Recommended Changes in 'Depressive Disorder Not Otherwise Specified' (code 311)

(2 January 2010)

A. The current DSM-IV definition of Depressive Disorder Not Otherwise Specified (NOS)

"The Depressive Disorder Not Otherwise Specified includes disorders with depressive features that do not meet the criteria of Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder With Depressed Mood, or Adjustment Disorder With Mixed Anxiety and Depressed Mood." Six examples of Depressive NOS disorders are provided in the main text but no separate diagnostic codes are specified for these examples:

1. Premenstrual dysphoric disorder;
2. Minor depressive disorder;
3. Recurrent brief depressive disorder;
4. Postpsychotic depressive disorder of Schizophrenia;
5. A Major Depressive Episode superimposed on Delusional Disorder, Psychotic Disorder NOS, or the active phase of Schizophrenia; and
6. A depressive disorder is present but the clinician cannot determine whether it is primary or due to a general medical condition or substance induced.

Appendix B of DSM-IV includes proposed diagnostic criteria for the first 4 of these examples.

B. Problems with the Depressive Disorder NOS category

1. ***HIGH PREVALENCE.*** Despite being a residual category the Depressive Disorder NOS diagnosis is very frequently used in routine outpatient care in the United States. In each of the seven sites participating in the DSM-IV field trials patients with affective symptoms that did not meet definitional thresholds for DSM-III-R Axis I disorders were at least as common as patients with several of the established anxiety and mood disorders.[1] Unpublished data provided by Mark Olfson on the primary diagnoses assigned by specialist and non-specialist clinicians to 1.5 million privately insured adults and 1.2 million adults on Medicaid in 2004 indicate that 37%-38% of all primary depressive disorder diagnoses are Depressive Disorder NOS.
2. ***THE REASONS FOR THE HIGH PREVALENCE ARE UNKNOWN.*** Depressive Disorder NOS is one of 41 NOS diagnoses in the DSM-IV. The frequent use of these diagnoses could be a reflection of billing practices or of clinicians' desired to avoid the stigmatizing effect of assigning a specific psychiatric label, but the high prevalence of NOS diagnoses in clinical settings in other

countries[2-5] (where billing is not an issue) and in epidemiological studies[6] (when stigmatization is not an issue) suggest that other factors may also be important. Depressive symptoms are experienced on a continuum and manifested in a variety of ways so it is not unreasonable to expect that substantial numbers of individuals have subsyndromal or atypical presentations that would fall into the Depressive Disorder NOS category. And busy clinicians who do not have the time or training needed to conduct a full evaluation may take the convenient short-cut of assigning an NOS diagnosis. The relative importance of these and other potential causes for the high prevalence of NOS diagnoses is unknown.

3. ***SOME INDIVIDUALS WITH NOS DIAGNOSES HAVE SUBSTANTIAL DYSFUNCTION AND DISTRESS THAT MERIT INTERVENTION.*** There are no equivalent diagnoses in the ICD system so one solution to the etiological ambiguity about NOS diagnoses would be to eliminate them from the diagnostic manual. But many studies report that individuals with these diagnoses have substantial levels of dysfunction associated with their symptoms[1,5,6], and some studies report that specific subsyndromal conditions predict negative outcomes (such as suicide[7], more serious conditions[8], etc.) and that medications or other interventions can prevent some of these negative outcomes.[8] These findings suggest that persons with NOS diagnoses merit detailed evaluation, follow-up, and, possibly, treatment, despite the fact that they are a heterogeneous group of individuals who do not meet diagnostic criteria of established disorders. The Depressive Disorder NOS diagnosis and other NOS diagnoses merit retention in DSM-V but changes in the formulation of the diagnoses will be needed to increase their utility.

4. ***THERE ARE NO SEVERITY CRITERIA FOR NOS DIAGNOSES.*** One potential reason for the high prevalence of NOS diagnoses is that the threshold for inclusion is too low. For example, the description of Depressive Disorder NOS (like that for other NOS disorders) simply refers to the presence of depressive symptoms without specifying any requirements for associated dysfunction or distress. This low threshold could lead to medicalization of normal distress and, thus, inflation in the number of individuals with psychiatric diagnoses. One solution would be to establish gateway criteria specifying the level of psychosocial dysfunction or distress that needs to be associated with the symptoms before the NOS diagnosis can be considered.

5. ***THE DEPRESSIVE DISORDER NOS DIAGNOSIS IS A 'BLACK BOX'.*** As currently employed it is not known why a particular patient is assigned a Depressive Disorder NOS diagnosis so the diagnosis encompasses a large numbers of individuals with unknown conditions, many of whom are receiving medications and other treatments. The proportion of these individuals that could be legitimately considered 'mentally ill' is unknown. Requiring sub-classification of the Depressive Disorder NOS diagnosis into groups of conditions or into specific diagnostic subtypes would provide information on the relative prevalence of the different conditions and, thus, make it easier to decide how to deal with this heterogeneous group of individuals. But a balance needs to be found between increased precision in the diagnosis and placing too heavy a diagnostic burden on the clinician, so only a limited number of groups or subtypes should be specified. Conditions included under the Depressive Disorder NOS rubric naturally fall into three broad groups: those in which there is insufficient information to determine a specific diagnosis, those in which the symptoms are subsyndromal, and those in which the

symptomatic presentation has atypical or special characteristics.

6. ***THE PROPOSED DEPRESSIVE DISORDERS IN APPENDIX B AND INCLUDED AS EXAMPLES OF DEPRESSIVE DISORDER NOS DISORDERS ARE NOT CODED AND, THUS, NEVER USED.*** The DSM-IV description of the Depressive Disorder NOS diagnosis includes six specific examples, four of which are proposed diagnostic entities that have suggested diagnostic criteria described in Appendix B. The evidence available at the time of writing DSM-IV was not sufficient to include these four proposed diagnoses among the established diagnoses, so as an interim step they were placed in the Appendix and included as listed examples in the NOS diagnosis. But these proposed diagnoses and the corresponding NOS examples do not have specific diagnostic codes so they are never identified in routine clinical or epidemiological work, which makes it difficult to gather the information about their prevalence, demographic profile and associated co-morbid conditions needed to decide whether or not they should become established diagnoses. Moreover, the process of deciding which proposed conditions get included or removed from the appendix and from the listed examples of NOS diagnoses has been haphazard. A more systematic method of including and removing proposed diagnoses needs to be established and the pros and cons of assigning proposed diagnoses specific codes (even if only used in research settings) should be considered.

7. ***CONDITIONS INCLUDED UNDER THE 'DEPRESSIVE DISORDER NOS' RUBRIC ARE NOT NECESSARILY DISORDERS SO THE DIAGNOSTIC LABEL IS NOT APPROPRIATE.*** By definition none or the conditions considered in the NOS category meet criteria of established disorders, so it is a matter of debate whether or not they can be considered 'disorders'. And some of the situations included under the NOS rubric do not include specific symptoms (e.g., non-specific depressive symptoms; lack of sufficient information to arrive at a specific diagnosis; etc.) so they would not meet even the most liberal definition of a 'disorder'. One way to avoid this confusion would be to change the label 'disorder' to 'condition'. Based on this, the label for this group of conditions would change to 'Depressive Conditions Not Elsewhere Classified', abbreviated as 'Depressive CNEC'.

C. Recommend revised text for DSM-V

Depressive Conditions Not Elsewhere Classified ('Depressive CNEC')

This group of diagnoses is reserved for individuals with depressive symptoms that do not meet diagnostic criteria of any other mood disorder, of 'Adjustment Disorder With Depressed Mood', or of 'Adjustment Disorder With Mixed Anxiety and Depressed Mood'. The depressive symptoms must be associated with moderate to severe psychosocial dysfunction or distress and are not due to the direct physiological effects of a substance or a general medical condition. There is no separate diagnostic code for the general group of 'Depressive Conditions Not Elsewhere Classified ' (hereafter, 'Depressive CNEC') so the condition must be categorized and coded as one of the three main groups described below (311.1--Depressive CNEC with insufficient information to make a specific diagnosis; 311.2--Subsyndromal Depressive CNEC; or 311.3--Other Depressive

CNEC):

311.1 Depressive CNEC with insufficient information to make a specific diagnosis.

This diagnosis is used for patients with depressive symptoms that have resulted in distress or psychosocial dysfunction when there is not sufficient information available to make a specific diagnosis. It includes, but is not limited to, the following situations:

1. *Uncertainty about primary versus secondary nature of Major Depressive Episode (MDE)*. Meets symptomatic and duration criteria of Major Depressive Episode but the clinician is unable to determine whether it is primary or due to a general medical condition (GMC) or substance induced.
2. *Patient is unable or unwilling to provide information about symptoms and/or history.* Depressive symptoms are observed and associated with distress or dysfunction but detailed information needed for a specific diagnosis cannot be obtained due to communication difficulties, mental retardation, uncooperativeness, or similar reasons.
3. *Clinician does not have the time or training needed to conduct a detailed examination.*

311.2 Subsyndromal Depressive CNEC

Characteristic symptoms depression are present and cause distress or dysfunction but are not of sufficient intensity or duration to meet criteria of an established depressive disorder diagnosis. It includes, but is not limited to, the following situations.

1. *Prodromal depression.* Depressed affect and at least one of the other symptoms of depression for a minimum of 5 days in an individual who has one or more prior episode(s) of Major Depressive Disorder (that remitted completely) and who does meet criteria for Dysthymia.
2. *Subsyndromal depression that meets duration criteria but not symptom count criteria for Major Depressive Episode (MDE)* Depressed affect and at least one of the other 8 symptoms of a major depressive episode associated with distress or dysfunction that persists for at least 2 weeks in an individual who has never met criteria for any other mood disorder, does not currently meet active or residual criteria for any psychotic disorder, and does not meet criteria for 'Mixed Subsyndromal Anxiety-Depressive Disorder' (below). *[NOTE: This is similar to the proposed criteria for 'Minor Depression' in Appendix B of DSM-IV.]*
3. *Mixed Subsyndromal Anxiety-Depressive Disorder.* Moderate to severe depression and anxiety symptoms that persist for a minimum of two weeks but that do not meet full criteria for any mood or anxiety disorder. *[NOTE: If this condition is approved as an established diagnostic category it would be removed from the Depressive CNEC listing. In DSM-IV this is one of the listed examples of Anxiety Disorder NOS (not Depressive Disorder NOS) and has proposed diagnostic criteria provided in Appendix B.]*

311.3 Other Depressive CNEC.

Atypical presentations of depressive symptoms and other circumstances not considered

above that cause distress or psychosocial dysfunction. It includes, but is not limited to, the following situations.

1. *Major Depressive Episode (MDE) superimposed on a psychotic disorder.* Meets symptomatic and duration criteria of Major Depressive Episode during the active or residual phase of a psychotic disorder. *[NOTE: This combines two subcategories listed as examples 4 and 5 in the DSM-IV description of the Depressive Disorder NOS diagnosis.]*
2. *Recurrent Brief Depressive Disorder* Concurrent presence of depressed affect and at least 4 other symptoms of depression for 2-13 days at least once a month (not associated with the menstrual cycle) for at least 12 consecutive months in an individual who has never met criteria for any other mood disorder and who does not concurrently meet active or residual criteria for any psychotic disorder. *[NOTE: Proposed criteria for this disorder were provided in Appendix B of DSM-IV.]*
3. *Premenstrual Dysphoric Disorder* For at least 6 of the last 12 menstrual cycles moderate to severe symptoms of depression and anxiety are present for most of the time during the last week of the premenstrual phase and remit within a few days of the onset of menstruation. *[NOTE: If this condition is approved as an established diagnostic category it would be removed from the Depressive CNEC listing. Proposed criteria were provided in Appendix B of DSM-IV.]*

If the symptoms of Depressive CNEC occur over the previous month in the absence of any other mood disorder this is considered a 'current' diagnosis. Only one current Depressive CNEC diagnosis can be made at a time. However, a current Depressive CNEC diagnosis can be made concurrently with diagnoses of other (non-mood) disorders. Lifetime diagnoses may include multiple Depressive CNEC diagnoses and other mood diagnoses provided that these episodes occurred at distinct periods of time.

D. Issues that remain to be discussed.

1. Operational definitions for 'moderate to severe psychosocial dysfunction or distress' need to be specified.
2. The discussion and proposed criteria for the examples of Depressive Disorder NOS currently provided in the Appendix B of DSM-IV need to be reassessed. They should be updated to match current thinking about these proposed conditions. Some of them may be deleted and new proposed depressive conditions could be added; if this occurs the examples of Depressive CNEC listed in the main text would be changed accordingly.

   To avoid excessive expansion of the named examples listed under the three groups of Depressive CNEC, criteria need to be developed for including and deleting a proposed diagnosis as a named example of Depressive CNEC. These criteria will, necessarily, be less rigorous than those proposed for an established diagnosis but rigorous enough to limit the rapid expansion of named examples. Moreover, a standardized method for presenting the material in the Appendix about proposed diagnoses should be specified.

3. The pros and cons of providing specific codes for the named examples of Depressive CNEC listed need to be discussed further. This could be done by using a second decimal digit to specify the specific condition; for example, 'Prodromal Depression' would be coded 311.21, 'Recurrent Brief Depressive Disorder' would be coded 311.32, and so forth. The use of this second decimal digit code could be optional, limited to research or other settings. Brief descriptions of the conditions would be provided in the main text (as in the examples listed in the prior section) and the detailed discussion of the conditions with proposed criteria would be in the appendix.

   The disadvantage of providing specific codes is that it would increase the diagnostic burden on the clinician, give quasi diagnostic status to conditions that don't yet meet the rigorous criteria for a 'disorder' and, possibly, expand the number of cases that are assigned a Depressive CNEC diagnosis—though the moderate to severe dysfunction or distress criteria for CNEC conditions should limit excessive use of these diagnoses. The advantage of providing specific codes is that it would clarify the relative prevalence of the various conditions included under the CNEC rubric. More importantly, the use of specific codes would provide an opportunity to systematically assess the prevalence, correlates and course of proposed diagnostic categories—information that is essential to deciding whether to adopt a new diagnosis or to drop it. In this way the CNEC subcategories could become the testing grounds for proposed diagnoses and, thus, help achieve the goal of making DSM-V a living document.

4. The minimum number and duration of depressive symptoms needed to justify clinical attention in an individual with prior episodes of Major Depressive Disorder (MDD) is uncertain, so the suggested definition for 'Prodromal Depression' provided above needs to be considered in more detail. Given the likelihood that clinicians will preemptively treat prodromal depression in individuals with multiple prior episodes of MDD, there may be an advantage to consider this condition a subtype of MDD rather than a Depressive CNEC. Another reason to consider this a MDD subtype is that some individuals have minimal dysfunction or distress during the MDD prodrome so they would be in a diagnostic limbo until they manifested sufficient distress or dysfunction to meet criteria of Prodromal Depression.

5. The pros and cons of combining or differentiating 'postpsychotic depressive disorder of schizophrenia' from 'major depressive episode superimposed on an active psychotic disorder' should be discussed further. In the suggested text for DSM-V the two conditions have been combined under a single label but in DSM-IV they were differentiated.

6. Further analysis of the insurance records data available to Mark Olfson would provide important information that could help inform discussions about how best to revise the description of these conditions. A number of questions could be addressed: What is the use of the Depressive Disorder NOS diagnosis among psychiatrists versus non-psychiatrists? What medications are patients with a primary diagnosis of Depressive Disorder NOS being given? How extensively is Depressive Disorder NOS used as secondary diagnosis?

7. Several established DSM-IV diagnoses are transitional states that may or may not progress to other diagnoses (e.g., Brief Reactive Psychosis, Schizophreniform Disorder, Acute Adjustment Disorder, etc.). Some of the conditions included under the Depressive CNEC rubric may serve a similar role. To help clarify this, efforts should be made to identify data sets that monitor

changes in primary and secondary diagnoses over time among persons with an initial primary or secondary diagnosis of Depressive Disorder NOS.

E. References.

1. Zinbarg RE, Barlow DH, Liebowitz M, Street L, Broadhead E, Katon W, Roy-Byrne P, Lepine JP, Teherani M, Richards J, et al. The DSM-IV field trial for mixed anxiety-depression. *Am J Psychiatry* 1994, 151: 1153-62.
2. Cwikel J, Zilber N, Feinson M, Lerner Y. Prevalence and risk factors of threshold and sub-threshold psychiatric disorders in primary care. *Soc Psychiatry Psychiatr Epidemiol* 2008, 43:184-91.
3. Ansseau M, Dierick M, Buntinkx F, Cnockaert P, De Smedt J, Van Den Haute M, Vander Mijnsbrugge D. High prevalence of mental disorders in primary care. *J Affect Disord* 2004, 78:49-55.
4. Qin XX, Wang W, Jin Q, Ai L, Li YL, Dong GH, Liu L, Phillips MR. Prevalence and rates of recognition of depressive disorders in internal medicine outpatient departments of 23 general hospitals in Shenyang, China. *J Affect Disord* 2008, 110:46-54.
5. Preisig M, Merikangas KR, Angst J. Clinical significance and comorbidity of subthreshold depression and anxiety in the community. *Acta Psychiatr Scand* 2001, 104:96-103.
6. Phillips MR, Zhang JX, Shi QC, Song ZQ, Ding ZJ, Pang ST, Li XY, Zhang YL, Wang ZQ. Prevalence, associated disability and treatment of mental disorders in four provinces in China, 2001-2005: an epidemiological survey. *Lancet* 2009, 373:2041-2053.
7. Phillips MR, Shen QJ, Liu XH, Pritzker S, Streiner D, Conner K, Yang GH. Assessing depressive symptoms in persons who die of suicide in mainland China. *J Affect Dis* 2007, 98:73-82.
8. Cuipers P, van Straten A, Smit F. Preventing the incidence of new cases of mental disorders: a meta-analytic review. *J Nerv Ment Dis* 2005; 193: 119-125.