SPECIAL ARTICLE

# Diagnostic and statistical manual-5: Position paper of the Indian Psychiatric Society

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## ABSTRACT

The development of the Diagnostic and Statistical Manual-5 (DSM-5) has been an exhaustive and elaborate exercise involving the review of DSM-IV categories, identifying new evidence and ideas, field testing, and revising issues in order that it is based on the best available evidence. This report of the Task Force of the Indian Psychiatric Society examines the current draft of the DSM-5 and discusses the implications from an Indian perspective. It highlights the issues related to the use of universal categories applied across diverse cultures. It reiterates the evidence for mental disorders commonly seen in India. It emphasizes the need for caution when clinical categories useful to specialists are employed in the contexts of primary care and in community settings. While the DSM-5 is essentially for the membership of the American Psychiatric Association, its impact will be felt far beyond the boundaries of psychiatry and that of the United States of America. However, its *atheoretical* approach, despite its pretensions, pushes a purely biomedical agenda to the exclusion of other approaches to mental health and illness. Nevertheless, the DSM-5 should serve a gate-keeping function, which intends to set minimum standards. It is work in progress and will continue to evolve with the generation of new evidence. For the DSM-5 to be relevant and useful across the cultures and countries, it needs to be broad-based and consider social and cultural contexts, issues, and phenomena. The convergence and compatibility with International Classification of Diseases-11 is a worthy goal. While the phenomenal effort of the DSM-5 revision is commendable, psychiatry should continue to strive for a more holistic understanding of mental health, illness, and disease.

**Key words:** Culture, diagnostic and statistical manual-5, India

## INTRODUCTION

The President and the Executive Committee of the Indian Psychiatric Society (IPS) constituted a Task Force to study the draft of the American Psychiatric Association's (APA's) Diagnostic and Statistical Manual-5 (DSM-5) in May 2012. The mandate of the Task Force was to examine the DSM-5 and its implications, discuss issues, consult members of the IPS, and submit its report to the Executive Committee of the IPS by early June 2012. The shortage of time necessitated consultations by email.

A basic ground rule adopted for this exercise was that while individuals were free to express their opinions, such views needed to be substantiated by evidence. This report is a

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consensus of issues, which were raised and discussed. The report is divided into the following sections:

a. DSM-5: A brief overview of the development process
b. Research from India on classification of mental illness
c. DSM-5: Universal categories for diverse cultures
d. DSM-5 and primary care
e. DSM-5 and use in community settings
f. Practical issues of relevance to India

## DIAGNOSTIC AND STATISTICAL MANUAL-5 A BRIEF OVERVIEW OF THE DEVELOPMENT PROCESS

DSM-5 has been years in the making. The process included planning sessions, international research conferences, and a series of monographs. These conferences involved hundreds of scientists and clinicians. The DSM-5 Task Force and Work Groups included experts and advisors from various specialties and sub-specialties from many countries. The DSM-5 Task Force website, www.dsm5.org, provided details of the process, criteria, evidence and updates and allowed for comments and suggestions from the public. The development process included review of literature, secondary analysis of data, and field trials. Research evidence guided the process, which prioritized clinical utility.[1]

The revision process set out four major principles: Clinical usefulness in routine specialist practice, based on evidence, continuity with past revisions, and the absence of *a priori* limits to change.[2] The work groups recognized available clinical and research knowledge, identified new and recent developments in the field, and planned to actively investigate areas of ambiguity and those with promise. The work groups agreed on the criteria for change and for validity, the need to satisfy the proposed definition of mental disorders, and identify potential harm and available treatments. The deletion of existing categories was to be based on clinical utility and evidence of validity.

Clinical utility, feasibility, and reliability of the existing categories and the proposed diagnostic groupings were checked during the DSM field trials.[1] Field trials included patients and clinicians. Patients were/are being evaluated using DSM-IV and the proposed DSM-5 criteria to see the impact on prevalence rates. The fieldwork also involved psychiatrists (with backgrounds in general adult, geriatric, child/adolescent, addiction, and liaison psychiatry) as well as psychologists, psychiatric nurses, counsellors, marriage and family therapists, and clinical social workers.

The process involves many iterations, field trials, and reviews. The DSM-5 has ongoing consultation and coordination with the World Health Organization's (WHO's) Mental Disorder Advisory Group for International Classification of Disease (ICD)-11; several internal reviews provided by the Scientific Review Committee, a Clinical and Public Health Committee review, and the Task Force as a whole, collectively provide the most far-reaching review ever undertaken for any DSM revision. Nevertheless, epidemiological, neurobiological, cross-cultural and behavioral research validity as envisaged by Robins and Guze, early pioneers of operational diagnostic criteria, remains elusive for many categories.[2] DSM-5 hopes that at least some of these categories will have such construct validity in the near future, after the publication of the manual. DSM-5 accepts the lack of "gold standard" for diagnosis and recognizes that it is not set in stone and will remain work in progress.

The DSM-5 revision paid for by the APA is primarily for use of its members. However, the society is also keen that it is used for clinical, teaching, and research across disciplines and countries. Many other interest groups have been watching the process and outcome closely as the DSM has a wide impact: Neurologists, psychologists, insurance, and pharmaceutical industries, legal and forensic fraternity, military veterans, and anti-psychiatry groups. The public dispute with Allen Frances, the Chair of DSM-IV, and issues related to financial conflicts of interest suggest that there are also many axes to grind.[3-5]

### A critique

Psychiatry now has a technical language, diagnostic categories, elaborate classificatory systems, and empirical data to support it. Yet, its theories and categories lack the predictive power required of hard science. While its theories are based on available data, much of the theory is forced to fit the data. Its theories do not explain many aspects of mental health and illness. Human cognition, emotion, and behavior are complex, interconnected, and under a variety of influences from genetics and biology to psychological, social, and cultural forces. The effects of these factors cannot be studied in randomized and controlled experimental conditions. Despite decades of using operational diagnostic criteria, achieving good inter-rater reliability is a poor substitute for the lack of robust concurrent and predictive validity. At best, such data can only act as guide, without the certainty of hard science.

Psychiatry faces many challenges. The DSM and classificatory movement has also had some unintended effects. Its quest to provide a scientific basis for its diagnostic criteria and classification has resulted in a widening of the disease–illness divide between physician perspectives and patient experience.[6-8] Recent technological leaps have focused on the body and have made it easier to standardize clinical symptoms, signs, laboratory results, and treatments, with much less progress in understanding the mind and social factors.[7,8] Biomedical approaches, despite the pretence of their *atheoretical* nature, play out many dichotomies: Subjective versus objective, nature versus nurture; mind versus body, biological versus psychological, disease versus illness, form

versus content, public versus private, etc., These oppositions are not just distinctions but implicit hierarchies with objective valued over subjective, biological over psychological, disease over illness, etc., Framing the issues within such value-laden structural dichotomies distracts us from the task of trying to understand the complex interaction, interdependence, and issues related to mental health and illness.

Clinical categories are useful in medical practice, across specialties. Consequently, the disadvantages of categorization (e.g., overlap between categories, indistinct boundaries, generation of stereotypes, forcing patients into ill-fitting categories, need to follow ill-suited treatment protocols, legal implications of diagnosis, etc.,) call for renewed efforts at individualizing assessments and treatment to optimize care.

These issues, though occasionally highlighted in psychiatric literature, are rarely discussed in current clinical practice and pedagogy. The younger generation of psychiatrists, raised in the DSM tradition, consider the diagnostic system and criteria as authoritative text.[9] The original "gate-keeping function," which intended to set minimum standards, is lost and these texts have become resource and reference material for clinical psychiatry. Its impact on research has annihilated approaches other than biomedicine. While the phenomenal effort of the DSM-5 revision is commendable, clinical psychiatry should continue to strive for a more holistic understanding of mental health, illness, and disease.

## RESEARCH FROM INDIA ON CLASSIFICATION

The contribution of Indian psychiatry to classification of mental disorders has been restricted to acute and transient psychosis, possession states, and post-traumatic stress disorder (PTSD). This section briefly summarizes the contribution and its relevance to DSM-5.

### Acute and transient psychosis

Recent reviews on the subject were examined.[10-12] Wig and Singh extracted psychiatric categories from the APA DSM-II relevant for use in India.[13] They also argued for the category of acute psychosis for brief episodes precipitated by stress, which does not fit into the Kraepelinian dichotomy. They cited Asian, German, and Scandinavian work in support of a clinically different group of psychosis whose presentations and outcome differed from that of schizophrenia and manic depression. They sub-classified acute psychosis into confusional, paranoid hallucinatory, schizoaffective, and also mentioned hysterical psychosis. The category of acute psychoses was also reiterated by Teja.[14] He also highlighted the need for a category of acute psychosis of psychogenic and uncertain etiology. He subcategorized it into reactive depressive psychosis, reactive excitation, acute paranoid reaction, and reactive confusion.

Psychoses of brief duration are commonly seen in the developing world and pose a challenge to clinicians. Such atypical psychoses have been historically described in literature under a variety of diagnostic labels. Many studies on acute and transient psychosis have been done in India and have been extensively reviewed by Malhotra.[10] The first major study which recognized the problem of acute onset of psychosis with a good prognosis was the International Pilot Study of Schizophrenia (IPSS) (1968-1970).[15] The Agra center contributed to this international multicenter investigation. The main finding in relation to acute and transient psychosis was the fact that the course and outcome of people living in the developing world was better than those living in developed countries. About a quarter of people diagnosed to have schizophrenia had only one episode and good outcome. The findings of the IPSS raised the question as to whether these subjects with good outcome had a separate psychosis or they were part of the schizophrenia group.

The Determinants of Outcome of Severe Mental Health Disorders Study (DOSMeD) (1978-1980), although designed to study first onset psychosis and provide information on the incidence of schizophrenia, also provided findings related to acute and transient psychosis.[16] Chandigarh was the Indian center and part of the multinational effort. The incidence of broadly defined schizophrenia (which included the ICD-9 reactive and unspecified psychosis) was 1.5-4.2/100,000/year, compared to narrowly defined schizophrenia (0.7/100,000/year). The incidence of broadly defined schizophrenia, which included non-affective, acute, and remitting psychosis, was 10 times higher in the developing world than in the developed countries. These patients also exhibited a benign course at 2-year follow-up.

The cross-cultural study of acute psychosis (CAP) (1980-1982)[17] was an offshoot of the DOSMeD study. The study aimed to differentiate acute and transient psychosis from schizophrenia and manic-depressive psychosis. It also aimed to understand its relationship with psychological and physical stress. Its main findings included the fact that 41.2% of patients had symptoms of schizophrenia, while affective symptoms were documented in 20% of the sample of 1004 patients with acute psychosis. About 41.7% reported stress at onset and two-thirds of the subjects remained without relapse at 1-year follow-up. The outcome of patients with schizophrenia symptoms was similar to those with affective presentations.

The Indian Council of Medical Research's multicenter study of acute psychosis carried out in Bikaner, Goa, Patiala, and Vellore documented 52% of patients with acute psychotic presentations who could not be classified as schizophrenia or Manic Depressive Psychosis (MDP).[18] The findings of the Chandigarh Acute Psychosis Study were similar with 40% receiving the label of acute psychosis.[19]

These studies provided evidence of a non-affective, non-schizophrenia psychosis with remission and good outcome and lead to the inclusion of acute and transient psychotic disorder (ATPD) as a separate category in the ICD-10.[20] Acuteness of onset, brief duration, and polymorphic picture were accepted as the defining criteria. The presence of stress was coded as an additional feature. Organic conditions, substance abuse, and affective disorders were to be excluded.

Studies which have examined the association between stress and vulnerability in acute and transient psychosis have documented that those with higher stress have a lower genetic vulnerability and vice versa, supporting the stress vulnerability hypothesis for the development of such psychosis.[21]

The follow-up studies of acute psychosis from Chandigarh have shown that 14 out of 17 patients maintained full recovery throughout the 12-year follow-up.[22] The average duration of acute psychosis was 2-4 months, which was longer than the 1-3 months suggested by ICD-10.[23] The recurrence in the DOSMeD cohort of acute and transient psychosis was 11.76% at 12-year follow-up.[12]

Other workers have also followed up patients with acute and transient psychosis.[24,25] A large proportion of patients were later diagnosed to have affective disorder (9.2%), schizophrenia (26.4%), or recurrent episodes of acute psychosis (11.5%), and others did not present with psychotic symptoms over the follow-up period, suggesting that it is clearly difficult to predict their response to medication, course, and outcome. However, it is well known that acuteness of onset is a good prognostic factor in both schizophrenia and mood disorders. They have argued that the concept of acute psychosis is necessary since many patients may present within a short time of the onset of their illness, at which point the clinical features may not allow them to be categorized into any of the more classical disorders. Although many patients recover, some have relapses with similar acute psychotic presentations and a significant proportion also develops schizophrenia and mood disorders. The difficulty in reaching a diagnosis at the time of the initial presentation is because it is often difficult to recognize the classic syndromes at the onset of the illness. However, these can be identified over time as they develop the syndrome later. Thus, acute psychoses can be a presentation of the more traditional syndromes. They can also be separate clinical entities, which may or may not recur over time. Assuming that those who present with acute psychosis conform to a homogenous group does not fit in with clinical reality.

### Diagnostic and statistical manual-5 brief psychotic disorder and schizophreniform disorder

The DSM-5 category of brief psychotic disorder (BPD)[26] requires the presence of at least one of four symptoms of delusions, hallucinations, disorganized speech, or grossly disorganized behavior for a 1-day to 1-month duration, with eventual return to pre-morbid functioning. Culturally sanctioned responses to severe stress are excluded. The differential diagnoses would include psychotic depressive and bipolar disorders, schizoaffective disorder, schizophrenia, and psychosis secondary to substance or medical conditions and need to be excluded. The presence or absence of marked stressor(s) and post-partum onset are specifiers. The DSM-5 also has a 0-4 severity criterion, which is based on disturbance related to delusions, hallucinations, abnormal motor behavior, disorganized speech, negative symptoms, impaired cognition, depression, and mania.

Schizophreniform disorder requires that the patient satisfy symptom criteria for schizophrenia, but whose duration is greater than 1 month and less than 6 months. The presence of good prognostic features is a specifier and includes acute onset of symptoms, confusion, and perplexity, good pre-morbid functioning, and absence of blunted affect. It has a 0-4 severity criterion similar to BPD.

## COMMENTS

DSM-IV and DSM-5 criteria for BPD are very similar with minor differences in wording. DSM-5 BPD, ICD-10 ATPD, and the definitions employed in the WHO studies also have differences in wording. However, it is possible that there will be a large overlap in people identified using these different operational definitions. Nevertheless, there are no Indian studies, to the best of our knowledge, which have compared these definitions.

However, there are data from the Germany[27] comparing ICD-10 and DSM-IV categories. 61.9% of those diagnosed ATPD also fulfilled the DSM-IV criteria of BPD; 31.0%, of schizophreniform disorder; 2.4%, of delusional disorder; and 4.8%, of psychotic disorder not otherwise specified. BPD showed significant concordance with the polymorphic subtype of ATPD, and DSM-IV schizophreniform disorder showed significant concordance with the schizophreniform subtype of ATPD. BPD patients had a significantly shorter duration of episode and more acute onset compared with those ATPD patients who did not meet the criteria of BPD (non-BPD). The study concluded that DSM-IV BPD is a psychotic disorder with broad concordance with ICD-10 ATPD. However, the group of acute psychotic disorders with good prognosis extends beyond the borders of BPD and includes a subgroup of DSM-IV schizophreniform disorder. The 1-month restriction on duration of psychosis for DSM-5 BPD implies that some patients diagnosed to have ICD10 ATPD will be diagnosed to have DSM-5 schizophreniform disorder.

Thus, patients diagnosed as ICD-10 ATPD are classified as DSM-5 BPD or schizophreniform disorder. The justification

for the division of BPD and schizophreniform disorder solely on the basis of the 1-month duration threshold appears arbitrary as many such presentations may last 2-4 months. Data from India support the ICD-10 category of ATPD rather than the DSM-5 subdivision into BPD and schizophreniform disorder based on the 1-month duration criteria. However, there seems to be broad agreement that there are more similarities than differences between the ICD-10 ATPD and the DSM-5 BPD/schizophreniform disorder, arguing for greater consensus and concurrence between the two classificatory systems.

## Possession disorders

Possession and trance states have been commonly reported from India. Localized epidemics of mass hysteria have also been documented.[28] A systematic epidemiological and community-based study from Karnataka, South India, documented a 1-year period prevalence of 3.7%.[29] 90% of the respondents believed in spirit possession. Other studies have documented dissociative disorders in hospital populations. 6.13% of out-patients and 6.67% of inpatients attending a tertiary referral psychiatric hospital were diagnosed to have dissociative disorders over a 10-year period.[30] Dissociative amnesia accounted for 4.1%, dissociative fugue 1.4%, dissociative stupor 6.6%, dissociative motor disorder 43.3%, dissociative convulsions 23.0%, dissociative anesthesia 0.8%, trance and possession disorder 11.5%, mixed dissociative disorder 4.1%, and other dissociative disorders 2.4% among outpatients. The majority of inpatients were diagnosed to have dissociative motor disorder (37.7%), followed by dissociative convulsions (27.8%), trance and possession disorders (5.3%), and dissociative stupor (5.3%).

Studies from India have also attempted to use DSM definitions, criteria, and classifications for dissociative disorders with limited success as the majority of patients receive the diagnosis of dissociative disorder not otherwise specified.[31-33]

## Diagnostic and statistical manual-5 dissociative disorders

The proposed classification of dissociative disorders[34] includes depersonalization–derealization disorder, dissociative amnesia, and identity disorder. The dissociative disorders not elsewhere classified category is large and lists a variety of conditions including subsyndromal identity disorders, due to intense coercion, mixed depersonalization, derealization, and dissociative states, mixed psychotic and dissociative states, stupor, trance, and Ganser syndrome. DSM-5 clearly specifies that trance states diagnosed as dissociative disorders should not be a normal part of a broadly accepted collective cultural or religious practice.

## Comments

DSM-5 dissociative trance excludes possession episodes seen in India as part of religious and cultural practice. Only patients with the symptoms and incapacitation out of keeping with the local culture and those who are brought to hospital for treatment should be considered for the diagnosis of dissociative trance.

DSM-IV and DSM-5 have prioritized dissociative disorders commonly encountered in the United States, leaving many conditions in other parts of the world under the "not classified elsewhere" category. Consequently, this category is cluttered with a wide variety of dissociative conditions. Many dissociative disorders commonly encountered in India, Asia, Africa, and Latin America are all listed under the residual category. If the DSM-5 dissociative disorders categories and criteria are to be relevant to countries in these continents, then it will have to have separate categories and criteria for possession states and other dissociative disorders.

## Post-traumatic stress disorder

PTSD is now a standard psychiatric diagnosis. Its criteria have undergone many revisions including the DSM-5.[35-39] It is now regarded as a standard long-term consequence of traumatic stress. It has been described from different parts of the world.

## A critique

The category created in the context of the Vietnam War in the United States of America, has been de-contextualized, its original meaning and links rendered invisible, its criteria loosened as it was moved to the civilian sector and universalized.[40,41] It pathologizes individuals, equates the problems of perpetrators of crimes with the suffering of victims of trauma, and shifts the blame for manmade disasters to the victims. It employs symptom checklists and does not examine the pre-and post-trauma context, vulnerability, and supports or the clinical picture. It medicalizes personal distress, assumes biological causation, and argues for medical solutions.

Detailed critiques have been published,[41] and the issues are briefly highlighted.

1. The dominant view that reactions to traumatic events during war were transient and that only people with unstable personalities, pre-existing neurotic conflicts, or mental illness would develop chronic symptoms was rejected after the Vietnam War
2. Returning Vietnam War veterans successfully lobbied the APA to construct a diagnosis, recognise psychopathology, and provide therapeutic services and disability support[40]
3. There have been many changes to the PTSD symptom list over the numerous iterations of the DSM[35-39] with a progressive relaxation of the criteria of traumatic stress. The concept has been broadened and moved into the civil sector, which means that the harm suffered would be taken seriously, covered in insurance policies, and the individuals could claim compensation/sue for damages

4. The change over to smaller professional armies in the West, specifically screened, trained to survive stress (or not to react with ordinary human responses to what they experience or are required to do), and debriefed, has reduced acute psychiatric casualties, but it has not reduced the risk of long-term psychiatric consequences[42,43]
5. Many reasons have been proposed to explain the long term-consequences of war[41-43] including antiwar public opinion, disability insurance, public concern about unexplained syndromes (e.g., multiple chemical sensitivity, Gulf War syndrome), shift in culture of reporting war atrocities (e.g., "Kill and Tell"), veterans emphasizing victimhood to combat the view that they were perpetrators of the war, and the dominance within psychiatry of the medical model of disease, with symptom counts and specified criteria for diagnosis.

## Concerns about post-traumatic stress disorder framework

Many of the issues that trouble the PTSD category arise from the current frameworks employed by the DSM criteria and classification.[41] Many issues specific to PTSD have been discussed in literature:[40-45]

1. Unpleasant feelings and phenomena part of normal range of emotions are generically labeled and pathologized (e.g., anxiety, dreams, memory flashbacks)
2. Purposive and normal responses of people who are stressed are considered pathological (e.g., efforts to avoid thoughts, feelings, conversations, activities, places associated with the traumatic event)
3. Other responses (e.g., hyper-vigilance or numbing) which may be reasonable responses in specific contexts are labeled as abnormal
4. The *post* in PTSD emphasizes that the trauma is past and the world is now a safe place. This may not necessarily be true for victims of continuing abuse within families, women in patriarchal societies, for people with homosexual orientation in a heterosexual world, for racial, religious, or ethnic minorities generally
5. The lack of even one pathognomonic symptom, typical of the condition, and the marked overlap of symptoms with other categories like generalized anxiety disorder, acute stress disorder, borderline personality disorder. A combination of symptoms of major depression and specific phobia fully constitutes the requisite criteria for PTSD
6. The polythetic format for diagnosis results in marked heterogeneity. There are said to be 175 possible combinations of symptoms by which PTSD can be diagnosed
7. No definition of trauma is or can be provided
8. The concept tends to assume a universal response to trauma, appears to be comprehensive, and discounts variation among different people who survive different kinds of traumatic events
9. The importance of the context of the trauma and the person's current situation is regarded as unimportant
10. While a possible relationship between the trauma (Criterion A) and the subsequent problems (Criteria B, C, D, E) is posited, such causal relationships are ruled out in the definition of "mental disorder," which forms the basis of DSM
11. The label assumes specific etiology despite the fact that the symptoms are documented after a variety of non–life-threatening events and the co-occurrence of its symptoms with other psychiatric disorders (e.g., people with depression and with social phobia who have not experienced life-threatening circumstances)
12. The denial of the fact that pre-incident vulnerability and post-incident support have a greater impact on morbidity than the incident *per se* is seldom highlighted
13. Only acute traumas are included as causal, with the often more insidious and chronic trauma excluded
14. The 1-month duration criterion implies pathology in all those whose reactions persist for longer
15. Poor concordance[46] of diagnosis between ICD-10[47]and the DSM-IV TR[38] despite agreement on major issues
16. The category does not focus on or highlight the strength of the survivors of trauma or the different community and social contexts in which the meaning of the traumatic event is established and recovery takes place
17. Problems in living are construed as actual mental disorders by the psychiatric classificatory systems, when viewed through the medical lens. The use of the PTSD model for a variety of stress-related adjustment disorders across cultures suggests the medicalization of normal human emotions.

The DSM construct of PTSD, while legitimizing the long-term impact of trauma, does not clearly implicate the external event in causation.[41] On the contrary, it pathologizes the person and invalidates his/her ways of coping with trauma. It turns the trauma/violence into a preceding event, one that is now over. In the context of violence against women and children, it is the oppressed that are treated as mentally ill. The shift of focus from the crime of the perpetrators to disease in the victim creates an image of pathology for social issues that are dangerous to pathologize. Many would also argue that a single label to explain/represent experiences of trauma is inadequate as there is no single profile of PTSD. In addition, information relevant to the diagnosis and treatment of PTSD victims goes far beyond the effects of the symptoms. Also, PTSD is not unique in its relevance to understanding legal issues related to crimes against victims. Many of these issues are similar to those in the "Battered Woman Syndrome."

## Post-traumatic stress disorder and India

As with the DSM system as a whole, this category has been adopted by psychiatry in India with very little debate

or discussion.[41] The pressure to adopt the DSM as both the Indian and universal standard or be "left behind" and considered "unscientific" was tremendous.

Nowadays, the label PTSD seems to be employed in clinical psychiatric practice for patients who present with symptoms after a traumatic event.[41] The label is also discussed in literature related to natural and manmade disasters in India. PTSD is a diagnosis employed in clinical practice in India for people who present with the "classical" symptoms of the syndrome after a traumatic event. While there are no systematic studies on the prevalence of the condition in the different hospital settings in India, Indian mental health professionals do not seem to be averse to using the label.

A review[41] using the PubMed search employing MeSH terms "post traumatic stress disorder" and "India" identified articles which did not refer to soldiers or war contexts, but included cross-sectional studies of the condition in the civilian environment. The industrial accident at the Union Carbide plant in Bhopal resulted in the deaths of thousands (estimated 2500-8000), and acute and chronic physical injury and disease to many thousands more (estimated over 100,000). The Indian Council of Medical Research collected data on psychiatric morbidity from clinics and from community surveys and described anxiety, depression, and adjustment reaction after the disaster, but made no mention of PTSD.[48,49] Although experts from the West predicted high incidence of PTSD, the data on the ground did not support its existence.[48,49]

The state of Gujarat was engulfed in communal riots in February 2002 and the carnage resulted in an estimated 2000 people dead, many thousands injured, 30,000 households destroyed, and about 100,000 internally displaced to relief camps. A qualitative study examined symptoms and experiences of people affected by the riots.[50] They documented the cardinal symptoms of PTSD (i.e., re-experience, avoidance, and arousal) and their relation to the trauma. The authors argued for the cross-cultural validity for the core symptoms of PTSD. However, the report failed to mention either the role of the government in the riots or the persistence of threats and violence against the very people who were traumatized, the majority of whom are unable to return to their homes to restart their livelihood and resume their lives.[41]

Similarly, reports of PTSD have been described among Kashmiri Pundits forced to leave their homes and livelihoods.[51] Government statistics have recorded the fact that 56,246 families had migrated from Kashmir in the 1990s. PTSD, using standard instruments and criteria, has been documented in refugees living in camps for internally displaced people. The targeting, sudden and forcible displacement, separation of families, loss of livelihoods, poor facilities in the camps, and lack of opportunities to return to their homes and resume their lives were acknowledged as causal.[51]

The Asian tsunami, which struck the State of Tamil Nadu in 2004, caused about 7983 deaths and the need to relocate 44,207 individuals to relief camps and 499,962 people to safer areas. Psychiatrists who visited the area immediately after the tsunami did not report PTSD among the survivors.[52,53] Many reasons have been attributed to the absence of the condition, including differences in culture and religion, prior poverty and hardship, concerted community response, that it was a natural rather than manmade disaster, the lack of compensation for persistent symptoms, and the disadvantages of sick role. However, research studies in the area using internationally developed instruments and criteria report PTSD with variable prevalence.[54-57] Detailed evaluations of these reports reveal that many subjects with PTSD also satisfied the criteria for major depression, and had lost property and family members, and would also qualify for the label normal grief.[41]

PTSD has also been reported among children and adults after the super cyclone which hit Orissa[58,59] and after earthquakes.[60,61] Studies on Tibetan refugees[62-65] have reported PTSD in adults and in children of who were imprisoned or tortured[66,67] and in those who suffer intimate partner violence.[68] It has also been reported to occur in people after witnessing road traffic accidents,[69] suffering from physical injuries,[70,71] physical disease[72] and its treatment.[73]

## DISCUSSION

While the DSM system of classification and the ICD-10 are supposedly *atheoretical*, they essentially view mental illnesses through the disease lens and employ a medical conceptual model for diagnosis and management. The international classificatory systems push psychiatric diagnosis toward the assumption that illnesses like PTSD stem from a biological core, and that the individuals experiencing the symptoms are to be medically treated.

Context, history, and politics, all of which are so crucial to the formation of the disease category, are considered not to matter, or regarded as non-essential and somehow external to the disease.[41] A category created after the Vietnam War is projected into the past, linked with description of other superficially similar conditions (e.g., Da Costa's syndrome, Soldier's heart, Shell shock), which had a entirely different context and meaning and gradually elaborated into its present form using a so-called scientific process. The context in which PTSD appeared, its historical and social links, and the systems within which it operated, are now rendered invisible. The "condition," stripped of its original context, has been moved into other geographic areas like civilian life and into different parts of the world and universalized. The

diverse contexts under which the condition now exists are brought together as many strands, de-contextualized, and subsequently unified into a single disease label.[41] The PTSD story is now authoritatively used across cultures, contexts, and very different kinds of trauma experience.

Genealogical investigations into PTSD can examine the supposedly scientific synthesis and identify the specific context that spawned the category, and highlight the overarching hold of the "disease" concept, which conceptualizes disease as located within the body and suggests biomedical cures.[41] The lack of pathognomonic symptoms, the use of responses which are within the normal range of coping to identify the disorder and consider it as pathology, the de-contextualization of the issues, the assumption that the trauma is in the past and does not operate in the current context, the medicalization of personal distress, and universalizing the label are major issues.

The issues raise the question of relevance of PTSD to India.[41] Can the category, PTSD, standardized to suit the context of the post-Vietnam War and the changing culture in the US, be directly applicable to other kinds of trauma in other historical situations? Can treatment protocols devised for a completely different context half a world away be employed in managing natural and manmade disasters in India? Should the label be employed to focus on the victims of riots (e.g., Delhi 1984, Gujarat 2002) while remaining silent on the perpetrators of the crimes against humanity? Should the category be used to shift the emphasis from the perpetrators of the Bhopal tragedy to innocent and poor victims? Can arousal and hyper-vigilance be employed as symptoms of pathology in situations where the dangers of another tsunami for people living in coastal areas are always present? Can distressing re-experiencing of traumatic events, where people have lost family members, be called disease when they are part of normal grief and bereavement? Should avoidance and arousal in contexts with the persistent dangers of violence for a particular community being ever present, where such behaviors may be protective, be called pathological? Can people who continue to live in relief camps years after the trauma, whose lives and livelihoods continue to be on hold, not express their grief? Can such people relive their traumatic experience or express a numbing of general responsiveness toward the environment? Can people who have suffered physical harm and continue to suffer from severe and chronic physical diseases (due to negligence of a large multinational corporation and the insensitivity of the government more concerned with foreign investment than the health of its own people) express their distress?

## Helping people who have been traumatized

Helping people cope with the trauma would necessitate understanding the context, focusing on their strengths and empowering them to handle the continued stressors.[41] Symptomatic relief rather than category specific-treatments is called for. Establishing rapport, allowing for ventilation, and understanding the issues past and present would be crucial in helping people overcome severe stress. Medications, if any, should be employed for short-term relief of symptoms. A stepped care approach is useful. Many would benefit with recognition of their grief and "permission" to grieve.

The WHO recommends general psychological support for natural and manmade disasters much more than "managing PTSD." It argues for the management of a variety of issues:[74] (i) pre-existing social problems (e.g., extreme poverty, belonging to a group that is discriminated against or marginalized, political oppression); (ii) emergency-induced social problems (e.g., family separation, disruption of social networks, destruction of community structures, resources, and trust, and increased gender-based violence); and (iii) humanitarian aid-induced social problems (e.g., undermining of community structures or traditional support mechanisms).

Exploring the meaning of the traumatic events and the available support after the incident would be useful.[41] The majority will require limited interventions and specific suggestions to cope. A very small minority will require intensive psychiatric and psychological treatment. However, research evidence for the usefulness of psychiatric treatment after natural and manmade disasters is thin.[74,75]

Efforts should also focus on the perpetrators of crimes and of manmade trauma, which may provide closure for victims. Social, political, and legal solutions may be more effective in a situation where grave injustice has been done to large sections of the community (e.g., the Bhopal Gas tragedy) and continues to be done.[41] People who are not able to cope with the persistent threat of continued trauma may require relocation and help in rebuilding their lives. Livelihood issues will be more important in situations where the fishermen in Tamil Nadu who have no alternate employment need help with learning new skills.

Psychiatry and medicine tend to focus on individual health and sickness. While it does help individuals in coping with crises, it does not have a major impact on the mental health of communities. The interventions required when large sections of society are affected by natural and manmade disasters will be community-based interventions.[74,76] These are usually public health efforts at providing basic needs (e.g., water, sanitation, shelter, health, education, and employment), macroeconomic and microeconomic solutions to empower people in rebuilding their lives, and social, political, and legal remedies to alter the climate in situations of genocide. The issues raised demand a debate and a rethinking on the use of the PTSD label in India.[41]

## DIAGNOSTIC AND STATISTICAL MANUAL-5 UNIVERSAL CATEGORIES FOR DIVERSE CULTURES

While DSM-5 is primarily for use in the United States, the APA is also keen that it is used for clinical, teaching, and research around the world. The categories and criteria will be employed in culturally diverse populations in America and around the world. The use of universal categories for mental illness and common operational criteria for diagnosis is a challenge given the diverse cultural, social, ethnic, and religious environment. Realizing the difficult task, the APA has placed a special emphasis on the cultural formulation in order to enhance its usefulness and validity across cultural settings. Many would argue that imposing Euro-American concepts and standards on non-western cultures is likely to be problematic when viewed from an anthropological perspective. This section examines the issues from an Indian perspective and argues for cautious use of the categories.

### Cultural formulation and interview

The Cultural Formulation, introduced in DSM-IV as an appendix,[37] has been expanded in DSM-5 in the form of a detailed interview.[77,78] It has a set of 14 questions, which explores four domains: (i) cultural definition of the problem; (ii) cultural perceptions of cause, context, and support; (iii) cultural factors affecting coping and past help seeking; and (iv) current help seeking. The detailed interview has additional semi-structured questions with probes and prompts. The interview also highlights cultural identity and preferences, and discusses the patient–physician relationship. It is hoped that the interview process and the information elicited will enhance the cultural validity of the diagnostic assessment, facilitate treatment planning, and promote patient engagement and satisfaction.

### Culture and mental illness

Collective knowledge, shared beliefs, values, language, institutions, symbols, and images result in a shared worldview. These systems have a major impact on the idioms of distress, symptoms, and clinical presentations of illness. They also affect help seeking, treatment compliance, and patient satisfaction. Illness perspectives (also called explanatory models or EMs) among patients suffering from a variety of conditions have been the focus of recent studies. EMs denote the "notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process."[79] *Emic* models elicit patient perspectives by the way patients conceptualize their sickness episode including beliefs and behaviors concerning etiology, course, timing of symptoms, meaning of sickness, diagnosis, methods of treatment, roles, and expectation of sick individuals.[79,80] EMs influence many aspects of the human behavior like help seeking, treatment compliance, patient satisfaction, and coping.

### EMs of mental illness in India

EMs related to mental illness have been examined in the following populations in India: (i) patients with unexplained medical symptoms,[81] (ii) patients attending traditional healers,[82] (iii) patients with psychosis,[83] and (iv) EMs of psychosis among community health workers.[84,85] EMs of illness and issues related to insight have been assessed in patients with schizophrenia[86-94] and with bipolar disorders,[95] and their relatives. The findings of these studies suggest the following broad conclusions:[93,96]

(i) Patients, relatives, and health workers often provide non-medical explanations for the cause of illness (e.g., karma, evil spirits, black magic, sin, punishment by God, etc.,)
(ii) Many patients and relatives hold multiple beliefs including medical, non-medical, supernatural, religious, and black magic beliefs. These beliefs are simultaneously held and are often contradictory
(iii) Many patients (and their relatives) simultaneously seek biomedical and non-biomedical interventions.[97,98]

Studies done in the West have also documented multiple and contradictory EMs among patients with psychiatric disorders.[99,100] The immediate subculture seems to play a big role in determining EMs of illness. Western philosophy and logic suggests the holding of single causal explanations of illness and the seeking of corresponding treatment. The reality on the ground reflects otherwise. The flourishing alternative medicine industry and practice in the West also supports such a contention.

The implications of these findings include the following:[93,96] (i) the need to accept multiple approaches to restoring health; (ii) the need to understand the patient's perspective; (ii) the need to explore different dimensions of patient experience; (iv) the necessity to integrate the apparent contradictions between the biomedical and non-medical beliefs; (v) the requirement to emphasize role of medication compliance; (vi) to encourage use of diverse strategies to restore and improve psychological health and functioning; and (vii) to reduce stigma related to mental illness (so that people can identify with the medical model).

### Form–content dichotomy in psychopathology

Concepts of illness vary between social groups and different cultures express their symptoms differently.[79] What is regarded as abnormal in western culture may be considered culturally acceptable in non-western societies and vice versa. For example, brief episodes of trance and possession occurring within a religious or culturally accepted situation are normal in the South Asian culture. Cross-cultural variations in the presentation of many syndromes have been documented. For example, patients with the *Dhat* syndrome present with a variety of "neurotic" symptoms.[101,102] These patients also offer "loss of semen" as the explanation for these disabling symptoms. Such

patients are diagnosed as *Dhat* syndrome if the physician is aware of the label and the explanation and if he/she focuses on the content.[103,104] These patients could also receive a label of anxiety, depression, somatization, or neurasthenia if the physician emphasizes the form of the presentation. The patient perspective of "loss of semen" as cause of the symptoms is the EM of his illness.

The culture in South Asia tends to highlight sexual beliefs as the cause for a variety of neurotic phenomena. These explanations generate more acceptance and understanding for the patient than if he/she highlighted symptoms of anxiety, depression, or somatic symptoms *per se*. Such beliefs are reinforced by traditional Indian systems of medicine which subscribe to these concepts and whose physicians and healers are often the first contact in the "pathway to care." Sexual misconceptions related to *Dhat* are also seen in patients with schizophrenia, substance dependence, bipolar disorders, delusional disorders, and major depression. Similarly, *Ataque de Nervios, Koro, Brain fag, Amok, Possession syndrome*, etc., are idioms of distress.[104,105] The focus on form allows the psychiatrists to differentiate the different syndromes.[106] International classifications have emphasized form over content as the response to the various treatment modalities based on the recognition and treatment of the clinical syndrome. This does not imply reduced importance being placed on the person's culture and beliefs. It mandates the management of the patient's EM. This is also true for other culture-bound syndromes.[105] Similar forms can be recognized across cultures, while content is culture specific. Clinicians focusing on content make such presentations appear exotic. Physicians emphasizing form are able to recognize behavioral syndromes across cultures.

### Form–content dichotomy in therapy

The diversity of patients, problems, beliefs, and cultures mandates the need to educate, match, negotiate, and integrate interventions.[104] This is necessary in all cultures and every setting. Many schools of psychotherapy offer specific theory and particular techniques. Yet, they share many common approaches. Their individual techniques allow therapists form and structure to treat different clinical problems, discuss diverse content, and use it in varied settings and among people with assorted cultural backgrounds. The heterogeneity within cultures, regions, and populations demands that therapists understand the local and individual reality. The apparent contradictions between standard psychological therapies and their use across cultures, when viewed through a form–content framework, allows for matching strategies for specific individuals and their distress and for choosing the best treatment options from a diverse therapeutic armamentarium.[104]

The form–content division is also obvious in psychotherapy theory and practice.[104] For example, behavior therapy with its focus on learning, classical and operant conditioning, behavioral analysis, identification of maladaptive behaviors, reinforcement schedules, and exposure and response prevention highlights form and structure. The consequent structural analysis is applied across content, situations, regions, and culture. Similarly, cognitive therapies with their spotlight on cognition identify faulty schemas, dysfunctional thought patterns, cognitive biases, and distortions. They employ Socratic questioning, collaborative empiricism, and guided discovery to change beliefs, thoughts, attitude, and practice, and are applied across contexts and cultures to diverse problems related to anxiety and depression and to different stressors and situations. The more recent cognitive therapies include mindfulness-based cognitive therapy (MBCT) and acceptance and commitment therapy. MBCT blends features of cognitive therapy with mindfulness techniques of Buddhism.[107] Acceptance and commitment therapy employs acceptance and mindfulness strategies and commitment and behavior-change techniques to improve psychological functioning.[108]

Psychodynamic psychotherapies argue that intra-psychic and unconscious conflicts are causal while the resolution of such tensions and the use of mature defences are part of treatment. Psychoanalysis has its own structure and detail. Similarly, interpersonal psychotherapies, supportive psychotherapy, client-centered approaches, and crisis intervention have their different foci, form, and structure, and are used to manage diverse contents across contexts and cultures. This is also true for non-western psychological interventions like yoga and meditation, which are employed across diverse clinical problems and are popular across cultures. The different schools of psychotherapy have different theories and techniques, and yet only provide structures for psychological interventions. These are useful in the management of a range of contents in dissimilar contexts, regions, and cultures.[104]

Psychotherapies are at their weakest when they attempt to provide explanations across cultures and are at their strongest when they are used as vehicles for engagement with patients. The challenge is to find a common psychotherapeutic language, which attempts to bridge the divide between the issues facing the patient and the armamentarium of the therapist. The form–content paradigm at least partly explains the complexity of the issues within psychotherapy. It also allows the therapist to move from the therapy-centric orientation of western approaches to patient-centric orientations required for success in psychological therapies.[104]

The diversity of patients, problems, beliefs, and cultures mandates the need to educate, match, negotiate, and integrate interventions in all cultures and every setting.[104] This is also true for medication-based treatments. The individual techniques allow clinicians form and structure

to treat different clinical problems, discuss diverse content, and use it in varied settings and among people with assorted cultural backgrounds. The apparent contradictions between standard therapies and their use across cultures, when viewed through a form–content framework, allow for matching strategies for specific individuals and their distress and for choosing the best treatment options from a diverse therapeutic armamentarium.

### Cultural sensitivity and competency

The diversity of beliefs within cultures, regions, and populations demands the need to understand the individual patient's perspective and explore different dimensions of patient experience, and is part of all doctor/therapist–patient interactions. Psychiatrists will have to enquire about common EMs prevalent in the community and elicit the patient's causal and treatment beliefs. The integration of the apparent contradictions between the patient's EM with the biomedical model and the negotiation of a treatment plan are cardinal for success. Psychiatrist will have to put forward the specific biomedical model without dismissing or directly challenging patient beliefs. The presentation of the biomedical framework, the education about the nature of the illness, and the negotiating of a shared model are mandatory for proceeding with therapy and for success.[90,104] The education package should cover a variety of topics including: Symptoms, local beliefs about causation, biomedical models, psychosocial influences, prevalence, diagnosis, treatments including medication and compliance, side effects of medication, role of hospitalization, and coping strategies for families. While the patients and their families are encouraged to comply with medication schedules, they can also be encouraged to seek non-medical interventions as these have a powerful impact of their psychological health.[104]

Cultural competency in clinical psychiatry has become an explicit goal.[104] Cultural pluralism, a worldwide reality, demands cultural competence and mandates a cultural formulation, which examines the identity of the individual, societal explanations of the illness, the psychosocial environment, and the differences in backgrounds of the patient and the clinician.[37] Psychiatrists need to be aware and enquire about the patient's self-perceptions and attributions regarding ethnicity, race, social class, and religion.

Matching of therapist and patient characteristics (e.g. ethnicity) has been suggested to better understand patient reality. However, the heterogeneity with cultural groups and the many differences in social class, educational status, language, and dialects suggest that strict matching is not practically possible and that clinicians and therapists should be aware of the local cultural organization, worldviews and values, *etic-emic* differences, linguistic concepts, and idioms of distress.[104] The challenge is to find a common therapeutic language, which attempts to bridge the divide between the issues facing the patient and the armamentarium of the clinician.

### Comments

The Cultural Formulation and Interview attempt to negotiate and solve the complex issues related to the impact of culture on diagnosis of mental illness. Purists would argue that imposing Euro-American concepts and diagnosis on non-western cultures results in category fallacy.[79,80] Anthropological orientations have employed cultural yardsticks and have argued against biomedical categorization. Much of the debate on culture and mental illness has emphasized the differences between cultures and systems of medicine. However, the problems related to the diagnosis and management of mental illness facing health professional worldwide are similar.[97] For example, an examination of the diagnosis of mental illness in Ayurveda, an Indian system of medicine, reveals that these systems are also plagued by similar problems. All current classifications of mental illness, indigenous/regional and western/international, and the use of clinical standards for diagnosis, have heterogeneity within categories, employ symptomatic treatments, and result in variability of treatment response.[97] This argues for the inadequacy of all individual systems of medicine to manage all mental disorders. The situation demands less rigid theoretical frameworks, a study of cultural issues, and an eclectic approach to the care of mental illness using available concepts, categories, and treatments.

The form–content dichotomy in diagnosis prioritizes form and allows for the recognition of categories, which have evidence-based treatments.[104] The form–content dichotomy in therapy argues for the use of the different structures of therapy across cultures to discuss diverse contents. The exploration and elicitation of EMs and the patient's culture will allow for negotiating and matching treatments and in developing a shared management plan.[104]

The Cultural Formulation and Interview needs to be implemented in letter and in spirit to deliver culturally appropriate and biomedically relevant care to people with mental illness. This is true for people of all cultures and across all counties. There should be increased efforts to assess and manage issues related to context and cultures, meaning and idioms of distress, and coping and stress.

## DIAGNOSTIC AND STATISTICAL MANUAL-5 AND PRIMARY CARE

The APA plans to bring out a primary care version for DSM-5 in 2014. It will be much slimmer than the DSM-5 main version, as it will mainly focus on diagnosis common to primary care. However, recent trends in diagnosis and classification suggest that the current sub-categorizations/divisions of common psychiatric presentations in primary care will continue. Anxiety,

depression, panic, phobia, medically unexplained somatic symptoms, etc., will form separate diagnosable categories. All current psychiatric classifications for primary care and medical practice recommended by specialist psychiatrist have required correspondence with the main psychiatric classifications. Consequently, it is most probable that the DSM-5 primary care version will continue this trend. This critique discusses the issues related the diagnosis and management of common psychiatric presentations in primary care from a primary care perspective. It summarizes evidence presented in other detailed appraisals.[109-111]

## Psychiatric presentations in primary care

Many investigations have established the prevalence of depression in primary care.[112] Numerous studies from India have also documented depression, anxiety, and common mental disorders in general hospital settings.[113,114] The prevalence estimates have ranged from 10 to 50% of patients attending primary care with an average of about a quarter to a third suffering from such conditions.[112]

The high prevalence of these disorders and the magnitude of disability and distress have focused the efforts on managing them within the context of primary care.[115,116] Educating GPs, preparing practice guidelines, and conducting courses to improve their clinical skill have been attempted.[117] The WHO has developed diagnostic algorithms in order to make diagnosis easier.[118] It has recommended protocols for the management of such presentations.[119] These efforts resulted in the expectation that depression would be managed in primary care.

Nevertheless, despite such expectations, the detection rate for depression in primary care continues to be low. Despite piloting, field studies, and acceptance by academic GPs, the watered-down psychiatric approach, when employed in primary care, has few takers in actual practice.[120,121] Many physicians find the numerous case-finding instruments and screening questionnaires to diagnose depression too cumbersome and time consuming for routine use. The many diagnostic criteria for depression are elaborate and difficult to apply in routine medical practice. Treatment guidelines also do not seem to improve the situation.[122,123]

## Recent trends in medicine

The growth of medicine, particularly tertiary care, over the last century has resulted in the decline of family medicine and general practice. This decline has been inversely proportional to the meteoric rise of specialist approaches. Many problems of patients presenting to primary care are now viewed from a specialist perspective. This is true across all medical disciplines and particularly true of psychiatric disorders in primary care.

The second trend which has significantly affected the diagnosis and management of psychiatric presentations in primary care is the progressive medicalization of all personal and social distress.[124] This has lowered thresholds for the tolerance of mild symptoms and for seeking medical attention for such complaints. Patients visit general practitioners (GPs) when they are disturbed or distressed, when they are in pain or are worried about the implication of their symptoms. However, the provision of psychological and social support currently mandates the need for medical models, labels, and treatments to justify medical input.

The culture of psychiatry in primary care borrows heavily from academic and tertiary care psychiatry and attempts to adapt it to the reality of primary care.[125] The compromise is uneasy, unstable, and difficult to apply in general practice.

## General practitioners' perspective

The GPs' perspectives differ from those espoused by psychiatry. People with depressive symptoms often present to GPs.[125] Patients visit GPs when they are disturbed or distressed, when they are in pain or are worried about the implication of their symptoms.[126] Bereavement, marital discord, inability to cope at work, and financial problems can also lead people to seek help. The difficulty in separating distress from depression becomes a major issue. While psychiatrists suggest that brief screening instruments can easily identify people with depression, most GPs would argue that many of those identified are distressed.[127] The depression GPs encounter is often viewed as a result of personal and social stress, lifestyle choices, or as a product of habitual maladaptive patterns of behavior. Consequently, GPs often hold psychological and social models for depression.

Most GPs and physicians working in primary care accept the medical model of depression during discussions with psychiatrists and academic GPs.[128] However, low detection and treatment rates suggest that the majority subscribe to non-medical social and psychological perspectives. Resolution of social adversity, the presence of social support, and the person's psychological resources seem to have greater impact on outcome than medical solutions. Antidepressants and short-term counseling do help certain patients. Nevertheless, they are not the answer for all types of "depression." The difficulty in separating disease from distress and the absence of effective medical solutions for "depression" in primary care are often the compelling reasons for the reluctance of GPs to accept the medical model of depression.

## The different reality of primary care

The differences in concepts, perspectives, and frameworks between psychiatry and general/family practice is based on the differences in settings.[109-111] Psychiatrists practice in specialist settings and see different subgroups of patients, compared to physicians working in primary care. The

differences between the two settings, which might explain the divergence in perspectives, include the following:

1. There are differences between patients attending a psychiatric hospital and those who present to primary care. Patients who visit psychiatric facilities often have severe, complex, and chronic illness, and are highly motivated to receive specialist treatment. On the other hand, those who visit GPs have milder and less distinct forms of illness with concomitant psychosocial stress
2. Differing conceptual models and perceptions are employed in different settings. Psychiatrists, employ. Psychiatrists employ medical models while GPs focus on the psychosocial context, stress, personality and coping
3. Symptom scores, in patients attending primary care, on standardized interview schedules [e.g., Revised Clinical Interview Schedule (CISR)][129] are distributed continuously with no point of rarity between cases and non-cases, making dichotomous clinical decision making difficult
4. Mixed presentations of anxiety, depression, and somatic symptoms are common in primary care[130]
5. Many patients who cross the case threshold do not have the full syndrome attributes of depression or of anxiety[131]
6. The labeling of patients with sub-syndromal presentations based on distress and impairment essentially implies a lowering of the threshold for diagnosis[132]
7. Studies using statistical techniques have failed to show superiority of the two-factor anxiety-depression models over the one-factor solution.[133,134] In addition, the anxiety and depression factors of the two-factor model have always been highly correlated
8. The commonest presentation of psychiatric problems in primary care is with medically unexplained somatic symptoms.[135] However, a significant number of such patients also mention the presence simultaneous psychological stress or distress
9. The etiology of medically unexplained somatic symptoms is unclear.[136] The general tendency is to assume psychogenesis. However, the label "somatization" actually acknowledges to medical ignorance rather than understanding
10. The numerous categories of depression in the ICD-10, a classification for specialists,[137] for use in psychiatric settings have been clubbed into a single category of depression in the ICD-10 for primary care,[116] resulting in patients with features of biological depression being clubbed with normal people with adjustment reactions due to stress and with those who cannot cope with the demands of life because of poor coping skills
11. Many studies have shown a high rate of spontaneous remission of depression and common mental disorders in primary care. Literature on major depression also supports the argument that there is a high rate of spontaneous remission[138]
12. Many authors have highlighted the high rate of improvement in the placebo arms of randomized trials employed to test the efficacy of antidepressant medication[139]
13. Despite efforts at simplification, the guidelines for managing Common mental disorders (CMD) in primary care have proposed elaborate and separate protocols for each of the traditional psychiatric categories,[119] making them impractical for routine use[121]
14. The treatment of common psychiatric presentations in primary care is essentially symptomatic with both non-specific and specific psychiatric interventions[140,141]
15. The diagnostic categories recommended should complement existing physical symptoms cluster diagnosis (e.g., irritable bowel syndrome, non-cardiac chest pain, etc.,)[140]
16. The impact of culture on psychiatric presentations has been documented.[142] The oriental culture tends to focus on somatic symptoms, which are found across psychiatric categories. This is particularly true of non-psychotic psychiatric morbidity.

## THE INDIAN CONTEXT OF PRIMARY CARE

Common mental disorders have been widely documented in primary care and general medical settings in India.[143-150] However, the recognition rates and treatment are less than optimal.[112] The reasons for this are complex. A recent qualitative study, which employed standard focus group discussion methodology, aimed to gain insight into physician perspectives on anxiety, depression, and somatization.[151] It focused on the conceptual models employed and the practical problems faced in managing patients with such presentations in general medical settings. Family and primary care physicians admitted to a high prevalence of patients who present with medically unexplained symptoms. They noted the co-occurrence of psychosocial stress. All physicians working in general medical settings admitted to difficulty in separating anxiety, depression, and somatic presentations because of milder, less distinct syndromes and overlapping symptoms. They argued that it was difficult to employ the current three-category division and that more complex classification would be time consuming and impractical in primary care. The study concluded that psychiatric classifications for use in primary care should consider the different context and employ physician perspectives rather than push specialist concepts and criteria.

## THE NEED FOR A RADICALLY DIFFERENT APPROACH

The differences between patients attending primary care and those attending specialist settings mandate the need for approaches based and developed in primary care.[109-111] The different reality of presentations in primary care makes

diagnostic decision making difficult and argues strongly for the futility of sub-categorization of psychiatric presentations in primary care. The failure to recognize and label psychiatric disorders in primary care has often been blamed on poor education and skill among GPs. Psychiatrists who regularly work in primary care appreciate the complexity of the task. Psychiatrists would also misclassify patients, for reasons mentioned, if their diagnostic skills are compared against standardized interview schedules in primary care settings. The minority of patients who present to primary care with specific classical and identifiable psychiatric syndromes are treated with symptomatic treatments, arguing against the usefulness of diagnostic sub-categorization.

The advantages of an approach which does not sub-categorize non-psychotic psychiatric presentations in primary care include the following:[109-111]

(i) The use of neutral diagnostic labels reduces stigma associated with psychiatric terms. Terms like "functional somatic symptoms," "unexplained medical symptoms," and "somatic symptom disorder" more accurately describe such cases and should be preferred to "somatization" which rewords the same phenomenon in psychiatric jargon
(ii) It avoids the distress/disease controversy
(iii) It avoids the threshold debate separating distress and disease
(iv) The identification of multiple diagnostic heads due to the high correlation between traditional categories will be avoided
(v) It focuses on holistic approach rather than symptom checklist.

The approach advocated argues that the symptom presentation be treated without labels. However, such an approach would go against medical tradition. Nevertheless, the mixed emotional states and the arbitrary divisions make psychiatric classification, especially when applied in primary care, much less meaningful, making such an approach worthwhile. This approach is complemented by the use of common and general management protocols, which are currently employed by skilled physicians.[140,141]

The use of antidepressant medication as a panacea for all types of depression has been recently challenged, arguing against the concept of using disease categories for mild and moderate common mental disorder.[152] Their role in mild to moderate depression has been questioned and the more recent guidelines do not recommend pharmacological interventions for these conditions.[153]

## CONCLUSION

Strategies suggested are based on the arguments that it is difficult to sub-categorize clinical presentations of common mental disorders in primary care and that current psychiatric treatments are essentially symptomatic and are delivered across diagnostic categories. It supports the contention that the presentations currently labeled anxiety, depression, or common mental disorders in primary care are illness experiences, which do not require disease labels. It makes a case for the provision of support without medicalizing the issues. It also suggests that the standards for medical practice should be based on the issues as seen in primary care rather than those employed in tertiary and specialist settings.

The focus on clinical presentations without diagnosis and the symptomatic management of people with emotional distress who present to primary care are complimentary.[109-111] These approaches are not new and describe the current practice among competent physicians in primary care. Recent concepts and interventions, based on specialist perspectives, have not only complicated the issues but also have disempowered GPs with psychiatric jargon and techniques, which are impractical and counterproductive in primary care settings. The reality of primary care, its problems and opportunities demand unique solutions. Transplanting knowledge structure, formations, and practices developed and employed in tertiary care and specialist facilities results in a lack of goodness of fit.[109-111] Context and local knowledge are critical to understanding illness in primary care. Universal abstractions may not fit local reality and artificially force structures. Primary care should be able to chose a different framework for the management of psychiatric and emotional problems. Contexts not only can change medical practice, but also should be able to change medical perspectives.

The ICD-10[119] for Primary Care, a simplified version of the main ICD-10,[137] which had common psychiatric diagnosis seen in primary care and which corresponded with the specialist version, was practically unknown and unused in primary care practice around the world. A similar fate awaits all tertiary care formats imposed on primary care and will result in the DSM-5 being "often praised but seldom practiced" in primary care (unless enforced by insurance industry when they will employed mechanistically to claim reimbursement).

The complexity of the issues related to the diagnosis and management of such presentations demand a re-evaluation of the issues. The alternative approaches have to be rooted in primary care in order that they are useful and can be successfully employed.

## DIAGNOSTIC AND STATISTICAL MANUAL-5 DIAGNOSIS IN THE COMMUNITY

Although DSM-5 will be work in progress, it is bound to be treated as authoritative text by many. Its categories, which are to be essentially used in tertiary and specialist settings, will be employed in other contexts – the community, primary and secondary care. Data from India mandate caution in

using specialist criteria from being directly employed in the community, in people who do not complain about their symptoms and whose relatives do not suggest abnormality. It also cautions against using diagnostic categories across cultures. It suggests that minor differences in operational definitions have significant impact on recognition, and consequently prevalence. The study and the issues are briefly discussed.

Dementia is a cause of significant burden across countries and cultures. Many issues related to mental health problems among older people living in low- and middle-income countries (LMIC) have been highlighted in literature. However, much of the work in LMIC examines the issues through western–international perspectives. The dearth of local contextually relevant investigations forces academics to rely on universal facts and concepts, discounting uniqueness of the context and cultures.

There have been many studies on dementia among older people living in India. Many issues have been systematically examined, instruments developed and validated, and the nature of cognitive impairment, its prevalence, and risk factors identified.[154] Many other investigations have also examined these issues in different parts of the country.[155-159] However, these investigations unquestioningly employed standard western perspectives.

## Vellore data

Vellore was part of the 10/66 Dementia Research Group (10/66 DRG),[160] which is the Alzheimer's Disease International's (ADI)[161] effort to bring together researchers based around the globe. Investigators from diverse centers in different countries in Asia, Africa, and Latin America used common and standard methodology to study issues. Many papers arising from the effort have been published as part of the 10/66 DRG publications.

## Diagnostic dilemmas

Community surveys have documented different prevalence rates for dementia.[162,163] The 10/66 DRG tested a variety of instruments individually and in combination to identify dementia in over 25 centers.[164] They employed Community Screening Instrument for Dementia (CSID),[165] Geriatric Mental State (GMS),[166,167] and CERAD 10-word-list-learning-task[168] in a single package. The algorithm identified 94% of dementia cases with false-positive rates of 15%, 3%, and 6% in the depression, high-education, and low-education groups, respectively.[164] The procedure worked equally well in Indian, Chinese, and Latin American centers, in dealing effectively with different educational levels and coping well with the effects of language and culture. The 10/66 DRG developed computer algorithms for diagnoses.[164,169]

Despite the sophistication of the 10/66 DRG approach, the Vellore data, analysis, and interpretation argue that major issues are brushed under the carpet.[170,171] One thousand older subjects living in the community were evaluated in detail. The prevalence of dementia at Vellore was 0.8%, 10.6%, 21.2%, and 63% using DSM-IV,[37] Education adjusted 10/66 algorithm,[169] 10/66 Lancet algorithm,[164] and GMS AGECAT,[166,167] respectively.

The wide range of prevalence in the same population mandates review. Information and criterion variance contribute to variations in the identification and prevalence rates of dementia. However, while there is agreement on the major criteria for diagnosis, even minor variations in information and criteria result in substantial variations in prevalence rates and in the people identified.[170] How do we arrive at best criteria, which produce true prevalence rates? How do we define the threshold for the age-related cognitive decline–mild cognitive impairment-dementia spectrum?

The symptoms of dementia and depression in late life are considered part of normal aging in India and are not perceived as requiring medical care.[172] Primary health physicians in India rarely see dementia in their clinical work while community health workers can recall many individuals with such conditions. Many informants in this study did not complain of problems, although their older relatives had significant cognitive impairment. The high levels of tolerance of such symptoms and disability is due to the low levels of expectation of older people in India, many of whom continue to live with their relative in large extended/joint families. This has a significant impact on the diagnosis, as reporting deterioration of social and occupational functioning is mandatory for a diagnosis of dementia by DSM criteria.[37]

The variation in prevalence rates demands a debate on the criteria for dementia in the community in general and for less literate populations in India in particular.[170] Can criteria employed in patients with symptoms who are brought to hospitals be employed in patients living in the community who have not sought treatment for symptoms or whose relatives have not considered symptoms as abnormal? Can criteria designed for specialist and tertiary centers, which manage patients who have passed through a referral system, be employed in the community? Should different populations have specific tailor-made criteria (e.g., adjusted for education, age, etc.,) to diagnose the condition? Should we factor in the informant's ability to recognize abnormality and their tolerance of symptoms in assessing dementia? Should baseline function be accounted and should reporting impairment in occupational and social function be mandatory for a diagnosis?

## Comments

This study employed standard international protocols to evaluate cognitive function. Minor and major variations in

diagnostic criteria resulted in wide variation in prevalence rate in the same population. The results of the study raise the following questions:

(i) Can criteria employed in specialist practice be used in the community?
(ii) Can criteria used to assess people brought to hospital with symptoms be employed in people living in the community whose relatives do not complain of deficits?
(iii) Can criteria for diagnosis be employed across cultures, which place different emphasis on tolerance of symptoms and respect for older people?
(iv) Can the same diagnostic criteria be employed in literate and less literate population?

The results of the study demand caution in using the same criteria across different settings and cultures.[173] This is probably also true for categories other than dementia.

## PRACTICAL ISSUES

Some of the proposed changes in DSM-5 criteria have major practical implications for a large country like India with its diverse regions, cultures, languages, religions, and ethnic groups. However, the lack of access to the DSM-5 text revision and the ambiguous nature of some of the current draft criteria make it difficult for definitive comments. For example:

1. The rationale of DSM-5 diagnosis of Intellectual Developmental Disorder clearly states that it should be diagnosed based both on clinical assessment and standardized testing of intelligence.[174] However, Intelligence Quotient levels are omitted from the criteria and are to be mentioned in the DSM-5 text revision
2. The role of neuropsychological testing in the diagnosis of DSM-5 major and mild neurocognitive disorders (i.e., dementia and mild cognitive impairment) is ambiguous. For example, criterion A2 states: "A decline in neurocognitive performance, typically involving test performance in the range of 2 or more standard deviations below appropriate norms on formal testing or equivalent clinical evaluation."[175] This criterion is ambiguous about the exact role of neuropsychological testing
3. The *Dhat* syndrome,[176] a common clinical presentation in South Asia and other countries, was mentioned in the DSM-IV appendix[37] on culture-bound syndromes. Maintaining its status in DSM-5 would encourage research into the cultural aspects of somatic symptom presentations
4. DSM-5 somatic symptom disorder[177] focuses on distressing somatic symptoms and related excessive thoughts, feelings, and behaviors, and deemphasizes the central role of medically unexplained symptoms. The conceptualization and criteria is an advance. However, it does not have any exclusion criteria for anxiety, depression, and mixed anxiety/depression. As these symptoms and syndromes commonly co-exist,[109] a hierarchy will prevent multiple co-morbid diagnosis
5. The proposal[178] to move mixed anxiety/depression[179,180] from Section III of the DSM to the main DSM-5 classification is welcome particularly for use in primary care and general medical practice.

## CONCLUSION

The development of the DSM-5 has been an exhaustive and elaborate exercise involving the review of DSM-IV categories, identifying new evidence and ideas, field testing, and revising issues in order that it is based on the best available evidence. However, the DSM-5 should serve a gate-keeping function, which intends to set minimum standards, and should not be considered the last word on the subject. It should be considered work in progress and will continue to evolve with the generation of new evidence. While the DSM-5 is essentially for the membership of the APA, its impact will be felt far beyond the boundaries of psychiatry and that of the United States of America. Its *atheoretical* approach, despite its pretensions, pushes a purely biomedical agenda to the exclusion of other approaches to mental health and illness. For the DSM-5 to be relevant and useful across the cultures and countries, it needs to be broad-based and consider social and cultural contexts, issues, and phenomena. The convergence and compatibility with ICD-11 is a worthy goal.

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