Trends in Subthreshold Psychiatric Diagnoses for Youth in Community Treatment

Daniel J. Safer, MD; Thiyagu Rajakannan, PhD; Mehmet Burcu, MS; Julie M. Zito, PhD

IMPORTANCE Patterns and trends of subthreshold DSM-IV mental health diagnoses for youth within US community treatment settings merit systematic research.

OBJECTIVE To quantify and assess temporal patterns of DSM-IV diagnoses not otherwise specified (NOS) among youth during physician office visits.

DESIGN, SETTING, AND PARTICIPANTS We conducted a retrospective study using psychiatric diagnostic data from the US National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey (n = 16,295) from 1999 through 2010, combined in 4-year intervals. Using diagnoses from visits to physicians, we compared trends of the proportional distribution of the major psychiatric diagnoses with subthreshold criteria (coded as NOS) with proportions of diagnoses reaching full criteria.

MAIN OUTCOMES AND MEASURES Specific common psychiatric diagnoses NOS compared with full-criteria psychiatric diagnoses.

RESULTS Between the 1999-2002 and 2007-2010 periods, the proportion of US medical visits reporting DSM-IV NOS psychiatric diagnoses compared with the proportion reporting full psychiatric diagnostic criteria for youth aged 2 to 19 years rose prominently for major mood diagnostic subtypes. Among all visits for mood disorders, NOS visits grew proportionally 1.5-fold from 45.3% in the 1999-2002 period to 68.8% in the 2007-2010 period (P < .001). Among visits for bipolar disorder, NOS visits increased more than 18-fold, from 3.6% in the 1999-2002 period to 72.6% in the 2007-2010 period (P < .001). In addition, anxiety disorder NOS increased from 44.6% in the 1999-2002 period to 58.1% in the 2007-2010 period. Overall, NOS visits constituted 35.0% of the total psychiatric visits in 2007-2010 but represented 55.9% when attention-deficit/hyperactivity disorder codes were excluded.

CONCLUSIONS AND RELEVANCE The expansion of subthreshold (NOS) DSM-IV diagnoses of mood disorder, bipolar disorder, and anxiety disorder in youth that has occurred since 1999 in all likelihood will continue in the DSM-5 era unless administrative efforts are made to alter this practice. Unspecified diagnoses lack research reliability and potentially increase the likelihood of off-label prescribing of psychotropic medication.
Substantial research evidence indicates that the overall prevalence of emotional and behavioral disorders in research-assessed populations has not increased during the past 2 to 3 decades. This conclusion may not apply strictly to certain specific disorders, such as bulimia and marijuana abuse, but has been reported consistently in research samples of youth and adults in the United States, Canada, the Netherlands, and England. Nevertheless, population surveys during this period have shown clearly that many more community-treated persons have been diagnosed with and treated for 1 or more psychiatric disorders than occurred in previous decades.5,11-15

Such increases in psychiatric diagnosis and treatment in the United States can be explained partially by the following factors. First, an increasing number of individuals have been diagnosed as having expanding, less severe, and broader categories of psychiatric disorders. In clinical assessment studies using DSM-III-R and DSM-IV criteria, for example, 40% to 50% of those interviewed and given a diagnosis of a DSM psychiatric disorder were judged to have a mild disorder (rated as the lowest severity of 5 gradations).16 Second, marketing by drug companies stressing the merits of medication treatment has a profound effect.17 Third, the availability of insurance coverage and outpatient treatment have increased in the United States. Finally, pharmacologic treatments for emotional disorders are increasingly accepted by the US public. Whether the increased diagnostic trends apply equally to all subtypes of a particular psychiatric diagnosis in children and adolescents is unclear.

This research report will focus on the frequency of DSM-IV psychiatric diagnoses not otherwise specified (NOS) that were recorded during US physician office visits for youth from 1999 through 2010. The NOS is a DSM-IV category that is characterized by consistently (>95%) meeting subthreshold but not full diagnostic criteria and by causing distress or impairment. Providers and investigators generally agree that NOS is coded when (1) diagnostic criteria are subthreshold, (2) there is uncertainty about the etiology of the diagnosis, (3) some relevant symptoms fall outside the listed criteria, and (4) insufficient diagnostic criteria are obtained during the examination.18-21

Initially, NOS codes were included in the DSM-I (4 unspecified diagnoses) and were expanded thereafter as NOS, although the terminology has been slightly modified in the DSM-5 to unspecified or other specified. Twenty NOS codes were included in the DSM-II and DSM-IV; at present, 31 unspecified diagnostic codes are included in the DSM-5. Also of note is that mood disorder NOS and pervasive developmental disorder (PDD) NOS from the DSM-IV are not included in the DSM-5.

Specifically, this study will describe national trends in major psychiatric NOS diagnoses given to youth during community physician office visits during the calendar years 1999 through 2010. In the analyses, we compare the proportion of NOS diagnoses for specific common psychiatric disorders given during these visits over time with the proportion of full-criteria (FC) diagnoses recorded in the same category to document NOS diagnostic trends statistically. The discussion that follows will assess the benefits and drawbacks of including an NOS category in the nomenclature.

Methods

Study Design and Data Source

Because the data set consisted of deidentified data and was publicly available, the study was exempt from institutional review board review at the University of Maryland, Baltimore. In a cross-sectional design comparing visit data from annual surveys, this retrospective study analyzed data derived from the National Ambulatory Medical Care Survey (NAMCS) and the National Hospital Ambulatory Medical Care Survey (NHAMCS) for youth (aged 2-19 years) receiving ambulatory care during the calendar years 1999 through 2010 (total visits, 120 795; total psychiatric visits, 16 295). The NAMCS and NHAMCS are annual surveys conducted by the National Center for Health Statistics on a nationally representative sample of visits to physicians in office-based practices and hospital outpatient departments.22 The NAMCS and NHAMCS use a multistage probability design, which samples visits from primary sampling units (ie, a county, a group of adjacent counties, or a standard metropolitan statistical area) from physician practices according to specialty within these units and from patient visits within these practices. The NHAMCS uses outpatient visits in hospital settings within primary sampling units, in clinic outpatient departments, in emergency service areas within these hospitals, and in patient visits to these clinics. During the survey years, survey response rates varied from 58.3% to 70.4%, with a median response rate of 62.5% for the NAMCS. For the NHAMCS, the median response rate was 90.5% (range, 71.0%-95.6%). Each visit is assigned a visit weight as well as values for clustering and stratification to account for the complex multistage probability survey design.23

Physician and staff members provided sociodemographic data and diagnoses.

Measures

Main Independent Variable

To evaluate changes in patterns for psychiatric diagnoses, the primary independent variable was the period. Following the guidelines of the National Center for Health Statistics, we combined NAMCS and NHAMCS medical visit data from contiguous survey years to arrive at stable estimates. Medical visits were grouped into periods from 1999 to 2002, 2003 to 2006, and 2007 to 2010.

Psychiatric Diagnostic Codes

The primary dependent variable was the proportion of youth visits that had a psychiatric DSM-IV NOS diagnostic code compared with the proportion of youth visits with FC psychiatric diagnostic codes within the category. Psychiatric diagnoses were assessed using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Diagnoses recorded by physicians using DSM-IV codes were matched to the ICD-9-CM codes. As many as 3 diagnoses were recorded for each visit.

The FC diagnostic codes for bipolar disorder included the following: 296.0, 296.1, and 296.4 through 296.7 for bipolar I disorder; 296.89 for bipolar II disorder; and 301.13 for cyclothymic disorder. The codes for anxiety disorders included...
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To describe dynamic changes in the patterns of all youth visits over time, we compared differences in sociodemographic and administrative characteristics of youth visits across 3 study periods (1999-2002, 2003-2006, and 2007-2010) by population-weighted χ² analyses. Among youth mental health visits (ie, youth visits with clinician-reported psychiatric diagnoses), we analyzed trends in psychiatric diagnostic groups across 12 years by population-weighted χ² analyses. To elucidate NOS diagnostic trends across 12 years, we compared the proportion of NOS diagnoses given for selected psychiatric diagnostic groups over time with the proportion of FC diagnoses recorded for the same diagnostic groups.

Results

Characteristics of Physician Office–Based Youth Visits Across 12 Years

Total physician office–based youth visits (N = 120,795) were analyzed for the study years 1999 through 2010. As a proportion of all youth visits, visits to physician offices for any psychiatric diagnosis increased from 7.7% in the 1999-2002 period to 8.3% in the 2007-2010 period. Table 1 describes demographic and administrative characteristics of youth with physician office visits. Across the 12 years, young children (aged 2-9 years) represented nearly half of the youth visits (48.3%). Most of the visits were made by youth who were white (64.7%-71.5%), privately insured (64.1%-72.9%), and residing in metropolitan areas (85.0%-88.0%). Compared with the 1999-2002 period, the proportion of physician office visits in the 2007-2010 period by youth who were nonwhite (35.3% vs 28.5%) and not privately insured (35.9% vs 27.1%) increased significantly. The pattern of youth visits did not differ appreciably by US region across the periods (Table 1).

NOS as a Proportion of Total Psychiatric Visits

We ranked the NOS diagnoses as weighted proportions of all psychiatric visits. In the 2007-2010 period, the most frequent DSM-IV subthreshold psychiatric diagnoses were depressive disorder NOS (8.1%), anxiety disorder NOS (7.3%), mood disorder NOS (3.9%), bipolar disorder NOS (3.6%), and disruptive behavior disorder NOS (2.2%). Following in rank order were PDD NOS (2.0%), learning disorder NOS (1.1%), tic disorder NOS (0.7%), psychotic disorder NOS (0.7%), and adjustment disorder NOS (0.6%).

Proportions of FC vs NOS Diagnoses

Table 2 conveys physician office visit data with their weighted percentages in relation to DSM-IV diagnoses and trends over time. We compared data for FC diagnostic patterns proportionally with NOS diagnostic patterns. The distinctive findings reveal that (1) FC ADHD represented approximately half of all the diagnoses recorded in psychiatric visits (48.3%); (2) the number of ADHD NOS visits was miniscule; (3) the composite FC mood disorder visits (including all FC depressive and bipolar disorder visits) decreased profoundly as the composite mood.
disorder NOS visits proportionally increased; (4) FC bipolar disorder visits dramatically decreased as bipolar disorder NOS visits expanded; (5) FC anxiety disorders experienced the same pattern of NOS increase; (6) depressive disorder NOS increased proportionally to 58.1% of the diagnostic category total; (7) PDD NOS decreased prominently as FC autistic disorder increased; and (8) learning disorder NOS rose from 15.1% of the learning disorder total in the 1999-2002 period to 60.3% in the 2007-2010 period.

**NOS Diagnostic Trends Over Time**
A marked shift occurred in the proportional distribution of FC diagnoses vs NOS diagnoses for certain psychiatric disorders (Figure 1 and Figure 2). Figure 1A reveals that, during the study period, the proportion of visits for composite FC mood disorders (combining all FC depressive, bipolar, and cyclothymic disorder visits) declined from 54.7% to 31.2%, whereas the proportion of visits for composite mood disorder NOS (combining visits for mood disorder NOS, bipolar disorder NOS, and depressive disorder NOS) increased proportionally to 58.1% of the diagnostic category total; (7) PDD NOS decreased prominently as FC autistic disorder increased; and (8) learning disorder NOS rose from 15.1% of the learning disorder total in the 1999-2002 period to 60.3% in the 2007-2010 period.

### Table 1. Trends in Psychiatric Diagnoses Among Physician Office Visits for Youth During the 12-Year Study Period *

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<tbody>
<tr>
<td>ADHD</td>
<td>2068 (99.9)</td>
<td>7 (0.1)</td>
<td>2849 (99.7)</td>
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</tr>
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<td>Adjustment disorders</td>
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<td>179 (38.4)</td>
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<tr>
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<td>163 (84.9)</td>
<td>31 (15.1)</td>
<td>153 (73.7)</td>
<td>70 (26.3)</td>
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<tr>
<td>Disruptive behavior disorders</td>
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<td>190 (38.3)</td>
<td>532 (64.2)</td>
<td>206 (35.8)</td>
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<tr>
<td>MDD and dysthymic disorders</td>
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<td>540 (52.5)</td>
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<tr>
<td>PDD</td>
<td>107 (47.6)</td>
<td>85 (52.4)</td>
<td>218 (63.3)</td>
<td>165 (36.7)</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>49 (41.8)</td>
<td>98 (58.2)</td>
<td>69 (51.0)</td>
<td>91 (49.0)</td>
</tr>
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**Abbreviations:** ADHD, attention-deficit/hyperactivity disorder; FC, full criteria; MDD, major depressive disorder; NOS, not otherwise specified; PDD, pervasive developmental disorder.

* Data are from the National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey (1999-2010).

### Table 2. Trends in Psychiatric Diagnoses Among Physician Office Visits for Youth During the 12-Year Study Period *

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**Abbreviations:** ADHD, attention-deficit/hyperactivity disorder; FC, full criteria; MDD, major depressive disorder; NOS, not otherwise specified; PDD, pervasive developmental disorder.

* Data are from the National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey (1999-2010).

* Unweighted observations of less than 30 visits are unreliable.
pressive disorder NOS) rose from 45.3% to 68.8% (P < .001). Independently, visits for mood disorder NOS increased from 1.1% to 4.5% of the total number of psychiatric visits during the 12-year study period (χ² = 17.79; P < .001). In Figure 1B, it shows that the largest temporal increase in NOS diagnoses was in the visits reporting a bipolar disorder diagnosis. Bipolar disorder NOS diagnoses rose more than 18-fold during the 12-year period from 3.6% to 72.6% (P < .001), whereas the diagnostic visits of FC bipolar I and II disorders decreased nearly 5-fold.

Figure 2A shows the decline in visits for FC anxiety disorder during the 12-year study period compared with an increase in visits for anxiety disorder NOS. The NOS proportion rose during the study period from 44.6% to 58.1% (P = .09).

In Figure 2B, it shows the increase in visits for depressive disorders NOS during the study period. The proportion of visits for depressive disorders NOS rose from 52.5% in the 1999-2002 period to 58.1% in the 2007-2010 period. This increase was not statistically significant, but it should be noted that, over time, an increased majority (58.1%) of depressive disorder visit diagnoses became NOS.

### Proportional Changes in NOS Diagnoses

In a number of disorders, we found no significant trends in the proportion of NOS diagnoses compared with the proportion of FC diagnoses between the 1999-2002 and 2007-2010 periods. These diagnoses included adjustment disorder NOS (42.8% to 34.8%), mental retardation unspecified (41.8% to 43.8%),

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**Figure 1. Proportional Distribution of Visits for Mood Disorders and Bipolar Disorders for Youth in 3 Periods**

<table>
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<tr>
<th>Period</th>
<th>Mood Disorders</th>
<th>Bipolar Disorders</th>
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<tbody>
<tr>
<td>1999-2002</td>
<td>FC Mood disorders</td>
<td>FC Bipolar I and II disorder</td>
</tr>
<tr>
<td>2003-2006</td>
<td>Mood disorders NOS</td>
<td>Bipolar disorder NOS</td>
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<tr>
<td>2007-2010</td>
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**Figure 2. Proportional Distribution of Visits for Anxiety Disorders and Depressive Disorders for Youth in 3 Periods**

<table>
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<tr>
<th>Period</th>
<th>Anxiety Disorders</th>
<th>Depressive Disorders</th>
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<tbody>
<tr>
<td>1999-2002</td>
<td>FC Anxiety disorders</td>
<td>FC MDD/dysthymic disorder</td>
</tr>
<tr>
<td>2003-2006</td>
<td>Anxiety disorder NOS</td>
<td>Depressive disorder NOS</td>
</tr>
<tr>
<td>2007-2010</td>
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Downloaded From: http://archpsyc.jamanetwork.com/pdfaccess.ashx?url=/data/journals/psych/931896/ on 04/05/2017
and disruptive behavior disorder NOS (38.3% to 32.6%). Pervasive developmental disorder NOS had a significant decline from 52.4% to 37.8% (P = .02). Learning disorder NOS had a significant increase from 15.1% to 60.3% (P < .001), and tic disorder NOS showed an increase from 40.9% to 65.0% that approached statistical significance (P = .08).

Excluding FC ADHD Diagnoses
By far the most common FC psychiatric diagnosis was ADHD, representing 48.3% of all psychiatric diagnoses in the 2007-2010 period; however, its DSM-IV NOS diagnosis (314.9) was 0.4% of all ADHD (code 314) diagnostic visits (Table 2). Thus, the very low number of ADHD NOS diagnostic visits and the high number of ADHD FC visits profoundly altered the overall NOS distribution. From 1999 through 2010, when ADHD and all other FC diagnoses were combined, the NOS proportion of all psychiatric diagnostic visits increased from 31.2% to 35.0% of all psychiatric visits (P = .25). Excluding ADHD visits from total psychiatric visits resulted in a proportional increase of all NOS diagnostic visits from 48.7% to 55.9%, representing a significant (P = .02) rise during the 12-year study period.

Discussion
A major finding in this national study is that the proportion of psychiatric visits for youth who received a DSM-IV diagnosis coded as NOS (compared with the proportion of visits coded with full diagnostic criteria) dramatically increased in internalizing diagnostic categories between the 1999-2002 and the 2007-2010 periods. This change was most apparent in the comparison between the composite mood disorders NOS and the composite FC mood disorders (Figure 1) and specifically in the diagnostic categories of bipolar disorder NOS, mood disorder NOS, anxiety disorder NOS, and depressive disorder NOS. During the 12-year study period, proportional increases in NOS diagnoses of these mood and anxiety categories rose significantly from 3.6% to 52.5% in the 1999-2002 period to 58.1% to 72.6% in the 2007-2010 period (Figures 1 and 2).

Two child psychiatry diagnostic categories did not experience a major NOS increase during the study period. The ADHD NOS category remained extremely small, with a diagnostic proportion of less than 0.4% over the 12-year assessment. However, ADHD subthreshold diagnoses have been found to be very common in community research studies.28-30 One suggested explanation for the almost exclusive use of FC to diagnose youth with features of ADHD is up-coding.14,31 This possibility is based largely on the explanation by Blader and Carlson14 for the profound recent diagnostic increases in bipolar disorder in youth.

In the PDD diagnostic category, youth were diagnosed increasingly as having autistic disorder (DSM-IV code 299.00) rather than PDD NOS (DSM-IV code 299.8) during the 12-year study period (47.6% to 62.2%; P = .02). This increase occurred in all likelihood because of the advantages of the more serious diagnosis for special education placement.32 As Judith Rapoport, MD, has noted in this respect: “We’ll call a kid a zebra if he needs to be called a zebra to get the educational and other services that he needs and deserves.”33(p69)

Further evidence clarifying this pragmatic diagnostic shift to autistic disorders consists of research studies revealing that, unlike prevalence study results based on special education searches, diagnostic prevalence findings using community assessments consistently identified PDD NOS at least twice as often as autistic disorder.34-36

Is Use of NOS DSM Diagnoses Justified?
For diagnostic precision, it is important to document the fact that many youth with psychiatric symptoms do not meet full DSM criteria. This fact has been reported to be particularly frequent in primary care settings,37-40 in part because the more serious cases are referred to specialists. Similarly, in this physician office visit-based study, nonpsychiatric medical practitioners made proportionally more NOS internalizing diagnoses than psychiatrists (P < .001).

For clinicians, NOS categories serve a number of useful functions. The NOS categories “provide indispensable placeholders when patients definitely need ...[diagnoses that] don’t fit existing molds.”41(p10) The categories apply also when “there is an appreciable level of diagnostic uncertainty—a useful thing when the simple fast answer is so often wrong and harmful.”31(p10-11) The NOS categories also provide the clinician time before committing to a firm diagnosis.42

For researchers, NOS diagnostic categories represent subthreshold levels of psychopathology that produce problematic symptoms and often predict future similar FC disorders.43 Nonetheless, numerous critics find that DSM NOS diagnoses have major limitations. Their concerns and criticisms follow.

How Precise and Useful Are NOS Diagnoses?
Rutter and Uher44(p523) critically concluded that the NOS diagnosis was a “rather unhelpful ‘rubbish basket’ diagnosis.” Paris45(p70) similarly termed the NOS code a “waste basket for the patient who does not meet criteria for any specific diagnosis.” First46(p458) termed the NOS diagnosis a “catch-all” category that results in “a loss of important clinical information.”

Do We Know Why Physicians Are Diagnosing NOS So Frequently?
Surveys of physician practice are uncommon. Psychiatric researchers in this field ascribe the large number of NOS diagnoses reported by primary care practitioners to the following: pediatricians are very busy, with a mean of 13 minutes per case48; they seldom review the diagnostic codes before recording a psychiatric diagnosis; they rarely report psychiatric comorbidities; and they commonly refer cases that have any complicated psychiatric feature.47-49 Mojtaba50 reported that more than 60% of community-treated adult patients who use antidepressants did not meet DSM-IV criteria. The author hypothesized that a major cause of increased antidepressant use related to “clinical uncertainty about diagnostic criteria and ambiguity regarding subthreshold syndromes.”51(p1063)
Will Subthreshold DSM Diagnoses Increase Further?
In all likelihood, subthreshold mental health diagnoses will increase in the future. In their follow-up study of 1704 high school students, Lewinsohn et al found that 53% of these adolescents had 1 or more subthreshold DSM psychiatric disorders by young adulthood. Paris added: “Admitting subclinical phenomena into a diagnostic classification is a very slippery slope. The lifetime prevalence of mental disorders could easily come to approach 100%.” Such an expansion of psychiatric diagnoses would be more likely to occur within spectrum disorder categories. This possibility led McClellan to write: “Labeling wide swaths of the population as spectrum cases creates vast heterogeneity and confounds biological and intervention research.”

Effect of an Increase in Subthreshold Diagnoses on Off-Label Treatment
In depressive disorders, the only diagnostic indication for psychotropic medication treatment by the US Food and Drug Administration is MDD. Because only about one-third of youth with depressive disorder diagnoses were given an MDD diagnosis in this and other national data sets, those treated with psychotropic medication for other DSM-IV depression diagnoses would have been given off-label treatment. This consequence also holds true for bipolar diagnoses other than bipolar I disorder. On the effect of such treatment, Frances wrote: “None of the suggested subthreshold disorders has a proven effective treatment. In fact, there is good reason to doubt whether currently available [NOS] treatments will have any specific positive effect.” Furthermore, “the cost, side effects, and complications of subthreshold medication treatment are considerable.”

Subthreshold diagnoses also tend to increase prevalence rates of disorders and comorbidity, whereas FC diagnoses decrease these rates. Treating subthreshold psychiatric disorders can also result in the misallocation of needed treatment services away from those with chronic ailments, although— for some patients—treatment of subthreshold disorders may limit subsequent psychopathology.

Should Subthreshold Categories Become Part of a Spectrum Disorder?
Although the DSM-IV included bipolar disorder NOS as a subthreshold diagnostic category, some clinical investigators have established specific guidelines for this diagnosis in youth. These authors report that youth who meet their bipolar disorder NOS criteria are similar to and are as treatment responsive as youth who meet full diagnostic criteria for bipolar I disorder. Consequently, they combine bipolar I and II disorders and bipolar disorder NOS as a bipolar spectrum in their diagnostic and treatment analyses.

Other investigators find that the arbitrary criteria modifications and the shortening of the symptom duration required for bipolar disorder NOS described by the previous investigators is nonspecific and misleading. In fact, major US investigators achieved an interclass correlation agreement of only 0.03 for bipolar disorder NOS in a recent attempt to measure the specificity of bipolar disorder diagnoses in youth. A European reliability study showed similar low specificity. In addition, diagnostic criteria described by bipolar spectrum researchers are quite different from bipolar spectrum criteria used by community child psychiatrists, and interview measures used to support a bipolar disorder diagnosis in youth are mixed and inconsistent.

System Suggestions About the Frequent Use of NOS Categories
Academicians increasingly are making major suggestions concerning subthreshold diagnoses. One suggestion is to merge related diagnostic features into a graded spectrum perspective. This process has been proposed for bipolar disorder, obsessive-compulsive disorder, and schizophrenia. Already, PDD NOS has been incorporated into an autism spectrum for DSM-5. The desire by many to record and use dimensional levels of psychopathology to increase diagnostic specificity is also strong. In this respect, Zimmerman et al wrote: “From a nosological perspective, the relatively high frequency of subthreshold diagnoses lends support to the dimensional rather than categorical approach toward classification.” Still another effort has been to weed out very vague NOS categories. As a result, the DSM-5 committee removed DSM-IV mood disorder NOS.

To increase the accuracy of the unspecified disorder category in the DSM-5, it seems possible to include a specifier as part of the diagnosis, preferably related to the degree of severity. The specifier could be modeled after the specifiers included within the diagnosis of MDD, one of which is rated as the degree of severity (from 1 to 4).

Limitations
The diagnostic findings in this study are based on physician office visit data from a national probability sample of community medical treatment providers for youth. Although diagnoses were made by US medical providers using DSM-IV codes and were recorded as ICD-9 codes, the two were accurately matched. Psychiatric NOS prevalence data in adults were not included in this analysis; however, adult NOS findings are similar in many respects. Clinical diagnoses from visit data may not be as technically accurate as research diagnoses, although they provide useful information about medical diagnostic practice in the community. Details on severity and medication response associated with NOS diagnoses could not be assessed from the available data.

Conclusions
A driving force for relatively uncomplicated categorical psychiatric diagnoses is their practical time-saving value for clinicians of different professional backgrounds. Categorical diagnoses also simplify reimbursement efforts. Although the DSM-5 has added some dimensional diagnostic features, it still primarily depends on this categorical nomenclature and continues to be overinclusive. Other specified and unspecified diagnoses in the DSM-5 are generally coded the same as the DSM-IV NOS codes. Barring unforeseen marked scientific prog-
ress, which could fuel a large expansion in the use of dimensional DSM criteria, most of the unspecified increases in diagnosis described in this 1999-2010 DSM-IV data set are likely to continue into the near future.

ARTICLE INFORMATION
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Study concept and design: Safer, Rajakannan, Zito.
Acquisition, analysis, or interpretation of data: All authors.
Drafting of the manuscript: Safer, Rajakannan, Zito.
Critical revision of the manuscript for important intellectual content: All authors.
Statistical analysis: Rajakannan, Burcu.
Study supervision: Safer, Zito.
Conflict of Interest Disclosures: None reported.

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Psychiatric Diagnoses for Youth

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