3. Maternity length-of-stay legislation moves forward in several states. HMO Manager's Lett July 24, 1995:4-5.
4. Check in, deliver, go home; hospitals re hustling new mothers out in a day—or less. Is it risky? US News and World Report 1994;17(22):98-100.
5. Longer hospital stays for childbirth are needed, pediatricians say. New York Times 1995 Oct 11;Sect C18(N), A17(L), col 2.
6. Britton JR, Britton HL, Beebe SA. Early discharge of the term newborn: a continued dilemma. Pediatrics 1994;94:291-5.
7. Braveman P, Miller C, Egerter S, Bennett T, English P, Katz P, Showstack J. Health service use among low-risk newborns after early discharge with and without nurse home visiting. J Am Board Fam Pract 1996; 9:254-60.

The DSM-IV-PC: Toward Improving Management of Mental Disorders in Primary Care

David S. Brody, MD

Mental disorders are common in primary care, occurring in 20 percent to 39 percent of patients seen.[1-4] In fact, more patients with mental disorders are seen by primary care physicians than by mental health care providers.[5] Mental disorders result in substantial patient suffering, disability, and health care costs.[6-9] Despite their wide occurrence and importance, mental disorders are frequently not recognized by primary care physicians.[1,2,10,11] Even when they are aware of the symptoms of a mental disorder, primary care physicians rarely make an accurate diagnosis.[12]

There are many reasons why mental disorders are not accurately diagnosed by primary care physicians. These reasons include inadequate knowledge of the diagnostic criteria, lack of time during the medical visit, and primary care physicians' doubts about the clinical utility of psychiatric diagnoses and their own ability to manage these types of problems effectively once they have been diagnosed.[13,14]

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Primary Care Version* (DSM-IV-PC) was developed to address some of the obstacles to the accurate diagnosis of mental disorders by primary care physicians. It is one eighth the size of the DSM-IV and is therefore much more concise and easier to read than the DSM-IV. This reduction in size has been accomplished largely by focusing on disorders that are most relevant to primary care. The DSM-IV-PC is also easier to use than the DSM-IV because it is organized around nine algorithms and supportive text that enable the primary care physician to go efficiently from symptoms to diagnoses.

A paper in this issue of the *Journal*, written by 2 of the principal architects of the DSM-IV-PC, describes its development and organization.[15] The authors recognize that the DSM-IV-PC is a work in progress and that the manual will need to be revised as more data are obtained about mental disorders in the primary care setting. The development of the DSM-IV-PC, nonetheless, represents an important step toward improving primary care physicians' ability to recognize and treat mental disorders effectively. It is likely to be of most benefit as a tool for training students and residents. Whether or not primary care physicians will take the time to review it and follow its algorithms when a mental disorder is suspected remains to be seen.

The development of the DSM-IV-PC should be viewed in the context of other efforts to improve the diagnosis and treatment of mental disorders in the primary care setting. Two diagnostic systems have recently been developed to help primary care physicians make diagnoses of common mental disorders consistent with DSM-IV.[4,16,17] Both PRIME-MD and the Symptom-Driven Diagnostic System for Primary Care (SDDS-PC) are two-stage processes for detecting and diagnosing mental disorders. The stages consist of a screening questionnaire followed by a structured physician interview with those patients who meet the criteria for a possible mental disorder. Both systems have been well validated in the primary care setting. These systems take the work done on the DSM-IV-PC to the next level by providing tools both to

Submitted 6 February 1996.
From the Division of General Internal Medicine, Hahnemann University Hospital, Philadelphia. Address reprint requests to David S. Brody, MD, Division of General Internal Medicine, Hahnemann University Hospital, Broad & Vine, Mail Stop 427, Philadelphia, PA 19102-1192.

train future primary care physicians and to facilitate the detection and diagnosis of mental disorders by practicing primary care physicians.

Further work must be done to validate the DSM-IV-PC diagnostic criteria in the primary care setting and to develop new criteria that are simpler but more descriptive and inclusive of the types of mental health problems seen in primary care. Comorbidity is common among primary care patients.[3,4] For example, patients with mood disorders frequently have symptoms of substance abuse, anxiety, or somatoform disorders. Diagnostic classification systems, therefore, need to be developed that capture the broad array of mental health symptoms experienced by primary care patients. The level of mental health symptomatology required to diagnose a disorder is also currently receiving a great deal of attention. Recent research has documented that patients with subthreshold levels of mental health symptoms experience considerable impairment in quality of life and functional status, sometimes equal to patients with a DSM-based diagnosable disorder.[6] This finding suggests that thresholds for diagnosing certain mental health disorders need to be reexamined and validated in the primary care setting.

Primary care physicians might be more willing to invest themselves in screening and accurately diagnosing mental disorders if they have a better understanding of the utility of that diagnosis. Mental diagnoses will become more meaningful if they are shown to be associated with specific management recommendations that have been proven to be effective in the primary care setting. Further work is therefore needed to build and evaluate the connections between mental disorder diagnoses and specific types of treatment.

As our knowledge about the epidemiology and treatment of mental disorders in primary care increases, the clinical importance of arriving at an accurate diagnosis of the mental health problem will also increase. The same is clearly true for other medical disorders such as hyperthyroidism or pneumococcal pneumonia. In each case, treating the specific disorder is much more effective than simply treating the symptoms of fatigue or cough. The development of the DSM-IV-PC has made the diagnostic classification system for mental disorders much more accessible to primary care physicians. This important advance, coupled with the ongoing efforts to (1) further refine and validate this diagnostic system in the primary care setting, (2) develop tools (ie, diagnostic tests) to facilitate the efficient and accurate collection of information required to make a diagnosis, and (3) link specific mental disorders to management strategies that have proven efficacy in the primary care setting, should dramatically improve primary care physicians' ability to detect, diagnose, and effectively manage mental disorders.

References

1. Schulberg HC, Burns BJ. Mental disorders in primary care: epidemiologic, diagnostic, and treatment research directions. Gen Hosp Psychiatry 1988; 10:79-87.
2. Kessler LG, Cleary PD, Burke JD Jr. Psychiatric disorders in primary care. Results of a follow-up study. Arch Gen Psychiatry 1985;42:583-7.
3. Barrett JE, Barrett JA, Oxman TE, Gerber PD. The prevalence of psychiatric disorders in a primary care practice. Arch Gen Psychiatry 1988;45:1100-6.
4. Spitzer RL, Williams JB, Kroenke K, Linzer M, deGruy FV III, Hahn SR, et al. Utility of a new procedure for diagnosing mental disorders in primary care: the PRIME-MD 1000 study. JAMA 1994; 272:1749-56.
5. Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. Arch Gen Psychiatry 1993;50:85-94.
6. Wells KB, Stewart A, Hays RD, Burnam MA, Rogers W, Daniels M, et al. The functioning and well-being of depressed patients. Results from the Medical Outcomes Study. JAMA 1989;262:914-9.
7. Johnson J, Weissman MM, Klerman GL. Service utilization and social morbidity associated with depressive symptoms in the community. JAMA 1992; 267:1478-83.
8. Broadhead WE, Blazer DG, George LK, Tse CK. Depression, disability days, and days lost from work in a prospective epidemiologic survey. JAMA 1990; 264:2524-8.
9. Spitzer RL, Kroenke K, Linzer M, Hahn SR, Williams JB, deGruy FV III, et al. Health-related quality of life in primary care patients with mental disorders: results from the PRIME-MD 1000 study. JAMA 1995;274:1511-7.
10. Ormel J, Koeter MW, van den Brink W, van de Willige G. Recognition, management, and course of anxiety and depression in general practice. Arch Gen Psychiatry 1991;48:700-6.
11. Borus JF, Howes MJ, Devins NP, Rosenberg R, Livingston WW. Primary health care providers' recognition and diagnosis of mental disorders in their patients. Gen Hosp Psychiatry 1988;10:317-21.

12. Andersen SM, Harthorn BH. The recognition, diagnosis, and treatment of mental disorders by primary care physicians. Med Care 1989;27:869-86.
13. Andersen SM, Harthorn BH. The diagnostic knowledge inventory: a measure of knowledge about psychiatric diagnosis. J Clin Psychology 1989;45:999-1013.
14. Brody DS, Larson DB. The role of primary care physicians in managing depression. J Gen Intern Med 1992;7:243-7.
15. deGruy FV, Pincus H. The DSM-IV-PC: a manual for diagnosing mental disorders in the primary care setting. J Am Board Fam Pract 1996;9:274-81.
16. Broadhead WE, Leon AC, Weissman MM, Barrett JE, Blacklow RS, Gilbert TT, et al. Development and validation of the SDDS-PC screen for multiple mental disorders in primary care. Arch Fam Med 1995;4:211-9.
17. Weissman MM, Olfson M, Leon AC, Broadhead WE, Gilbert TT, Higgins ES, et al. Brief diagnostic interviews (SDDS-PC) for multiple mental disorders in primary care. Arch Fam Med 1995;4:220-7.