**The Primary Diagnosis and Why it Matters**

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Even if you don’t engage in formal diagnosis in your practice, identifying the primary concern or condition can help to improve your treatment practices and outcomes. This article reviews the role of the primary diagnosis in assessment and treatment planning.

I have found that one of the most helpful concepts in the design of the DSM diagnostic system is that of the *primary diagnosis*. In DSM parlance, this means the most prominent diagnosis whether that be due to its weightiness, the current risk it carries, or the level of distress it causes the individual. When there is only one diagnosis, this designation is easy to make. When two or more diagnoses are present, the decision can be more complicated.

**Co-occurring Conditions**

To appreciate the role of the primary diagnosis, we need to understand the relationship between the co-occurring conditions. When diagnoses hang out together, they are often referred to as *comorbid diagnoses*. However, comorbidity says nothing specific about the relationship between the conditions other than that they coexist at that point in time. I believe that it is important to understand their relationship, which may be: common, causal, or random. In the first case, two diagnoses may co-occur because of their common etiology. An example of this is an individual who develops both post-traumatic stress disorder and major depressive disorder following a car accident where they were severely injured and also lost a loved one. In the second case, diagnoses may co-occur because one has been induced by the other (either directly or indirectly). This might be considered a *secondary diagnosis* that would not exist without the first. An example of this relationship is a learning disability (LD) that eventually contributes to the development of a depressive disorder because of persisting underperformance. In the third case, co-occurring diagnoses may have little to do with each other aside from their common impact on daily functioning. For example, someone may have ADHD in childhood, but then later in life develop Cushing’s disease, a biological condition that elevates adrenaline levels and provokes an anxiety disorder. Their co-occurrence is essentially happenstance.

In some populations, secondary disorders are so common that they acquire unique terminology. In the case of people with substance use disorders, co-occurring mental health disorders are called *concurrent disorders[[1]](#footnote-1)*. In this case, the relationship can be bidirectional. About 1/3 of people who abuse alcohol and more than ½ of drug abusers experience mental health disorders, while about 1/3 of people who have mental health disorders also experience substance use disorders. The relationship is complex, but perhaps not surprising. For example, people with depressive disorders often gravitate toward cocaine and ecstasy because these substances help them to feel more alive and less depressed. In contrast, people with social anxiety disorder are more likely to gravitate toward alcohol because it is a central nervous system depressant that helps to reduce physiological symptoms of anxiety, which makes socializing tolerable. People with attention deficit hyperactivity disorder (ADHD) have higher rates of substance use and abuse than the general population, likely due to increased impulsivity and risk-taking. Looking in the other direction, substance use almost uniformly worsens mental health, and can even create mental health conditions. For example, some substances like marijuana can worsen depression or induce anxiety and panic attacks, while hallucinogens have the potential to create posttraumatic stress responses and anxiety. Cannabis use is also associated with the early emergence of psychosis.

When an intellectual disability (ID) co-occurs with a mental health disorder, it is known as a *dual diagnosis.* In most cases, the mental health condition should be considered secondary because the majority of intellectual disabilities emerge either during fetal development or the birth process. Medical conditions are also more likely to co-occur with ID (e.g., epilepsy, cerebral palsy). In the case of gifted students with a coexisting mental health condition or a co-occurring developmental disorder such as ADHD or autism spectrum disorder (ASD), the term *twice exceptional* is used.

In the case of some neurodevelopmental conditions, the functional impairments associated with the condition carry such a burden that people are highly likely to develop a secondary condition during their lifetime (e.g., ADHD comorbidities are as high as 70-90%). Other conditions with high levels of comorbidity include ASD, bipolar disorder, personality disorders, and Tourette’s. So when we diagnose these conditions, we should be actively looking for co-occurring disorders. Additionally, when someone presents with depression or anxiety, we should always consider the possibility that it is being driven by an underlying condition that may yet be identified. Importantly, if someone is not responding to treatment, we should always consider the possibility that another condition or significant circumstance has been missed.

Many medical conditions have the potential to generate mental health conditions. In some cases, these are biologically driven (e.g., hyperthyroidism contributing to anxiety disorders, and hypothyroidism contributing to depression). However in other cases, they are closely linked to experiences such as disability and loss of function (e.g., people who have a heart attack are at a significant risk for developing depression). The relationship between medical conditions and mental health disorders is so common that patients would be well served by deploying psychologists in every clinic within our medical system. It is no accident that 40% of patient visits to family doctors are for mental health.

Medications also carry a significant risk for inducing mental health disorders. Almost no corner of the medication catalogue is immune to these possible side effects. When clarifying this diagnostic relationship, it is important to establish the timing of the onset of mental health symptoms that emerge coincidental with or shortly after the initiation of a medication trial. Also note that natural supplements (which are often packaged in mixes of substances) can interfere with existing conditions and treatments, and can even induce mental health symptoms and disorders. Any substance that can have a beneficial effect has the potential to generate side effects.

**Identifying the Primary Disorder**

Our understanding of the multifaceted relationship between diagnoses brings us full-circle to the actual process of identifying the primary condition. Fortunately, we can follow some tried and true guidelines. First, we need to consider imminent risk and subsequent need for clinical intervention. Examples include suicidal depression, psychosis, and mania, which are severe conditions that usually take precedence over other conditions. Second, we must consider the client’s treatment priorities. For example, some people who experience regular panic attacks may have other treatment priorities because they have learned to live with the symptoms. Some clients with a history of abuse may decide to work on something more present focused because they don’t want to stir up ghosts from their past. Third, we must try to distinguish the primary condition’s relationship to secondary conditions. Often, the primary condition can be identified by its emergence in the timeline of the person’s life. For example, neurodevelopmental conditions like ADHD and autism are usually lifelong, typically emerge before other mental health conditions, persist long after they are gone, and are therefore designated as primary disorders. Similarly, the significant social and emotional impairments associated with personality disorders will often contribute to the development of anxiety or depression.

**Informing Treatment**

By effectively treating the primary condition, secondary symptoms and conditions can improve or even remit. For example, I once diagnosed generalized anxiety disorder and a tic disorder in a school-age boy. Since I had more experience treating anxiety disorders than tics, I focused my early treatment on intervention for the anxiety. As the boy’s anxiety improved, his tic resolved and did not require independent treatment. Although I was unaware of it at the time, his tics were secondary to his anxiety disorder. I have almost uniformly seen that effective management of ADHD (including medication) helps to ameliorate anxiety and depression symptoms. Similarly, effective management of autism can help to reduce anxiety. Effective treatment of the primary condition can speed up treatment response and in turn reduce the need for polypharmacy.

Another consideration is that of medical conditions. Sometimes, the primary focus of treatment must be on the medical condition. This might be the case with someone who has a thyroid disorder (where medical treatment is necessary), diabetes (where dietary and blood sugar management is critical), or sleep apnea (which can have implications for both medical well-being and mental health). Although we may not be the ones treating the medical condition, it should still be listed as the primary disorder. In this case, we would work with other professions to support the client. Similarly, when treating addictions, we may work together with an addiction specialist.

Understanding the relationships between conditions can help us to appreciate what might be the primary condition. In turn, knowing the primary disorder can help with treatment planning, shorten time in treatment, reduce polypharmacy, and contribute to improved client satisfaction and better treatment outcomes.

1. This terminology is used in Canada. In the US, it is called a *dual diagnosis*. [↑](#footnote-ref-1)