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Mental Health Disorders and Their Descriptive Criteria in Primary Care: Clarifying or Confounding?

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In their article, "Reflections on DSM Classification and Its Utility in Primary Care: Case Studies in 'Mental Disorders,'" Katerndahl and colleagues[1] provide us with a detailed examination of the month-by-month course of mental health symptoms over a 6-month period in 5 exemplar subjects. Not surprisingly, the symptom profiles show a complex weaving of waxing and waning symptoms of distress, depression, anxiety, and role dysfunction, with peaks where DSM disorders are diagnosable. Moreover, these constructs often did not vary in synchrony with each other; sometimes distress and dysfunction rose significantly without the emergence of a DSM diagnosis, and other times the reverse occurred. In sum, patients' misery and dysfunction are infrequently captured by DSM nosology.

The idea that the DSM has limitations in its ability to capture clinical reality is not new. Goldberg[2,3] has argued eloquently for the need to embody a more complex temporal and dimensional model of mental health symptomatology. Our own work has demonstrated that alternative schema of classification may be just as powerful in explaining functional status and health care utilization as the DSM[4,5] and that DSM mood and anxiety criteria are not particularly helpful in explaining the severity of illness or guiding treatment decisions in primary care patients.[6] Kendler and Gardner[7] have asserted that the DSM may too crudely "carve nature at its joints" with its insistence on strict symptom criteria, and Kendler[8] more recently pointed out the pitfalls of a reductionistic quest for unique biological explanations for discrete disorders. To this work, Katerndahl and colleagues[1] have added the in-depth perspective provided by close examination of individual patients and their symptoms over time.

What then are we to make of this? Should the DSM criteria for depression and anxiety be cast on the trash heap of mental cartography along with neurasthenia, phrenology, and the classical neuroses? More importantly, how are we to interpret and apply these findings in our daily work of caring for primary care patients?

First, this article emphasizes that we must resist the ready temptation to confuse labels and descriptions with reality. For example, a table may be described as a flat surface supported by 4 legs. Is this the only structure that can be called a table? Are all flat surfaces supported by 4 legs tables? Surely this is not the case. Likewise, in the DSM, we have descriptors that help clinicians and researchers identify patients with particular disorders. It is all too easy for clinicians and researchers to assert that "all patients who meet criteria have a disorder" and "all patients who do not meet criteria do not have a disorder." This shortcut, however, confuses the description with the disorder. Certainly, there is a continued need for emphasis on case-finding and monitoring instruments, like the Patient Health Questionnaire-9,[9] that enable clinicians and researchers to view patients' symptoms in both a categorical and dimensional fashion. While this may not re-

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quire adoption of the "new model" proposed by Katerndahl et al.,[1] it certainly requires that we remain intellectually humble about the limitations of our disorder descriptions and not confuse the description with the disorder.

Second, this article reminds us of the importance of life context in primary care, as many of the variations seen by Katerndahl et al.[1] were explainable by life events and the course of comorbid medical conditions. We do not have the luxury of viewing mental health symptoms in isolation. Neither do psychiatrists and mental health specialists, but it is clear that their patients are a fairly narrow subset of the wider population of primary care patients with mental illness, and their context and ecology are similarly more narrow. The context of life events and medical comorbidity plays an important role in how primary care patients experience and cope with their mental health symptoms. Efforts to address mental health issues in primary care can never be uncoupled from efforts to understand and address issues of medical comorbidity and social function. Individual clinical and larger health system efforts that fail to account for context when attempting to decrease symptoms and improve function have little chance of success.

Finally, this article leaves for future investigation the important question of how the complex interplay of symptoms, function, and life events drives help-seeking behavior. Is it enough to trust patients' wisdom to seek help when their pain and dysfunction begin to overwhelm them? How would patients know when they need help if they know no diagnostic criteria to which their symptoms can be matched or when they are least able to understand the contextual interpretation of their misery? The lack of road signs is possibly acceptable to the professional driver who knows the roads "by heart," but is disorienting and disturbing to the novice driver who has not passed that way before. The work of Katerndahl et al.[1] and many others has made clear that current DSM nosology does not fully capture the richness and complexity of primary care psychiatric diagnosis. The next step is far more challenging—to develop a new nosology that does.

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