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PSYCHIATRY IN PRIMARY CARE (BN GAYNES, SECTION EDITOR)

What Should Primary Care Providers Know About the Changes in DSM-5?

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Abstract Primary care providers are increasingly involved in the management of patients with mental disorders, particularly as integrated models of care emerge. The recent publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) represents a shift in the classification of several mental disorders commonly encountered by primary care providers. With the advent of ICD-10 and the movement toward diagnostic specificity, it is crucial that primary care providers understand the rationale behind these changes. This paper provides an overview of the changes in the classification of mental disorders in DSM-5, a description of how these changes relate to frequently used screening tools in the primary care setting, and a critique of how these changes will affect mental health practice from a primary care perspective.

Keywords DSM-5 · Primary care · Classification · Mental disorders

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Introduction

The Diagnostic and Statistical Manual of Mental Disorders (DSM) has long been regarded as the preeminent source for classifying mental disorders in the USA. Although the primary target for the DSM has been mental health specialists, primary care providers represent another important audience for the manual. In 2013, nearly 20 years after its last major revision, the American Psychiatric Association published the Fifth Edition of the DSM (DSM-5) [1], which included several structural and diagnostic changes. Given that primary care providers are commonly the first to diagnose and treat mental disorders [2], familiarity with an expert-derived classification system is important for reliable, scientifically grounded diagnoses of mental disorders in primary care. Primary care providers also increasingly co-manage patients with mental health specialists as part of integrated mental health care systems [3, 4]. Accordingly, a shared understanding of the latest changes in the DSM classification system is essential to optimizing communication with mental health specialists. The DSM has also provided the basis for many screening and diagnostic instruments used to detect mental disorders in primary care. Understanding the classification system that underlies these instruments represents another important reason why primary care providers benefit from becoming familiar with DSM-5.

The goal of this article is to provide an overview of the changes in DSM-5 that are most pertinent to primary care providers. We begin by describing the major structural changes in the DSM-5 classification system (Table 1). We next describe changes in the classification of those mental disorders that are commonly seen in primary care (Table 2). The release of DSM-5 was met with substantial controversy and criticism with some arguing that the changes from DSM-IV were too conservative and others arguing that the changes went too far in changing previous diagnostic criteria [5•, 6,

Table 1 Comparison of the structure of the DSM-IV and DSM-5 diagnostic classification systems

Characteristic	DSM-IV	DSM5
Year published	1994	2013
Approach to diagnostic classification	Categorical approach (i.e., disorder present or absent) Multiaxial system: Axis 1, primary mental disorders; Axis II, personality disorders; Axis III, general medical conditions; Axis IV, psychosocial factors contributing to disorder; Axis V, global assessment of functioning	Integrates a dimensional approach where possible (i.e., clinician determines severity of a disorder) Elimination of axial system: personality disorders (previously Axis II) becomes a distinct chapter, and Axes IV and V are eliminated
Number of diagnoses	172	152; combined certain disorders by describing them across a spectrum and using specifiers to denote severity
Childhood mental disorders	Distinct section	Included within chapter for which the childhood disorder is most closely related

Table 2 Major changes in the classification of specific mental disorders in DSM-5

Mental disorder	DSM-IV	DSM-5
Neurodevelopmental disorders	Pervasive developmental disorder Mental retardation	Autism spectrum disorder with replacement of subcategories of pervasive developmental disorders (i.e., Asperger's, childhood disintegration disorder, and pervasive developmental disorder NOS) with severity specifiers Renamed as intellectual disability (intellectual developmental disorders)
Bipolar and related disorders	Bipolar disorder Mixed episode	Period of persistently increased goal-directed activity or energy added as a cardinal symptom of mania. Use of antidepressants prior to onset of mania no longer an exclusion criteria for diagnosis of bipolar disorder Mixed episode is replaced by choosing depressive disorder or mania as primary diagnosis and then adding specifier "with mixed features"
Depressive disorders	Major depressive disorder is excluded if bereavement within 2 months of symptoms Dysthymia Premenstrual dysphoric disorder is an exploratory diagnosis only referenced in Appendix	Bereavement is no longer an exclusion criteria for major depressive disorder Renamed persistent depressive disorder Premenstrual dysphoric disorder is a distinct disorder included in the main chapter
Anxiety disorders	Self-recognition of excessive anxiety required for diagnosis Agoraphobia only diagnosed in conjunction with panic disorder Panic attacks are discrete diagnoses	Clinician but not patient recognition of excessive anxiety required for diagnosis Agoraphobia a distinct disorder Panic attacks can be added as specifier to any other diagnosis
Trauma and stressor-related disorders	Included within chapter on anxiety disorders Acute stress disorder (ASD) and post-traumatic stress disorder (PTSD) require recall of intense fear or helplessness at time of trauma for diagnosis PTSD comprised of three cardinal symptom clusters: 1) reexperiencing, 2) hypervigilance, 3) avoidance and numbing	Separate chapter, adjacent to chapter on anxiety disorders ASD and PTSD no longer require recall of intense fear or helplessness at time of trauma for diagnosis PTSD comprised of four cardinal symptom clusters: 1) reexperiencing, 2) hypervigilance, 3) avoidance, 4) increased negativity or numbing
Somatic symptom and related disorders	Somatoform cluster comprised of somatization disorder, hypochondriasis, pain disorder, undifferentiated	Replaced by somatic symptom disorder and illness anxiety disorder; somatic symptom disorder diagnosed irrespective of identifiable organic etiology for symptoms
Substance-related and addictive disorders	Substance abuse and dependence are two distinct disorders	Replaced by substance use disorder with specifiers for severity; dependence no longer sufficient for diagnosis of a substance-related disorder

7]. We conclude by sharing the primary care provider's perspective on major critiques of the newest version of the DSM. This article is aimed at primary care providers who wish to understand how to incorporate key changes in the DSM into their practice. At the same time, it is hoped that this article will appeal to mental health specialists who wish to increase their understanding of the primary care perspective on DSM-5.

Major Structural Changes in DSM-5

Structural changes in DSM-5 were intended to reflect changes in psychiatry's understanding of mental disorders. Many of these changes are appealing from a primary care provider's perspective. To begin with, the title of the book changed from DSM-IV to DSM-5. The removal of the roman numerals was a conscious effort to give the manual a more accessible name and to lay the groundwork for a new system in which minor updates would be added in editions 5.1, 5.2, etc. [8]. In addition, the manual's section on diagnostic coding (Section II) is now organized into 18 chapters, beginning with neurodevelopmental disorders and ending with personality disorders, such that categories of disorders that are thought to be phenomenologically related are adjacent to one another. For example, schizophrenia spectrum and other psychotic disorders are followed by bipolar and related disorders to reflect the overlapping features between bipolar disorder and psychotic illness. Another change in the organization of the manual is that instead of locating childhood disorders in a separate section, these disorders are now located within the chapter in which the disorder is most closely linked. For example, separation anxiety disorders are now located in the chapter on anxiety disorders.

Another significant structural change in DSM-5 was the elimination of the multiaxial system. The previous 5-axial system was foreign to the rest of medicine and contributed to a communication barrier between primary care and mental health specialists. In DSM-IV, axis I disorders comprised the so-called primary mental disorders such as major depressive disorder, schizophrenia, and substance use disorders. Axis II referred to personality disorders and intellectual disability, Axis III referred to general medical conditions, Axis IV referred to psychosocial factors contributing to illness, and axis V was called the "global assessment of functioning." In DSM-5, Axis III on medical conditions is combined with the first two axes on mental disorders such that medical disorders and personality disorders are considered on par with mental disorders. Axis IV and V are removed. As a result, DSM-5 now classifies disorders in a similar manner as the primary care approach with medical and mental disorders considered as comorbid conditions. This approach is also consistent with the World Health Organization's International Classification of Disease (ICD) system which primary care providers use for billing and coding purposes. Overall, the structural changes to DSM-5 ensure that the manual more closely resembles the medical approach to classifying illnesses and increase the accessibility of the manual to primary care providers and their patients.

Major Changes to Classifying Specific Mental Disorders

Changes in the classification of specific mental disorders in DSM-5 were intended to address major concerns with prior editions, particularly the high rate of co-occurrence of mental disorders also known as "diagnostic overlap", the frequent use of the "not otherwise specified" designation, and the heterogeneous mix of clinical presentations that fit within specific diagnoses [9]. As will be elaborated below, DSM-5 sought to address these concerns by combining certain psychiatric disorders into fewer categories and by describing certain disorders across a spectrum using specifiers to denote levels of severity and specific features of illness [10, 11]. These changes resulted in an overall decrease in the number of diagnoses from 172 to 152 [12]. While not a major decrease from prior versions, DSM-5 is the first edition with fewer diagnoses than its predecessor. This increase in parsimony is appealing to primary care providers who are challenged by remembering the details of numerous categories.

DSM-5 also sought to alter diagnostic criteria across the manual to better apply to diverse cultures. For instance, the criteria for social anxiety disorder now includes the fear of "offending others" to reflect the Japanese concept in which avoiding harm to others is emphasized rather than harm to self. Primary care physicians frequently encounter patients from diverse racial, cultural, and ethnic backgrounds and understand that context is often integral to accurate diagnosis. Accordingly, these modifications in the manual are welcomed by primary care providers. Additional details on changes in the classification of mental disorders most relevant to primary care providers are described below.

Neurodevelopmental Disorders

Family practitioners and pediatricians are commonly the first providers to identify neurodevelopmental disorders in children. A major change in the classification of these disorders in DSM-5 was the replacement of the category of pervasive development disorder with autism spectrum disorder and the elimination of subcategories of pervasive developmental disorders (autistic disorder, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified) in favor of dimensional specifiers used to signify level of severity [13•]. These changes were consistent with DSM-5's aim to decrease the total number of diagnostic categories and move toward a dimensional approach that viewed mental disorders as existing along a continuum of severity as opposed to a categorical approach that defined disorders as present or absent [14]. Changes in the

classification of neurodevelopmental disorders led to concerns that certain high-functioning patients would no longer be classified as having a neurodevelopmental disorder (i.e., would be "off the spectrum") and could lose their eligibility for special education or other services [15]. As DSM-5 criteria take hold, primary care providers who care for patients with these disorders should be on the lookout for changes in eligibility for needed services and should be prepared to advocate for their patients when necessary.

Another significant change in the neurodevelopmental disorders chapter was the change in nomenclature for patients with cognitive impairments. In DSM-5, the term "mental retardation" was replaced with the term "intellectual disability (intellectual development disorder)." Intellectual disability is the term accepted by other medical professionals, the lay public, and advocacy groups in the USA, and the term intellectual development disorder is the term planned for ICD-11. This change in nomenclature is another example in which terminology used in DSM-5 is more in line with primary care, which should facilitate communication between the fields.

Bipolar and Related Disorders

Many primary care providers are responsible for diagnosing and treating bipolar disorder, particularly in regions with poor access to mental health specialists [16]. Prior to DSM-5, many patients were erroneously labeled with bipolar disorder [17]. To improve the specificity of a bipolar diagnosis, DSM-5 added persistently increased, goal-directed activity or energy for a distinct period of time as a cardinal symptom of mania. The other cardinal symptoms remain elation/euphoric and/or irritable mood [13•]. Although some have criticized this change as not being evidence-based and have expressed concern for an increase in the number of patients without a specific diagnosis (now referred to as "not elsewhere classified") [18], this change represents one instance where DSM-5 sought to increase the specificity of diagnosis and is particularly relevant to primary care providers. Recognizing bipolar disorder in patients presenting with depressive or anxiety disorder is important because the course of illness and treatment greatly differ. Yet, many primary care providers find it challenging to delineate manic periods from normal fluctuations in mood, and screening instruments based on DSM-IV criteria greatly overestimated the occurrence of bipolar disorder in primary care [19]. By encouraging providers to ask about periods with heightened energy combined with a decreased need for sleep may be helpful to primary care providers seeking to rule out bipolar disorder among patients presenting with depressive symptoms.

Another significant change in the classification of bipolar disorder is that patients who develop a manic episode while on treatment with conventional antidepressants are no longer excluded from a bipolar disorder diagnosis. This change is well-grounded in research showing that antidepressant-associated manic responses occur in up to 8 % of depressed patients treated with antidepressants, and bipolar symptoms commonly persist even after stopping antidepressant treatment [20, 21]. Primary care providers who elicit a history or observe manic symptoms among patients prescribed antidepressants should now consider bipolar disorder a likely diagnosis. This represents one example of how familiarization with changes in DSM-5 criteria can translate new discoveries in the understanding of a mental disorder into better care by primary care providers.

Finally, DSM-5 replaces the diagnosis of "mixed episode," which required a patient to concurrently meet criteria for both mania and major depression episodes, with a "mixed features specifier" that can be applied to episodes of major depression, hypomania, or mania. For instance, if a patient is predominantly depressed, a mixed features specifier can be included if a patient has at least three concurrent manic or hypomanic symptoms. This may allow physicians to more accurately diagnose patients with subsyndromal mixed symptoms and to better tailor treatment. This may aid primary care physicians, in particular, to better recognize and more closely monitor unipolar patients with concurrent symptoms who have an increased risk of progression to bipolar disorder, which is remarkably underdiagnosed in the primary care setting [22, 23].

Depressive Disorders

Since the publication of DSM-IV in 1994, there has been growing recognition of the importance of identifying depression in primary care. Depression screening is recommended by the US Preventive Services Task Force and is being adopted in multiple healthcare systems [24]. The main change in the classification of major depression, one that will not affect screening instruments frequently used by primary care providers like the Patient Health Questionnaire (PHQ-9) [25], is that bereavement of less than 2-months duration is no longer an exclusion criteria for diagnosing major depression. DSM-5 recognizes bereavement as a severe psychosocial stressor that can precipitate a major depressive episode in a vulnerable individual, particularly among those with a family history. In addition, people who suffered from all of the symptoms of depression in the context of bereavement have similar responses to treatment as non-bereavement-related depression [26]. It remains unclear to what extent the removal of the bereavement exclusion will produce an increased prevalence of major depressive disorder, as clinically significant symptoms must be combined with significant functional, social, or

occupational impairment to make an accurate diagnosis [27, 28].

Nevertheless, there have been concerns that this change will increase the number of individuals who are unnecessarily labeled with and treated for depression [29]. From the primary care provider's perspective, where underdiagnosis remains a major concern, this broadening of the criteria for a depression diagnosis may serve to increase awareness for significant emotional suffering following the loss of loved ones and may remove a barrier toward helping patients avail themselves of empirically validated and safe behavioral and/or pharmacologic treatments for depression in a timely manner.

Another change in the depressive disorders chapter of interest to primary care providers is the renaming of dysthymia as persistent depressive disorder. Also of relevance, premenstrual dysphoric disorder is now included in this chapter as a distinct depressive disorder rather than being relegated to the Appendix. This change was based on the significant advancement of epidemiologic research that had been conducted since DSM-IV [30]. Finally, DSM-5 now includes an option for an anxiety specifier for patients who have prominent anxious symptoms, a phenotype commonly seen in primary care. Given the frequent comorbidity of depression and anxiety as a single presentation, this specifier allows physicians to diagnose depression as the primary disorder and to acknowledge the anxious features that are so commonly paired with a major depressive episode without having to give two diagnoses.

Anxiety Disorders

The chapter on anxiety disorders no longer includes posttraumatic stress disorder (PTSD), acute stress disorder (ASD), or obsessive-compulsive disorder (OCD). Within the remaining anxiety disorders (i.e., panic disorder, agoraphobia, specific phobia, social anxiety disorder), self-recognition of excessive anxiety is no longer required for an anxiety diagnosis. Instead, in DSM-5, clinicians are expected to judge whether fear is out of proportion to actual danger or threat while accounting for cultural contexts. This change was based on observations that many patients overestimate danger and that older patients often misattribute specific phobic fears to aging and hence may not view anxiety that is impairing their function as excessive [5•, 13•].

Another substantial change to DSM-5 is that agoraphobia and panic disorder are classified as separate diagnoses. In prior editions, one could not be classified as having agoraphobia without coexisting panic disorder. This change was based on data showing that a number of individuals have isolated agoraphobia [13•]. Furthermore, it is now recognized that panic attacks can occur alongside mental disorders other than panic disorder. Though more commonly associated with some mental disorders than others, the presence of panic attacks can now be listed as a specifier to any DSM-5 disorder [13•]. This change implies that primary care providers should be attuned to symptoms of panic attacks even among patients with established diagnoses of mental disorders.

Trauma and Stressor-Related Disorders

Trauma and stressor-related disorders, including PTSD and ASD, now get their own chapter in DSM-5 as they are now viewed as disorders of fear extinction in relation to specific traumatic events. Trauma-related diagnoses have undergone significant changes in how they are diagnosed. The most substantial change is that ASD and PTSD no longer require patients to report an experience of intense fear or helplessness at the time of the trauma. This change was based on epidemiologic data showing that PTSD symptoms commonly ensued irrespective of these memories. Additionally, studies have shown that patients with PTSD often present with negative affective symptoms such as anger, shame, and guilt [31]. Accordingly, PTSD now encompasses four symptom clusters instead of three: reexperiencing of the traumatic event, alterations in arousal or reactivity, avoidance of anything associated with the trauma, and increased negativity or numbed emotional responses. These changes have been substantive enough to lead to revisions in the instruments commonly used to screen for PTSD in primary care settings such as the PTSD checklist for DSM-5 (PCL5) [32, 33]. PTSD is both common and under-recognized in the primary care setting [34, 35]. By providing a summary of the common symptoms of PTSD, DSM-5 can familiarize primary care providers with the most up-to-date understanding of its core symptoms.

Somatic Symptom and Related Disorders

Somatic symptoms are among the most frequent reasons patients seek advice from primary care providers [36]. These presentations are particularly challenging when the symptoms are medically unexplained and cause significant emotional distress. Primary care providers struggled to recall the criteria for DSM-IV's somatoform cluster (somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder) and, perhaps mindful of the negative association attached to symptoms without an underlying cause, rarely applied these diagnostic labels [37•]. DSM-5 is appealing in that it replaced the confusing cluster of somatoform disorders with two clearly delineated diagnoses: (1) somatic symptom disorder for patients with distressing somatic symptoms and (2) illness anxiety disorder for patients with marked fear of developing an illness but no severe somatic symptoms per se. In doing so, DSM-5 appropriately acknowledged the complex

bidirectional relationship between medical and psychiatric illness [13•]. Instead of putting the clinician in the uncomfortable position of determining whether symptoms do or do not stem from a medical disorder in order to make a psychiatric diagnosis, the somatic symptom disorder diagnosis focuses on the requirement for somatic symptoms to be accompanied by maladaptive thoughts, feelings, and behaviors for diagnosis, regardless of the underlying cause. This approach may be helpful for destigmatizing patients who suffer emotionally from somatic symptoms and may lead primary care providers to be more likely to use the somatic symptoms disorder diagnosis and, more importantly, to seek to link these patients to mental health treatment.

Substance-Related and Addictive Disorders

A major change in this chapter is that DSM-5 no longer separates substance abuse and dependence into two disorders but rather combines them into a single diagnostic category called substance use disorder along a dimensional spectrum including mild, moderate, and severe. There are many primary care patients who are physically dependent on prescription drugs such as opioids and benzodiazepines for treatment of chronic pain or other neurological disorders but who do not otherwise evince properties of a mental disorder. The recognition that dependence, alone, is not necessarily indicative of a disorder is appealing to primary care providers. Other significant changes to this section included the removal of "recurrent legal problems" and the addition of "craving or a strong desire to use a substance" as criteria for a substance use disorder.

Criticisms of DSM-5

There have been two major currents underlying criticisms of the changes in DSM-5 in the field of psychiatry [38]. On the one hand, some mental health specialists were disappointed that the DSM-5 classification system did not sufficiently distinguish itself from prior versions [39]. When the American Psychiatric Association began planning for DSM-5 in the late 1990s, there were tremendous advances in neuroimaging and genetics that fostered expectations for dramatic improvements in understanding the biological causes of mental disorders [40]. These advances fostered hopes that DSM-5 could mark the transition in the field of mental disorder classification from one that relied upon patient-reported symptoms to one that relied upon an understanding of dysregulations in biological systems. By the time DSM-5 was released, the National Institute of Mental Health (NIMH) was promoting a classification system that was based on an understanding of biological dysregulations and that was untethered from the DSM classification system [41].

While the approach taken by NIMH may make sense for accelerating research into the biological causes of mental disorders, there has been consensus that the advances in the biological understandings of most mental disorders have been insufficient to justify a fundamental change in the approach to diagnosis in clinical settings [42]. Revealingly, other than the indication for polysomnography to classify sleep-wake disorders, diagnostic tests are not yet specific enough to be incorporated into DSM-5. Accordingly, despite early hopes that DSM-5 would transform how mental disorders were classified, the final published version continues to represent expert consensus on the taxonomy of symptoms underlying mental disorders. Primary care providers are likely to be comfortable with the DSM-5 approach as they commonly diagnose and treat conditions such as migraine or irritable bowel syndrome that lack definitive diagnostic tests or proven biological models.

While some of the critiques levied against DSM-5 conveyed concerns that it did not go far enough, others affirmed that the changes went too far. Many of these critics argued that changes in the criteria for many diagnoses were promoting "diagnostic inflation" and increasing the potential for providers to pathologize normal behavior [43, 44, 45•]. The removal of bereavement as an exclusion criterion for a diagnosis of major depression was commonly used to exemplify this. Other examples included no longer requiring patients to recall experiencing horror at the time of a traumatic event to be diagnosed with PTSD and no longer requiring patients to have medically unexplained symptoms to be diagnosed with somatic symptom disorder.

Concerns that changes in DSM-5 could increase the number of individuals eligible for and diagnosed with a mental disorder were accentuated by rapidly rising number of prescriptions for psychotropic medications [46] and financial conflicts of interest among the majority of the members of the DSM-5 writing groups [39]. Nearly 70 % of DSM-5 task force members reported ties to the pharmaceutical industry. Concerns about these conflicts of interest were tempered by the fact that DSM-5 panel members were required to report conflicts openly. Furthermore, there was an effort to make the entire DSM-5 writing process more public with draft versions of DSM-5 classification process made publicly available for debate during the writing process. Ultimately, it will be incumbent upon primary care providers to be judicious about diagnosing and prescribing medications for patients with symptoms of mental disorders. Increased collaboration with and access to mental health specialists who offer non-pharmacologic treatments may be particularly important to reducing adverse effects from psychotropic medications in primary care patients [47].

Another critique of DSM-5 of relevance to primary care providers is the fact that trials in which diagnostic criteria for DSM-5 were tested took place exclusively in mental health specialty settings. Hence, the reliability of the new criteria to the primary care setting remains relatively untested. Without this testing, it will be reasonable for primary care providers to

be concerned that a substantial proportion of primary care patients will continue to have subthreshold levels of psychological symptoms that do not qualify them for a DSM diagnosis [48]. Yet, these subthreshold symptoms have been shown to contribute to poor quality of life and impact self-management and prognosis from comorbid medical conditions, and are potentially treatable through behavioral or pharmacological approaches. The removal of certain exclusion criteria for diagnoses such as depression and PTSD in DSM-5 may have a modest impact on increasing the proportion of primary care patients who meet criteria for mental disorders. In the meantime, additional research and collaboration are needed between primary care providers and mental health specialists to learn how to best classify and comanage patients with subthreshold symptoms.

Conclusions

There are many changes in DSM-5 that are compatible with the primary care providers' perspective. The removal of the axial system that was foreign to primary care settings and served as a barrier to communication with specialists should facilitate collaboration with specialists. The removal of the axial system now allows the placement of medical and mental disorders to be on the same plane for medical and psychiatric providers. The simplification of the diagnostic approach to several psychiatric conditions including somatic symptom disorders, substance use disorder, and autism spectrum disorders is likely to increase the appropriate use of these diagnostic classifications as the uptake of DSM-5 increases in primary care.

Although some psychiatrists initially espoused resisting changes in DSM-5, mental health specialists who collaborate with primary care providers are likely to adopt DSM-5. Insurers are already changing their requirements to align with DSM-5. Mental health specialty board exams are also changing in response to DSM-5. Accordingly, primary care providers should feel confident that DSM-5 does indeed represent the new standard, and DSM-5 will form the basis for shared communication with mental health specialists in the years ahead.

How detailed an understanding of DSM-5 should primary care providers have? The US health care system is currently undergoing a transformation in how it codes the medical record with the implementation of the ICD-10 classification system [49]. The hope is that ICD-10 will engender increased specificity of diagnoses and that health service researchers will be able to leverage the increased specificity within electronic health records to conduct large pragmatic clinical trials and epidemiology. DSM-5 has sought to clearly link its diagnoses with ICD-10 and the forthcoming ICD-11. Yet, the potential benefits of this increased specificity will be missed if diagnoses are coded inappropriately. In this spirit, familiarity with the key criteria for diagnosing and coding mental disorders commonly seen in primary care should facilitate not only communication with specialists but also stronger health services research. Of note, ICD-10 last updated the criteria that correspond to its codes for mental disorders in 1992; many of these criteria are out of step with the current understanding of mental health specialists. Hence, primary care providers are well-served by relying upon the DSM-5 classification system to recall the criteria for mental disorders and should consider using DSM-5 to provide the appropriate link to ICD-10.

From the primary care provider's perspective, much like other areas of medicine, the DSM classification system is a work in progress. While there remain challenges in applying DSM criteria to obtain reliable diagnoses in primary care, DSM-5 does represent a substantial improvement over its predecessors. Familiarity with DSM-5 should help advance the mission of greater collaboration and integration between mental health specialists and primary care providers [50•].

Compliance with Ethical Standards

Conflict of Interest Ian M. Kronish and Nathalie Moise declare that they have no conflict of interest.

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