Diagnosis and classification of mental illness: a view from primary care

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Summary

This chapter considers the nature of 'mental illness' before it moves on to review the problems with existing concepts of classification of mental illness when they are applied to the primary care setting. It considers the shortcomings in some detail before conclusions are drawn concerning what a diagnostic system should provide to have both validity and utility in primary care settings.

Differences between mental health and illness, and what is considered normal and abnormal in psychological terms, are perhaps not so easily determined in mental healthcare as in physical medicine. The term 'mental illness' is generally used in psychiatry when a clear syndrome can be identified *and* there has been a definite change from how the person used to be (which is important in differentiating illness from 'personality disorder', which is not viewed as 'illness') *and* there is a deterioration in the person's ability to function effectively. Dependence on alcohol or drugs is similarly not viewed as being mental illness but, again, mental health services are involved in treatment in order to attempt to relieve suffering, as experienced by either the persons themselves or those around them. Various different models of mental illness and health exist (Table 7.1). The biological perspective is often that to which a medically trained individual can particularly contribute. However, the psychological, social and spiritual perspectives are equally important in fully understanding the causes of a person's problems, what investigations to carry out and what treatment is required.

Diagnosis was, in the past, considered within psychiatry to be useful only if it conferred some utility, such as being able to predict what treatment would be indicated or predict response to treatment or prognosis (Kendell, 1975). In practice, categorical diagnoses continue to have practical utility in making simple treatment decisions, but they also have their limitations. In

Table 7.1 Models of mental illness and mental healthcare

	Biological	Psychological		Social			Spiritual
		Psychodynamic	Cognitive–behavioural	Stress models	Family models	Conspiratorial	
Influences	Strongly supported by doctors/nurses; some support from carers	Remains a powerful model in lay terms though 'out of fashion' in healthcare provision	Powerful model in psychology and current mental health policy	Influential in thinking of social workers and in primary care	Influences social work, child and family work and primary care	Survivor groups, radical professionals and anti-psychiatrists	Religious belief
Causal models	Physical changes in brain	Early experiences	Inappropriate learning, poor coping skills	Social and cultural stress	Whole family is 'sick' and person acts in response to family pressures	Myth of mental illness – result of the way a person is expected to behave by others	Variety of spiritual theories, reflecting culture/religion
Treatment models	Drugs, electro-convulsive therapy	Psychodynamic psychotherapy – one-to-one and group	Cognitive–behavioural therapy, behavioural therapy, social skills training	Social change and interventions	Family therapy	None – empower and advocate for person who is labelled as mentally ill	Faith-based therapies, retreat and meditation
Rights and duties of client/patient	Right to sick role but must cooperate	Responsible – but spared moral judgement	Responsible – with contract to cooperate	Right to help but must cooperate	Whole family duty to participate	Right to privacy and same rights as others	Obligation depends on personal faith

Adapted from Colombo *et al* (2003).

recent years, the need for more standardised approaches to diagnosis, driven by both research and billing requirements in some healthcare systems, has resulted in classification systems encompassing an ever-increasing variety of human experiences; for example, 'tobacco use disorder' and 'pre-menstrual dysphoric disorder' (PMDD) both appear in the US classification DSM–IV (the fourth edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association, 1995). Outside the USA, the World Health Organization's *International Classification of Diseases* (in its 10 revision, ICD–10, World Health Organization, 1992) is more generally used, and in some countries (notably the Netherlands, Belgium and Denmark) its *International Classification of Primary Care* (ICPC) is used in the primary healthcare setting (in its second revision, ICPC–2, World Health Organization, 2003). While the ICD and DSM have some notable differences, their criteria for specific diagnoses such as major depressive disorder (MDD) are quite similar. The criteria listed for diagnosis of 'depressive disorder' in the ICPC reflects a broader, primary care view of depression, with fewer specific criteria (Table 7.2).

Mad or bad? The problem of personality disorder

People with lifelong personality difficulties are not viewed as suffering from mental illness. However, this does not mean that mental health services should not be involved in trying to help them. Abnormal personality traits are common in the community and some confer considerable advantages on those who demonstrate them. Many people will have both abnormal personality traits and mental illness, and the former may result in both their being more impaired by their symptoms and slower recovery, as they may

Table 7.2 Comparison of the diagnostic criteria for depression across three classifications: DSM–IV (major depressive disorder), ICD–10 (major depressive disorder) and ICPC–2 (depressive disorder)

Symptoms of depression	DSM–IV	ICD–10	ICPC–2
1 Depressed mood	+	+	+
2 Markedly diminished interest or pleasure in activities	+	+	+
3 Loss of energy or fatigue	+	+	+
4 Loss of confidence or self-esteem	–	+	+
5 Unreasonable self-reproach or guilt	+	+	–
6 Recurrent thoughts of death or suicide, or any suicidal behaviour	+	+	–
7 Diminished ability to think or concentrate, or indecisiveness	+	+	+
8 Psychomotor agitation or retardation	+	+	–
9 Insomnia or hypersomnia	+	+	+
10 Change in appetite	+	+	+

lack the necessary social support required. Problems come with those with very severe personality disorders, who in lay terms may appear to be 'mad', as what they do is beyond the realms of normal human understanding, but they do not have symptoms of a specific mental illness that is treatable. In an increasingly risk-averse society, mental health professionals are under pressure to be involved in detaining such people under mental law *before* they commit a crime. This poses considerable threats to civil liberty and problems for already overcrowded hospital services, and is unlikely to be particularly cost-effective in terms of the number of people who would need to be detained to prevent a single crime.

Diagnosis and classification of mental health problems in primary care

Patients in primary care settings are much less likely to present with clearly identifiable diagnostic syndromes. People present with a wide variety of symptoms, concerns, worries and problems. These are not only undifferentiated, as originally described by Balint (1964), but also, crucially, at least at first presentation, unrehearsed by prior discussion with doctors versed in the agenda and language of diagnosis. Primary care clinicians will often encounter unfiltered and unrecognised symptoms that may or may not be identifiable as mental health syndromes, while specialist mental health clinicians will encounter filtered symptoms that are recognised and understood as representative of a mental health problem.

Thus, diagnosis is a less precise (and less frequent) activity in primary care than it is in specialist care. Family doctors are more likely to think in terms of problems than diagnoses. They are more likely to make a diagnosis of depression if they believe they can manage and treat it; that is, diagnosis tends to follow management decisions, not precede them (Dowrick *et al*, 2000). In particular, family doctors and patients may see making and accepting a mental health diagnosis as a social and moral decision. Women with depression, for example, may seek and accept help (e.g. medication) for the sake of others, when they feel they are not adequately fulfilling their social roles. Doctors may offer diagnosis and treatment in order to demonstrate that they are taking their patient's suffering seriously, despite considering that their problems are primarily social in origin (Maxwell, 2005).

Current classification systems are generally based upon research and experience in psychiatric settings. There is mounting evidence that there are indeed important differences between patients seen in primary care and specialty mental health settings. Patients who present with emotional symptoms in primary care are generally less distressed, are less likely to have a discernible mental disorder and are less impaired than are psychiatric cohorts within secondary care (Zinsbarg *et al,* 1994; Coyne *et al*, 1997).

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Distress versus disorder

Emotional distress can be present in patients for many reasons other than the presence of a mental health disorder, and patients with threshold disorders may not display any distress. Many primary care patients are clearly distressed, but do not exhibit other symptoms of mental illness (Katerndahl et al, 2005) – yet primary care physicians often recognise this distress and manage these patients differently from those without distress. They do so without guidance from most existing classification systems, which (with one or two exceptions – see below) do not account for 'distress'.

The relationship between physical, mental and social problems

Primary care patients frequently present a mixture of psychological, physical and social problems. Mental health problems occur more frequently in those with common chronic physical illness, such as diabetes, chronic obstructive pulmonary disease and heart disease, and their comorbid mental health problems may not be recognised, as attention is focused on their physical illness. One of the most important aspects of a classification of mental disorders for primary care is that it should enable primary care workers accurately to record core elements of the context of care, such as life events, undifferentiated symptoms, and patient perceptions, goals and preferences for care; this will in turn allow clinicians more effectively to help patients with 'mixed' physical, mental and social suffering. The traditional biomedical model, which still dominates the training pattern of health professionals, makes it difficult for them to deal with these patients, as there is often not a specific problem that can be solved.

Transient, recurrent or chronic symptoms

When primary care patients meet diagnostic criteria for specific disorders, their symptoms often fluctuate over time and their 'caseness' may be transient. Nosological diagnoses (nosology is the term in medicine that refers to classification of disease) have been demonstrated to last less than 4 weeks 30% of the time and less than 6 months 65% of the time (Lamberts & Hofmans-Okkes, 1993). There is an absence of good research on the long-term validity and prognosis of 'threshold' mental health diagnoses in primary care patient samples. Community-based epidemiological studies have confirmed that many patients have recurrent or chronic depression (Judd *et al*, 1998; Gask, 2005; Kessler *et al*, 2005), but the relative risk of recurrence or of developing chronic depression, and the level of disability associated with these potential outcomes are not clear (Van Weel-Baumgarten *et al*, 1999; Vuorilehto *et al*, 2005).

The fluctuating nature of symptoms has made it difficult to assess the performance of primary care workers in recognising and treating mental health problems. Recognition of their potential long-term impact

on health and function has led to aggressive case-finding and treatment efforts in primary care settings to prevent disability. Although primary care workers have frequently been criticised for their lack of skill in recognising threshold mental disorders, recognition in primary care is itself a complex phenomenon, related in part to the transience of symptoms. Higher rates of detection (and treatment) have been found for patients with more severe symptoms and higher levels of disability (Dowrick & Buchan, 1995; Thompson *et al,* 2001; MaGPIe Research Group, 2003) and there is some evidence that short-term outcomes for 'detected' and 'undetected' depression in primary care do not differ (Coyne *et al,* 1997).

How valid are existing diagnostic systems for application in primary care?

There are a number of ways in which existing diagnostic systems may have limited validity when applied in primary care settings.

The problem of comorbidity

Overlapping psychopathology may exist along a spectrum of anxiety (Fig. 7.1), depression, somatisation and substance misuse in primary care. This coexistence may be cross-sectional, in that all these symptoms appear together at the same time, or it may be longitudinal, in the sense that one set of symptoms is followed closely in time by another (Katerndahl, 2005). Much of the evidence regarding comorbidity was assembled during
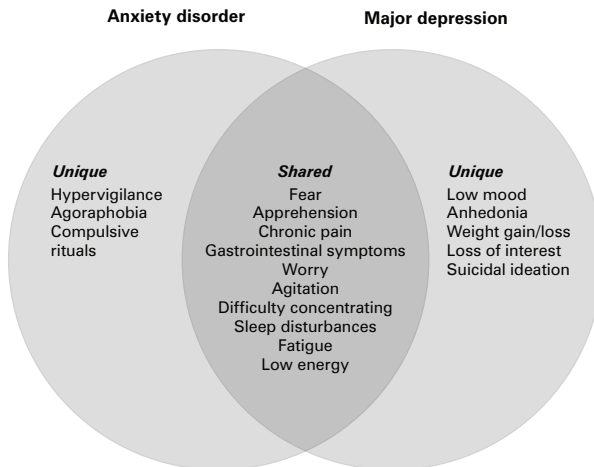

Fig. 7.1 Symptom overlap between anxiety and depression. Derived from Baldwin *et al* (2002).

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the 1990s in the WHO Collaborative Study of Psychological Problems in General Healthcare (Üstün & Sartorius, 1995), conducted in 15 centres in Asia, Africa, Europe and the Americas (see Chapter 2). Consecutive primary care attendees between the age of majority (typically 18 years) and 65 years were screened ($n = 25\,916$) and stratified random samples interviewed ($n = 5438$). The study found that 'well-defined' psychological problems (according to ICD–10) are frequent in general healthcare settings (median 24% of attendees) and among the most common were depression, anxiety, alcohol misuse, somatoform disorders and neurasthenia. The most common co-occurrence was depression and anxiety (Sartorius *et al,* 1996).

Medically unexplained symptoms pose a particular problem. There is now considerable empirical evidence suggesting that persistent medically unexplained symptoms frequently coexist with mood or anxiety disorders in primary care settings (Kirmayer & Robbins, 1991; Kessler *et al,* 1996; Garcia-Campayo *et al,* 1998; Toft *et al,* 2005). In Toft *et al*'s study in Denmark, comorbidity was highest for anxiety disorders – 89% of these patients had another diagnosis – but lowest for somatoform disorders (39%). The concept of somatisation is difficult because of the finding by Simon & Gureje (1999) that the majority of these symptoms (61%) will not be recalled as a problem a year later.

Substance misuse may also commonly coexist with anxiety and depression. A study by the MaGPIe Research Group (2003) in New Zealand revealed that more than one-third of people attending their general practitioner (GP) had had a diagnosable mental disorder during the previous 12 months. The most common disorders identified by accepted and well-validated psychological instruments were anxiety disorders, depression, and substance-use disorders, and there was high comorbidity of these three groups, with the experience of mixed pictures as common as disorders occurring alone.

Do all these findings constitute evidence of true comorbidity (i.e. coexistence of two or more discrete disorders), or rather an overlap between – and therefore confusion of – diagnostic categories? We consider the latter far more likely.

Subthreshold disorders

Subthreshold conditions (i.e. conditions meeting some but not all diagnostic criteria for a specific disorder in DSM–IV or ICD–10) are prevalent and associated with significant costs and disability. Pincus *et al* (1999) have shown how varying conceptualisations have been applied to define these conditions. Considerable attention was paid to the presence of sub-threshold disorders in the WHO study, where it was noted that roughly 9% of patients suffered from a 'subthreshold condition' that did not meet diagnostic criteria but led to clinically significant symptoms and functional impairment (Üstün & Sartorius 1995).

Cross-cultural application of systems

The complete DSM–IV and ICD–10 classifications in current use are the direct descendants of clinical and research diagnostic classifications developed in the USA and Western Europe. As such, they are based upon a Western conceptual framework of mental health and mental illness, and it is highly likely that some of their diagnostic categories will have limited validity in other parts of the world. It is also highly likely that some conditions important in other, non-Western cultures will have limited or inaccurate representation in DSM or ICD (Mezzich *et al,* 1999). This issue may be of particular relevance in cross-cultural primary care settings.

Classification systems developed or modified for use in primary care

Three classifications are in current use for mental health diagnosis in primary care: DSM–IV–PC, ICD–10–PHC and ICPC. Both DSM–IV–PC and ICD–10–PHC are simplified versions of the 'full' classification intended to be more accessible to primary care clinicians. However, the extent to which these systems have been adopted in *routine* data collection within primary care and monitoring across the world is unclear, although ICD–10–PHC has been widely disseminated. In contrast, ICPC was developed specifically for use in the primary healthcare setting. Translation between the three systems is possible but complex, and clinical comparability of the same diagnosis in different systems is limited by the characteristics of the different systems (Lamberts *et al,* 1998).

ICD–10–PHC

The primary care version of ICD–10's Chapter 5 (mental and behavioural disorders) was published first in 1995 (Üstün *et al,* 1995) and was finalised after a series of field trials in different countries (Jenkins *et al,* 2002). It is now the most widely used system for the diagnosis of mental health problems in primary care, although it has a range of uses and can be used as much for education and training as for data collection and coding. The classification bears a rough correspondence to ICD–10 categories, is user friendly, is based upon the different types of management that the various conditions require and includes detailed advice about the sort of psychological help that has been shown to be effective; it also provides the information about each disorder that should be given to the patient and family. Advice is given about drug treatments, where these are indicated, as well as features that require specialist referral. The system consists of 25 conditions (Box 7.1) that are common in primary care settings, but each country is encouraged to adapt the system to its own needs.

This classification was field tested in 30 different centres in 19 countries and published evidence is available from two large studies (Goldberg *et*

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Box 7.1 The 25 ICD–10–PHC disorders

The 25 included disorders, along with their full ICD–10 codes, are as follows:

Addictive disorders
1 Alcohol use disorder (F 10)
2 Drug use disorder (F 11)
3 Tobacco use disorder (F 17.1)

Common mental disorders
4 Depression (F 32)
5 Phobic disorders (F 40)
6 Panic disorders (F 41.0)
7 Generalised anxiety (F 41.1)
8 Mixed anxiety depression (F 41.2)
9 Adjustment disorder (F 43)
10 Dissociative disorder (conversion hysteria) (F 44)
11 Unexplained somatic complaints (F 45)
12 Neurasthenia (F 48.0)
13 Eating disorders (F 50)
14 Sleep problems (F 51)
15 Sexual disorders (F 52)
16 Bereavement (Z 63)

Organic disorders
17 Dementia (F 00)
18 Delirium (F 05)

Psychotic disorders
19 Chronic psychotic disorders (F 20)
20 Acute psychotic disorders (F 23)
21 Bipolar disorders (F 3)

Disorders of childhood
22 Mental retardation (F 70)
23 Hyperkinetic (attention deficit) disorder (F 90)
24 Conduct disorder (F 91)
25 Enuresis (F 98.0)

For multi-purpose health workers, an even simpler version is available, which consists of the following six categories:

26 Cognitive disorders
27 Alcohol and drug use disorder
28 Psychotic disorders
29 Depression
30 Anxiety disorders
31 Unexplained somatic complaints

al, 1995; D'A Busnello *et al*, 1999). In the UK study, a total of 478 GPs completed all stages of the study. Nearly all the participating GPs found the classification 'very useful' or 'useful'. Each category was also rated and most received high ratings; those that were criticised were amended by the group at a later meeting.

In the UK, the classification has been modified since the original publication, and the whole system has been re-issued twice, with a number of additional features, including information leaflets for the patient and information about voluntary agencies (see e-resources at the end of the chapter). ICD–10–PHC is simple and easy to use, and links diagnosis to treatment. However, it does not address issues of measurement of severity, associated disability or chronicity, or the accompanying social problems manifest in primary care settings. It is also important to note that simply disseminating guidelines developed from ICD–10–PHC did not improve outcomes in a British primary care study (Upton *et al*, 1999).

DSM–IV–PC

The primary care adaptation of DSM–IV was introduced in 1995 and contains a number of symptom-based clinical algorithms designed to guide the primary care physician through the diagnostic process (American Psychiatric Association, 1995).

A number of limitations are evident (Pingitore & Sansone, 1998). It is a large and complex volume that requires some level of familiarity before it can be used. The complexity of the diagnostic schemes, and the amount of time needed to reach a diagnosis, have been cited as conspicuous limitations.

ICPC

The *International Classification of Primary Care* (ICPC), first published in 1987 under the auspices of Wonca (the World Organization of Family Doctors) and now in its second edition (International Classification Committee of Wonca, 1998), represents a departure from the two classifications described above. ICPC was designed to capture and code three essential elements of each clinical encounter: the patient's *reason for encounter*, the clinician's *diagnosis*, and the (diagnostic and therapeutic) *interventions*, all organised in an *episode of care* data structure that links initial to all subsequent encounters for the same clinical problem. This approach permits coding of 95% or more of primary care visits and enables the calculation of prior and posterior probabilities for important diseases (Okkes *et al*, 2002).

Although the limited diagnostic specificity available in ICPC is problematic, ICPC offers a major advantage in its more complete capture of the context of mental health problems (Box 7.2). The episode structure of ICPC automatically accommodates mental health and biomedical comorbidity by simply noting all active problems at a point in time or over a specified time interval. The inclusion of symptoms as reasons for encounter at the beginning of a longitudinal data stream enables investigation of the relationship between somatic symptoms and mental health disorders at a level of resolution not possible when using other classifications. The routine coding of social problems provides detail about the social context in which mental heath problems occur that is not available anywhere else. Pilot studies to embed codes for additional context elements, such as

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Box 7.2 ICPC–2 diagnostic terms in Chapter P (Psychosocial)

Note: P01 to P29 can be recorded as symptoms or diagnoses. P70 to P99 are diagnostic terms. Each term has a definition as well as inclusion and exclusion criteria.

P01   feeling anxious/nervous/tense
P02   acute stress reaction
P03   feeling depressed
P04   feeling/behaving irritable/angry
P05   senility, feeling/behaving old
P06   sleep disturbance
P07   sexual desire reduced
P08   sexual fulfilment reduced
P09   sexual preference concern
P10   stammering, stuttering, tics
P11   eating problems in children
P12   bed-wetting, enuresis
P13   encopresis/bowel training problem
P15   chronic alcohol abuse
P16   acute alcohol abuse
P17   tobacco abuse
P18   medication abuse
P19   drug abuse
P20   memory disturbance
P22   child behaviour symptom/complaint
P23   adolescent behaviour symptom/complaint
P24   specific learning problem
P25   phase of life problems in adults
P27   fear of mental disorder
P28   limited function/disability psychosocial
P29   psychological symptom/complaint, other

P70   dementia
P71   organic psychosis, other
P72   schizophrenia
P73   affective psychosis
P74   anxiety disorder/anxiety state
P75   somatisation disorder
P76   depressive disorder
P77   suicide/suicide attempt
P78   neurasthenia, surmenage
P79   phobia, compulsive disorder
P80   personality disorder
P81   hyperkinetic disorder
P82   post-traumatic stress disorder
P85   mental retardation
P86   anorexia nervosa, bulimia
P98   psychosis not otherwise specified/other
P99   psychological disorder, other

severity of illness and disability, into ICPC have been completed (Parkerson *et al*, 1996).

Tools developed for primary care

Four types of tools used as *aids to diagnosis* in primary care are briefly reviewed here: interview schedules designed for use in primary care; screening tools; and tools for the measurement of severity and of disability.

Interview schedules

Interview schedules have primarily been used for research purposes. The exception is the PRIME–MD, which has been widely used across the world and generates DSM–IV diagnoses (Spitzer *et al*, 1994). However, it remains unclear to what extent such a formal schedule might be adopted into routine primary care consultations, particularly in low- and middle-income countries, given the very brief time available in the primary care consultation (see Chapter 6).

Screening tools

Screening instruments have also been widely used in research. The best-known is the General Health Questionnaire (GHQ; Goldberg & Williams, 1988), available in four versions (comprising 12, 28, 30 or 60 items) and translated into numerous languages. The GHQ is non-specific and does not provide specific diagnoses, unlike the Hospital Anxiety and Depression Scale (HAD; Zigmond & Snaith 1983) or the self-completion measures derived from PRIME–MD, the original comprehensive Patient Health Questionnaire (PHQ; Spitzer *et al*, 1999) and the depression-specific PHQ-9 (Kroenke *et al*, 2001), the Generalised Anxiety Disorder Scale (GAD-7; Spitzer *et al*, 2006) and the PHQ-15 for severity of somatic symptoms (Kroenke *et al,* 2002).

However, although a variety of other tools have been developed for screening, there is considerable disagreement in the literature about whether screening is of benefit in improving the psychosocial outcomes of those with psychiatric disorder managed in non-psychiatric settings (Gilbody *et al*, 2001). A brief screening tool consisting of only two written screening questions, plus the addition of a question enquiring whether help is needed, which can be completed in the waiting room and handed directly to the primary care worker (or the questions can be asked directly), has recently shown promising results in terms of diagnostic validity (Arroll *et al,* 2005). But, as some studies in Brazil have demonstrated, self-answered questionnaires in low-income countries usually have to be read by an interviewer, even for research purposes, as a significant proportion of the patients attending primary care units are only semi-literate (Mari & Williams, 1985).

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Measuring severity

Screening questionnaires can also be used to measure the severity of symptoms. The PHQ has been widely used for this purpose in depression. Other tools include the Inventory to Diagnose Depression (Zimmerman *et al*, 1986), the Primary Care Screener for Affective Disorder (PC-SAD) (Rogers *et al*, 2002), and the 21-item major depressive disorder (MDD) subscale of the Psychiatric Diagnostic Screening Questionnaire (PDSQ; Zimmerman & Mattia, 2001). All perform as well as the Beck Depression Inventory (Rogers *et al*, 2005), although most of these have not been validated for use in countries other than the USA or in languages other than English. Measurement of severity has been introduced in the UK through the Quality Outcomes Framework (QOF) in primary care, which has enabled assessment of severity to be directly linked to treatment guidelines for depression recommended by the National Institute for Health and Clinical Excellence (NICE).

Measuring impairment and disability

A 'clinical significance' criterion is a part of many DSM diagnoses, generally expressed in terms of functional impairment. In contrast, an explicit attempt has been made to separate functional impairment from diagnostic criteria in ICD. There has been a working assumption that increasing severity of disorders is directly associated with increasing disability and hence with worse outcomes.[1] However, there are two problems with this assumption. The first, as noted above, is that it tends to play down the considerable levels of impairment experienced by people with subthreshold disorders. The second is that severity and impairment may not after all be directly associated, but may rather form separate but overlapping domains. Research by Foley *et al* (2003) on the Virginia twin register found that, while the risk factors for major depression and associated functional impairment were substantially correlated, they were not identical. The most parsimonious model suggests that over a quarter of the variance in associated functional impairment was due to factors unrelated to risk of major depression.

This is potentially important in primary care. Family doctors are probably better at assessing impairment than at making formal psychiatric diagnoses. If impairment is indeed a separate problem from diagnosis, then awareness of and emphasis on this difference may well play to the strengths of primary care.

Disability in relation to depression has commonly been measured using the Sheehan Disability Scale (Sheehan, 1983), a three-item self-

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1 Note that disability differs from impairment: disability is the functional consequence of impairment and the relationship between them is open to debate in the mental health arena (Mulvany, 2000).

report scale measuring the severity of disability in the domains of work, family life/home responsibilities and social/leisure activities. The Social Functioning Questionnaire (SFQ), an eight-item self-report scale (score range 0–24), was developed from the Social Functioning Schedule (SFS), a semi-structured interview that has been used primarily with non-psychotic patients and that has good test–retest and inter-rater reliability as well as construct validity (Tyrer *et al*, 2005).

The World Health Organization Disability Assessment Schedule (WHO–DAS II) is a brief instrument which comes in a variety of versions for rating by observer, self or caregiver (see e-resources). The WHO–DAS has been largely supplanted by the new International Classification of Functioning, Disability, and Health (ICF) (see e-resources), now available for use worldwide.

Conclusion

Existing classification systems are unsatisfactory for primary care. Most have been *adapted for*, rather than *developed in*, primary care settings; the exception is ICPC. In general, they do not capture the complexity of psychological disorder as it manifests in primary care settings, with associated physical illness and social problems. Revision of both ICD and DSM is currently underway, and there is a strong desire for a simpler classification for use in primary care than in specialist settings, one that will prove to be clinically useful.

A classification system for primary care should: be characterised by simplicity; address *not only* categorical diagnosis, but also severity and chronicity; be linked to disability assessment; be linked to routine data-gathering, including gathering information on outcomes; be linked to training; and be useful in facilitating communication between primary and specialist care.

Key points

- There are a number of different 'models of mental illness'.
- Primary care patients frequently present a mixture of psychological, physical and social problems.
- Patients in primary care settings are much less likely to present with clearly identifiable diagnostic syndromes.
- There are a number of ways in which existing diagnostic systems may have limited validity when applied in primary care settings. Specifically, they do not address in a satisfactory way the problems of comorbidity; subthreshold disorders; cross-cultural applications; or the differences between severity and impairment/disability. A satisfactory diagnostic system for primary care needs to address all these factors.

Further reading and e-resources

ICPC (2nd edn) http://www.who.int/classifications/icd/adaptations/icpc2/en/index. html

International Classification of Functioning, Disability, and Health (ICF), http://www. who.int/classifications/icf/site/icftemplate.cfm

UK version of ICD–10PC, http://www.mentalneurologicalprimarycare.org

World Health Organization Disability Assessment Schedule (WHO–DAS II), http://www. who.int/icidh/whodas/index.html

References

American Psychiatric Association (1995) *Diagnostic and Statistical Manual of Mental Disorders (4th edition), Primary Care Version*. APA.

Arroll, B., Goodyear-Smith, F., Kerse N., *et al* (2005) Effect of the addition of a 'help' question to two screening questions on specificity for diagnosis of depression in general practice: diagnostic validity study. *BMJ*, **331**, 884–886.

Baldwin, D. S., Evans, D. L., Hirschfeld, R. M., *et al* (2002) Can we distinguish anxiety from depression? *Psychopharmacology Bulletin*, **36** (suppl. 2), 158–165.

Balint, M. (1964) *The Doctor, His Patient and the Illness*. Pitman.

Colombo, A., Bendelow, G., Fulford, B., *et al* (2003) Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams. *Social Science and Medicine*, **56**, 1557–1570.

Coyne, J. C., Klinkman, M. S., Gallo, S. M., *et al* (1997) Short-term outcomes of detected and undetected primary care patients and depressed psychiatric patients. *General Hospital Psychiatry*, **19**, 333–343.

D'A Busnello, E., Tannous, L., Gigante, L., *et al* (1999) Diagnostic reliability of mental disorders of the International Classification of Diseases – primary care. *Rev Saúde Pública*, **33**, 487–494.

Dowrick, C. & Buchan, I. (1995) Twelve month outcome of depression in general practice: does detection or disclosure make a difference? *BMJ*, **311**, 1274–1276.

Dowrick, C., Gask, L., Perry, R., *et al* (2000) Do general practitioners' attitudes towards the management of depression predict their clinical behaviour? *Psychological Medicine*, **30**, 413–419.

Foley, D., Neale, M. C., Gardner, C. O., *et al* (2003) Major depression and associated impairment: same or different genetic and environmental risk factors? *American Journal of Psychiatry*, **160**, 2128–2133.

Garcia-Campayo, J., Lobo, A., Perez-Echeverria, M. J., *et al* (1998) Three forms of somatisation presenting in primary care settings in Spain. *Journal of Nervous and Mental Disease*, **186**, 554–560.

Gask, L. (2005) Is depression a chronic illness? *Chronic Illness*, **1**, 101–106.

Gilbody, S. M., House, A. O. & Sheldon, T. A. (2001) Routinely administered questionnaires for depression and anxiety: systematic review. *BMJ*, **322**, 406–409.

Goldberg, D. & Williams, P. (1988) *A User's Guide to the General Health Questionnaire*. NFER-Nelson.

Goldberg, D., Sharp, D. & Nanayakkara, K. (1995) The field trial of the mental disorders section of ICD–10 designed for primary care (ICD10–PHC) in England. *Family Practice*, **12**, 466–473.

International Classification Committee of Wonca (1998) *ICPC–2: International Classification of Primary Care* (2nd edn). Oxford University Press.

Jenkins, R., Goldberg, D., Kiima, D., *et al* (2002) Classification in primary care: experience with current diagnostic systems. *Psychopathology*, **35**, 127–131.

Judd, L. L., Akiskal, H. S., Maser, J. D., *et al* (1998) A prospective 12-year study of subsyndromal and syndromal depressive symptoms in unipolar major depressive disorders. *Archives of General Psychiatry*, **55**, 694–700.

Katerndahl, D. (2005) Variations on a theme: the spectrum of anxiety disorders and problems with DSM classification in primary care settings. In New Research on the Psychology of Fear (ed. P. Gower), pp. 181–221. NovaScience Publishers.

Katerndahl, D., Larne, A. C., Palmer, R. F., *et al* (2005) Reflections on DSM classification and its utility in primary care: case studies in 'mental disorders'. *Primary Care Companion Journal of Clinical Psychiatry*, **7**, 91–99.

Kendell, R. (1975) *The Role of Diagnosis in Psychiatry*. Blackwell.

Kessler, R. C., Nelson, C. B., McGonagle, K. A., *et al* (1996) Comorbidity of DSM–III–R major depressive disorder in the general population: results from the US National Comorbidity Survey. *British Journal of Psychiatry*, **168** (suppl. 30), 17–30.

Kessler, R. C., Berglund, P., Demler, O., *et al* (2005) Lifetime prevalence and age-of-onset distributions of DSM–IV disorders in the National Comorbidity Survey replication. *Archives of General Psychiatry*, **62**, 593–602.

Kirmayer, L. J. & Robbins, J. M. (1991) Three forms of somatization in primary care: prevalence, co-occurrence and socio-demographic characteristics. *Journal of Nervous and Mental Disease*, **179**, 647–655.

Kroenke, K., Spitzer, M. & Williams, J. B. (2001) The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, **16**, 606–613.

Kroenke, K., Spitzer, M. & Williams, J. B. (2002) The PHQ-15: validity of a new measure for evaluating the severity of somatic symptoms. *Psychosomatic Medicine*, **64**, 258–266.

Lamberts, H. & Hofmans-Okkes, I. M. (1993) Classification of psychological and social problems in general practice. *Huisarts Wet*, **36**, 5–13.

Lamberts, H., Magruder, K., Katholm R. G., *et al* (1998) International classification of mental disorders in primary care: a guide through a difficult terrain. *International Journal of Psychiatry and Medicine*, **28**, 159–76.

MaGPIe Research Group (2003) The nature and prevalence of psychological problems in New Zealand primary healthcare: a report on Mental Health and General Practice Investigation (MaGPIe). *Journal of the New Zealand Medical Association*, **116**, u379. Downloadable from http://www.nzma.org.nz/journal/116-1171/379/

Mari, J. J. & Williams, P. (1985) A comparison of the validity of two psychiatric screening questionnaires (GHQ-12 and SRQ-20) in Brazil using relative operating characteristic (ROC) analysis. *Psychological Medicine*, **15**, 651–659.

Maxwell, M. (2005) Women's and doctors' accounts of their experiences of depression in primary care: the influence of social and moral reasoning on patients' and doctors' decisions. *Chronic Illness*, **1**, 61–71.

Mezzich, J. E., Kirmayer, L. J., Kleinman, A., *et al* (1999) The place of culture in DSM–IV. *Journal of Nervous and Mental Diseases*, **187**, 457–464.

Mulvany, J. (2000) Disability, impairment or illness? The relevance of the social model of disability to the study of mental disorder. *Sociology of Health and Illness*, **22**, 582–681.

Okkes, I., Oskam, S. K. & Lamberts, H. (2002) The probability of specific diagnoses for patients presenting with common symptoms to Dutch family physicians. *Journal of Family Practice*, **51**, 31–36.

Parkerson, G. R., Bridges-Webb, C., Gervas, J., *et al* (1996) Classification of severity of health problems in family/general practice: an international field trial. *Family Practice*, **13**, 303–309.

Pincus, H. A., Davis, W. W. & McQueen, L. E. (1999) 'Subthreshold' mental disorders. A review and synthesis of studies on minor depression and other 'brand names'. *British Journal of Psychiatry*, **174**, 288–296.

Pingitore, D. A. & Sansone, R. A. (1998) Using DSM–IV Primary Care Version: a guide to psychiatric diagnosis in primary care. *American Family Physician*, **58**, 1447–1452.

Rogers, W. H., Wilson, I. B., Bungay, K. M., *et al* (2002) Assessing the performance of a new depression screener for primary care (PC-SAD©). *Journal of Clinical Epidemiology*, **55**, 164–175.

Rogers, W. H., Adler, D. A., Bungay, K. M., *et al* (2005) Depression screening instruments made good severity measures in a cross-sectional analysis. *Journal of Clinical Epidemiology*, **58**, 370–377.

Sartorius, N., Üstün, T. B. & Lecrubier, Y., *et al* (1996) Depression comorbid with anxiety: results from the WHO study on psychological disorders in primary health care. *British Journal of Psychiatry*, suppl. 30, 38–43.

Sheehan, D. V. (1983) *The Anxiety Disease*. Scribner.

Simon, G. & Gureje, O. (1999) Stability of somatization disorder and somatization symptoms among primary care patients. *Archives of General Psychiatry*, **56**, 90–95.

Spitzer, R. L., Kroenke, K. & Williams, J. B. (1999) Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. *JAMA*, **282**, 1737–1744.

Spitzer, R. L., Kroenke, K., Williams, J. B., *et al* (2006) A brief measure for assessing generalized anxiety disorder: the GAD-7. *Annals of Internal Medicine*, **166**, 1092–1097.

Thompson, C., Ostler, K., Peveler, R. C., *et al* (2001) Dimensional perspective on the recognition of depressive symptoms in primary care. *British Journal of Psychiatry*, **179**, 317–323.

Toft, T., Fink, P., Oernboel, E., *et al* (2005) Mental disorders in primary care: prevalence and co-morbidity among disorders: results from the functional illness in primary care (FIP) study. *Psychological Medicine*, **35**, 1175–1184.

Tyrer, P., Nur, U., Crawford, M., *et al* (2005) The Social Functioning Questionnaire: a rapid and robust measure of perceived functioning. *International Journal of Social Psychiatry*, **51**, 265–275.

Upton, M. W., Evans, M., Goldberg, D. P., *et al* (1999) Evaluation of ICD–10 PHC mental health guidelines in detecting and managing depression within primary care. *British Journal of Psychiatry*, **175**, 476–482.

Üstün, T. B. & Sartorius, N. (1995) *Mental Illness in General Health Care*. Wiley.

Üstün, T. B., Goldberg, D., Cooper, J., *et al* (1995) New classification for mental disorders with management guidelines for use in primary care: ICD–10 PHC chapter five. *British Journal of General Practice*, **45**, 211–215.

Van Weel-Baumgarten, E., van den Bosch W., van den Hoogen, H., *et al* (1999) Ten year follow-up of depression after diagnosis in general practice. *British Journal of General Practice*, **48**, 1643–1646.

Vuorilehto, M., Melartin, T. & Isometsa, E. (2005) Depressive disorders in primary care: recurrent, chronic and co-morbid. *Psychological Medicine*, **35**, 673–682.

World Health Organization (1992) *The ICD–10 Classification of Mental and Behavioural Disorders. Clinical Descriptions and Diagnostic Guidelines*. WHO.

World Health Organization (2003) *International Classification of Primary Care* (2nd revision) (ICPC–2). WHO.

Zigmond, A. S. & Snaith, R. P. (1983) The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica*, **67**, 361–370.

Zimmerman, M. & Mattia J. I. (2001) A self-report scale to help make psychiatric diagnoses: the Psychiatric Diagnostic Screening Questionnaire. *Archives of General Psychiatry*, **58**, 787–794.

Zimmerman, M., Coryell, W. & Wilson, S., *et al* (1986) Evaluation of symptoms of major depressive disorder: self-report vs clinician ratings. *Journal of Nervous and Mental Disease*, **174**, 150–153.

Zinsbarg, R., Barlow, D., Liebowitz, M., *et al* (1994) DSM–IV field trial for mixed anxiety–depression. *American Journal of Psychiatry*, **151**, 1153–1162.