework for categorizing psychiatric illness used in the United States. **Eating disorders are discussed later in this chapter, and the biology of psychiatric and addictive disorders is discussed in Chap. 465e.**

GLOBAL CONSIDERATIONS

The DSM-5 and the tenth revision of the International Classification of Diseases (ICD-10), which is used more commonly worldwide, have taken somewhat differing approaches to the diagnosis of mental illness, but considerable effort has been expended to provide an operational translation between the two nosologies. Both systems are in essence purely descriptive and emphasize clinical pragmatism, in distinction to the Research Domain Criteria (RDOC) proposed by National Institute of Mental Health, which aspires to provide a causal framework for classification of behavioral disturbance. None of these diagnostic systems has as yet achieved adequate validation. The Global Burden of Disease Study 2010, using available epidemiologic data, nevertheless has reinforced the conclusion that, regardless of nosologic differences, mental and substance abuse disorders are the major cause of life-years lost to disability among all medical illnesses. There is general agreement that high-income countries will need to build capacity in professional training in low- and middle-income countries in order to provide an adequate balanced care model for the delivery of evidence-based therapies for mental disorders. Recent surveys that indicate a dramatic increase in mental disorder prevalence in rapidly developing countries, such as China, may reflect both an increased recognition of the issue, but also the consequence of social turmoil, stigma, and historically inadequate resources. The need for improved prevention strategies and for more definitive and effective interventional treatments remains a global concern.

ANXIETY DISORDERS

Anxiety disorders, the most prevalent psychiatric illnesses in the general community, are present in 15–20% of medical clinic patients. Anxiety, defined as a subjective sense of unease, dread, or foreboding, can indicate a primary psychiatric condition or can be a component of, or reaction to, a primary medical disease. The primary anxiety disorders are classified according to their duration and course and the existence and nature of precipitants.

When evaluating the anxious patient, the clinician must first determine whether the anxiety antedates or postdates a medical illness or is due to a medication side effect. Approximately one-third of patients presenting with anxiety have a medical etiology for their psychiatric symptoms, but an anxiety disorder can also present with somatic symptoms in the absence of a diagnosable medical condition.

PANIC DISORDER

Clinical Manifestations Panic disorder is defined by the presence of recurrent and unpredictable panic attacks, which are distinct episodes of intense fear and discomfort associated with a variety of physical symptoms, including palpitations, sweating, trembling, shortness of breath, chest pain, dizziness, and a fear of impending doom or death. Paresthesias, gastrointestinal distress, and feelings of unreality are also common. Diagnostic criteria require at least 1 month of concern or worry about the attacks or a change in behavior related to them. The lifetime prevalence of panic disorder is 2–3%. Panic attacks have a sudden onset, developing within 10 min and usually resolving over the course of an hour, and they occur in an unexpected fashion. Some may occur when waking from sleep. The frequency and severity of panic