Book Reviews

J. Sloan Manning, M.D., Editor

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Primary Care Version

Washington, D.C., American Psychiatric Association, 1995, 223 pages, no price listed (paper).

Strong evidence exists that primary care physicians underdiagnose psychiatric disorders and substance abuse in their patients. Over half of patients with depression, for example, are misdiagnosed by their doctors.[1] The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Primary Care Version* (DSM-IV-PC) goes a long way toward helping doctors identify these common problems in their patients. Future editions would benefit from a number of revisions and additions that would help the primary care physician make correct diagnoses.

The authors of the DSM-IV-PC have managed to condense and rearrange the 800-page DSM-IV into a format that busy primary care physicians can easily use to help them diagnose psychiatric disorders. The manual is laid out so that the physician faced with a patient suffering from, say, depressed mood can turn to a "quick reference algorithm"—a flowchart with minimal diagnostic criteria and information—or to a section with more detailed information to begin considering likely diagnoses. Alternatively, the physician can go to an index, find a symptom, and be directed to several parts of the manual to explore various diagnostic possibilities. There is a separate chapter on the diagnosis of disorders typically first seen in infants, children, and adolescents.

All of the DSM-IV-PC algorithms begin by advising the physician to rule out medical illness or substance abuse as a cause of a patient's psychiatric symptoms. The manual includes a section on clues that will alert the physician to the possible presence of a medical masquerade of psychiatric symptoms. It would be wise to highlight and add to this section in future editions. Anyone using the DSM-IV-PC (or the DSM-IV, for that matter) must keep in mind that DSM-IV labels are not etiologic diagnoses. Patients with psychiatric symptoms need to have their physicians do a thoughtful and thorough differential diagnostic workup to rule out organic illness.

The flowcharts in the DSM-IV-PC are useful for helping the physician make diagnostic decisions. In future editions, the authors of the DSM-IV-PC should provide physicians with more specific advice on the type of information they need to gather to make an expert differential diagnosis. For example, it will be especially important to revise the depressed mood algorithm. Physicians should be explicitly advised to consider the possibility of bipolar disorder when a patient presents with symptoms of depression. As it now stands, step 1 of the depressed mood flowchart merely suggests that the physician consider "another mental disorder" to explain a patient's depressed mood. If the doctor does not consult the more detailed information after the flowchart and is not aware that a large proportion of affectively ill patients in primary care may suffer from bipolar illness,[2] he or she might diagnose a patient with bipolar depression as suffering from unipolar depression. This is a potentially serious error. Primary care physicians are prescribing antidepressants more often, and there is now a growing body of evidence that treating bipolar patients with antidepressants alone can adversely affect the nature and course of their illness. Antidepressants can induce mania in vulnerable individuals, precipitate rapid cycling and mixed states with irritability, and lead to treatment-refractory depression.[3,4]

Even if physicians consult the more detailed information following the flowchart and turn to the section on manic symptoms, the lack of information provided on unique signs of bipolar depression could lead them to fail to consider the diagnosis of bipolar disorder. The DSM-IV-PC authors make only brief mention of the need to look for "a history of elevated, expansive, or euphoric mood," and then direct physicians to the section on manic symptoms. It would be better if the manual first advised physicians to ask patients directly about periods of hypomania. Most patients view these periods as normal and will not spontaneously mention them.[5] In addition, the manual should advise physicians to interview family members. Bipolar disorder is underdiagnosed by a factor of 2 if family members are not interviewed.[6] Finally, other clues suggestive of bipolar depression should be mentioned in the manual: seasonal variation in symptoms (typically winter depression and summer hypomania), multiple generation family history of depression and irritable mood, stormy relationships, chaotic life histories, and, most importantly, the presence of atypical symptoms and psychomotor retardation.[7]

The flowchart for unexplained physical complaints should be revised so that the physician is advised to consider depressive illness as a diagnosis. As it now stands, the chart merely alludes to the need to consider another mental disorder and buries information about depression in the text, where the busy physician can easily overlook it.

The substance abuse algorithm could be improved as well. The algorithm advises physicians to consider substance abuse if there is a history of problematic use of alcohol or drugs. But what questions should they ask to determine if there has been problematic use? The DSM-IV criteria for substance abuse, at best, merely imply that physicians should look for persistent or recurrent social or interpersonal problems. The manual should

advise physicians to ask specific questions, such as, Has your spouse or boy/girlfriend ever complained about your drinking or your behavior when you drink? Do they ever say you get embarrassing, nasty, or depressed, for example? Have you ever decided to quit drinking or cut down on your drinking? Did you ever regret anything you said or did while drinking?

With added information on how to detect medical mimics of psychiatric symptoms, the importance of medical differential diagnosis, and how to diagnose substance abuse, this manual could fulfill a critical need for improved diagnostic skills in psychologists, social workers, marriage counselors, and employee assistance and substance abuse treatment professionals, as well as the primary care physician. Nonmedical therapists have not been trained to consider the possible role of medical illness in their patients' presenting symptoms. In addition, they are often not familiar with psychiatric differential diagnosis and the psychiatric conditions that are responsive to medication. A revised manual geared toward nonmedical therapists as well as primary care physicians would help improve the quality of mental health diagnosis and treatment across the board.

References

1. Rodin G, Craven J, Littlefield C. Depression in the Medically Ill: An Integrated Approach. New York, NY: Brunner/Mazel; 1991
2. Manning JS, Haykal RF, Connor PD, et al. On the nature of depressive and anxious states in a family practice setting: the high prevalence of bipolar II and related disorders in a cohort followed longitudinally. Compr Psychiatry 1997;38:102–108
3. Altschuler LL, Post RM, Leverich GS, et al. Antidepressant-induced mania and cycle acceleration: a controversy revisited. Am J Psychiatry 1995;152:1130–1138
4. Akiskal HS. Dysthymic and cyclothymic depressions: therapeutic implications. J Clin Psychiatry 1994;55(suppl 4):46–52
5. Bowden CL. The clinical approach to the differential diagnosis of bipolar disorder. Psychiatr Ann 1993;23:57–63
6. Goodwin FK, Jamison KR. Manic-Depressive Illness. New York, NY: Oxford University Press; 1990
7. Akiskal HS. The milder spectrum of bipolar disorders: diagnostic, characterologic and pharmacologic aspects. Psychiatr Ann 1987;17:32–37

Brian P. Quinn, C.S.W., Ph.D.
Huntington, New York

Two Perspectives

The Depression Sourcebook

by Brian P. Quinn, C.S.W., Ph.D. Lincolnwood, Ill., Lowell House, 1998, 266 pages, $17.00 (paper).

From the Physician…

The pervasiveness of mood disorders is striking and well known to primary care practitioners. Treatment of these disorders is complicated by lack of public awareness about and prejudice against admitting to having such a condition. For example, the single mother who saw me last week to treat her child's attention deficit had attributed the last 5 years of intense mood swings to the stress of raising a hyperactive child. It is Dr. Quinn's admirable ambition to clear up some of this confusion for lay people. While writing from a strongly biological perspective, he commits to giving a balanced view of varied approaches including pharmacologic, psychotherapeutic, and natural. A prime goal of this education is to "give the reader hope" that his or her symptoms are treatable and can be greatly improved, if not cured. This is a worthy ambition, partly realized, but falls short of the ideal.

The first chapters, which attempt to orient the reader to the variety of mood disorders, need better organization. The book is liable to be of limited use to patients seeking to get acquainted with mood disorders for the first time or to answer the question that these chapters seem to address, namely, "Could I have a medical problem, and if so, what type?" Even to one familiar with the broad categories of these illnesses, the outline is perplexing and lacking parallelism, blurring the distinctions between diagnoses. It would have been better first to define, say, bipolar disorder and cyclothymia clearly, before showing how the boundaries between them are not always clear.

There is also a lack of conscious acknowledgment of the fuzzy border between normal and abnormal. This distinction is implicit in the biographical sketches of historical figures and modern celebrities, but the big question lingers. What separates illness, which should be treated medically, from character and life trials, which demand effort and force of will to overcome? This issue is not explicitly addressed. Van Gogh may not have died so early if he had taken lithium instead of absinthe, but would the world have seen *The Starry Night*? In treating individuals in distress, the ethical responsibility of the mental health provider is clear, but what are the cultural and societal consequences of taking a biological, largely deterministic approach to these types of problems? Such a discussion is beyond Dr. Quinn's scope. The book leaves me with a nagging feeling that we are at risk of losing the mystery and heroism of the human struggle.

In looking at the array of different approaches to these problems, the book will be more helpful to sophisticated readers already diagnosed (or having a family member diagnosed) with a mood disorder. At times, Dr. Quinn is a little strident. The chapter "Medication for Depression" takes the point of view that each imagined question or doubt about the pharmacologic approach can be dismissed quickly. But on the whole, a variety of approaches are described in detail and with respect, without weakening the author's argument for the power and safety of biological methods. The self-help chapter is long and involved with largely helpful tips about coping with difficult circumstances. The Appendix is a good source for resources and support groups. The book is replete with case histories, which illustrate well the complexities of these illnesses. The case histories work to call attention to the nuances of these illnesses and the difficulty of arriving at a proper diagnosis, but may be difficult for the first-time reader to penetrate, as they do not always describe "classic" symptoms. The histories could also have been amplified to add strength to the argument for the biological approach—the case reports of the early chapters, dealing with diagnosis, should have been concluded in the chapters on medication. Were these patients helped once their illness was properly diagnosed and treated with right therapy?

Finally, the *Sourcebook* has a flaw that may make it hard for primary care physicians and nurse practitioners to recommend it to their patients. Dr. Quinn does not recognize these types of providers as partners in the process of treating depressed patients. There is much to be done to upgrade training programs in this area, but the need to include primary caregivers as legiti-

mate therapists is unavoidable. First, there are just too many patients. Dr. Quinn reflects his sense that even many mental health professionals miss the boat with mood disorder patients, and his case histories serve to prove this point. He openly advocates seeking help from psychiatrists with special interest and skills in treating mood disorders. One can't help but wonder how many hours a week they would need to work in order to see all these patients. Most patients will present to primary care long before they recognize the need for mental health help. The presence of overlap syndromes such as chronic fatigue and pain syndromes is not well acknowledged in this volume. These disorders, as well as problems with "nerves," will continue to be frequently presenting complaints to medical caregivers. Many of these patients will continue to feel more comfortable getting care for these problems with their regular medical providers. Also, psychiatrists often need help in managing medications in the medically complex patient. There is clearly a great deal of work yet to do, not only in educating patients about depression and associated conditions, but also in educating a broad array of practitioners and in finding the best strategies for cooperation.

Joshua Gettinger, M.D.
Madisonville, Tennessee

From the Patient…

When first diagnosed with bipolar disorder, I immediately went into denial because I felt it was a grave flaw in my personality. The fact that I might have to take medication the rest of my life scared me. I set out to prove the diagnosis false. A year later (a turbulent one, I might add), I was beginning to take steps toward proper treatment. Over the years, I have gained greater knowledge about my condition. Just being able to identify with someone with the illness has helped fight the stigmas.

My doctor recently gave me a copy of *The Depression Sourcebook*. I would recommend that people suffering from mood disorders take the time to read this book. It reads facilely and is loaded with extremely beneficial information. Although the book has a simplistic quality, its insights into depressive illness are not. The explanations are sound. In the introduction, Dr. Quinn explicitly states his goals to (1) help readers determine if they suffer from a depressive illness, (2) provide a resource of information for patients and doctors, (3) offer insight into various approaches to treatment, and (4) give hope.

The directness with which Dr. Quinn has stated his goals is similar to the direct approach he uses to write the book. The outlining style allows use of this resource as a reference guide. For example, frequently asked questions are italicized. Most importantly, Dr. Quinn provides clear descriptions of the illness. He emphasizes the need to be aware of depression, its various causes, and the wide range of solutions. Also provided is an excellent guideline for patients to use when searching for help. The author wants people to be aware of themselves and the doctors with whom they are entrusting their well-being.

From a patient's point of view, Dr. Quinn's approach to describing depressive illness is strong and fascinating. The repetition of symptoms and the various scenarios act as an effective teaching aid. The reader is taken step-by-step through the onset of depression and how it may deepen if not treated properly. Hypothetical situations make for interesting reading, but the use of misplaced pronouns weakens the writing. That, however, is of minor importance in comparison to the valuable information provided.

The descriptions of how others may perceive the actions of those suffering from the illness are personally comforting. I have been given a glimpse of myself through different eyes. I want my family to read the book so they can better understand what is happening to me and why. It is important to have those closest to me aware of the illness and break down their misconceptions.

Yancey Allison
Memphis, Tennessee