

Psychiatry NOS (not otherwise specified)

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Editorial

One of the hallmarks of a classification system is its ability to cover natural features. Imagine entering a flower shop and ordering some tulips, some roses and one third of flowers «not otherwise specified» (NOS). Would that not be poor botany? Linnaeus would turn in his grave.

A primary purpose of a diagnostic classification system is to serve the practical needs of GPs and specialists. Unfortunately, we clinicians are confronted with a large number of psychiatric patients who, though treated, do not receive a psychiatric diagnosis, because they suffer from sub-diagnostic syndromes. Large US community studies found that almost half of the psychiatric patients who had been treated in the year before the interview did not meet DSM diagnostic criteria; most of them had emotional, behavioural and stress problems (Druss, Hoff, Rosenheck, 2000). Very little representative epidemiological research has been devoted to this diagnostic deficit or to seeking to apply precise diagnostic criteria to such patients. Until recently, epidemiological interviews were mainly tailored to DSM diagnostic concepts and not to the natural phenomena, making no attempt at more detailed clinical description of NOS disorders. And this despite studies such as the NCS on mild disorders (Kessler et al., 2005) and the large NIMH study of treated depressive patients on so-called «sub-syndromal» depressive syndromes (Judd, Paulus, Akiskal, Rapaport & Kunovac, 1997). There was even a reverse trend, with great concern being expressed about over-diagnosing psychiatric disorders, and efforts made to introduce yet more rigorous criteria for clinical significance (Narrow, Rae, Robins & Regier, 2002). The fact nonetheless remains that a major proportion of the treated psychiatric patients suffer from sub-threshold syndromes, raising the question whether the current diagnostic classification should not be systematically supplemented by well-defined sub-diagnostic groups, while taking all care to minimise false positives.

Psychiatry NOS is a major diagnostic problem for *research* as well. Failure to define sub-threshold categories

also means avoiding a more dimensional approach. There is wide agreement that a categorical diagnostic classification has to be supplemented by dimensional assessment (Angst, 1999), in the same way that in internal medicine hypertension is defined by a specific blood pressure. With scientific progress, including preventive medicine, the threshold for pathology may decrease. Up to now, dimensional measures of the severity of psychiatric syndromes have been the number of symptoms, the duration of episodes and clinically significant impairment or distress. These are certainly suitable but may need to be supplemented by frequency of episodes over one year and days spent with symptoms over the last twelve months. In addition, subjective distress and impairment at work or in other social roles could be measured systematically by visual analogue scales from 0 to 10 (Sheehan, Harnett-Sheehan & Raj, 1996) or 0 to 100 (Angst, Dobler-Mikola & Binder, 1984).

The serious reservations about including sub-diagnostic syndromes in the classification system and research interviews have general and economic grounds. There is a fear of pathologising normality and of increasing health care costs by over-diagnosing «cases». In structured epidemiological interviews, too, cost considerations have impaired the assessment of natural phenomena in order to avoid longer, more difficult and more expensive interviews. The main concern regarding pathologising is justified caution about treating subjects who are not in need of treatment. «To confuse making a mental disorder diagnosis with demonstrating treatment need, however, would be a serious mistake» (Spitzer, 1998). Treatment seeking is, of course, not the gold standard for caseness; it is highly correlated with subjective distress and a condition's social consequences and is also dependent on many other factors (stress-tolerance/resilience, coping, social support, money, etc.). Nevertheless, one validity criterion for NOS cases in the community should be treatment or perhaps even need for treatment.

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In our small Zurich study of a birth cohort followed from age 20 to 40 we found large percentages of patients who had been *treated* in the twelve months before the interviews, but whose DSM diagnosis was NOS: unipolar depression 48%, GAD 78%, panic 52%, neurasthenia (ICD) 60%, OCD 33% and insomnia 41%. The excessive 78% rate of treated NOS GAD syndromes is the consequence of the very strict temporal criterion of six months' minimum duration introduced by DSM-III R, which has been repeatedly criticised from an epidemiological viewpoint (Angst et al., 2006; Bienvenu, Nestadt & Eaton, 1998; Kessler et al., 2005). In the Zurich study, treatment was restrictively defined by consultations of MDs or psychologists and assessed for each syndrome separately.

Sub-threshold syndromes can be defined by fewer symptoms, as in the case of *minor depression* (for instance by 3-4 of 9 criterial symptoms of depression), but also by the inclusion of highly *recurrent brief episodes* with work or other role impairment. In the Zurich study large treated sub-groups of the aforementioned NOS cases qualified for the corresponding *recurrent brief psychiatric syndromes*, i.e. occurring at least about monthly (Angst, 1997), which casts serious doubt on the simple temporal threshold of episodes. Many treated patients who suffer from brief and highly recurrent episodes experienced distress and impairment comparable to the major threshold disorders.

Our future task is not to soften the criteria for major psychiatric disorders (with the exception of GAD). It is to develop valid new operational criteria for additional diagnoses of «minor» psychiatric syndromes of moderate severity, enabling clinicians to label treated syndromes correctly without too many false positives. Such sub-threshold concepts would give a powerful boost to research. This represents a great challenge to DSM-V and to epidemiological investigation. Given the shortage of

detailed epidemiological data on sub-threshold syndromes, however, it is to be feared that DSM-V may be unable to provide a definitive solution.

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