Psychiatry, NOS – Case Formulation, RIP

David M. Reiss, M.D.

The DSM includes a nifty device for dealing with situations in which presenting symptoms do not nicely fit into the pre-defined categories of diagnostic criteria which can lead to a specific diagnosis – by outfitting various numerically-coded diagnoses with the appendage, "NOS". The DSM includes diagnoses such as: 312.9 – Disruptive Behavior Disorder, 289.9 – Psychotic Disorder, NOS; 311 – Depressive Disorder, NOS; 296.90 – Mood Disorder, NOS; 300.00 – Anxiety Disorder, NOS; 300.81 – Somatoform Disorder, NOS; and of course, 301.9 – Personality Disorder, NOS.

Simply put, "NOS" is short hand for indicating that a certain *spectrum* of symptomatology is present, but the evaluating physician is unable to use the DSM to describe the pathology *other than in very general terms*.

Yet the real meaning of the "NOS" term has become distorted. While in reality, the NOS term indicates a lack of full understanding – providing a numerical diagnosis code for a diagnosis, including many times an *"NOS"* diagnosis, now suffices as the basis for providing various treatment interventions. More generally, the determination of diagnoses with assigned code numbers has come to constitute the basis for forming conclusions regarding specific treatment regimens – even when the diagnostic categories themselves are vague.

A patient may have an Axis I diagnosis, (i.e., acute psychiatric symptomatology) and may or may not have an Axis II diagnosis (i.e., significantly dysfunctional or pathological personality traits); or visa versa. While it is clearly a good idea to understand the difference between acute symptomatology and characterological pathology, there is no room in the DSM-style diagnostic description to provide an accounting for the interaction of "Axis I pathology", "Axis II pathology" as well as the situational factors, stressors and medical issues which may be listed on Axes III and IV. In reality, in every case, there is always a *complex and unique interplay* of acute symptomatology and underlying characterological structure, as well as external biological, psychological and social factors. Yet our diagnostic criteria provide no guide to describing those *interactions.* It is as if each diagnostic entity/Axis constituted a separate entity – in mathematical terms, "independent variables". But this simply is *not* the case in the real world.

During my training, too many years ago, I was repetitively taught that beyond dealing with emergency situations, you did not arrive at a comprehensive diagnostic conclusion, and you did not begin to provide definitive treatment, until you constructed (and usually committed to paper in writing) a Case Formulation. In the vernacular, 'Don't start treatment until you get to know the patient as a person." A Case Formulation was a detailed description of the *person* seeking treatment, including integrating issues of acute symptomatology; historical data; characterological strengths and weaknesses; the nature of psychological defenses being employed; and presence of situational biological,

psychological and social issues and the relationships of those issues to unresolved emotional conflicts.

Obviously, a Case Formulation does not lend itself to numerically-coded diagnoses. It is also true that using Case Formulations rather than specific criteria for numerically-coded diagnoses makes clinical research more difficult, especially vis-à-vis statistically determining the effectiveness of psychotropic medications – but using numerical diagnoses as opposed to Case Formulations actually makes true clinical research less accurate due to the loss of important clinical data, and at the same time, renders clinical treatment planning more superficial and unnecessarily generalized, less patient-specific, and overall in the long run, less effective. Symptoms may be more easily identified and contained using diagnostic categories to determine acute treatment interventions, but it must be asked, are our *patients* actually obtaining optimal long-lasting benefits to their ability to cope with life, beyond a suppression of symptomatology and/or the superficial resolution of an acute crisis?

While typical psychiatric and psychological records which I read (in performing many medical-legal evaluations) offer typical Axis-based numerically-coded diagnoses, often with well-described rationales as to why the manifest symptomatology present fits the diagnostic code used – in reading those diagnoses, there is no sense of who the patient is *as a person*, nor is there a reasoned discussion of how a specific and individualized combination of therapeutic approaches (psychotherapeutic, psychopharmacological, psycho-social) should be employed to help the patient, and to address *the totality* of the pathology and dysfunction present.

Perhaps we have in essence, embraced a watered-down “Psychiatry, NOS”, and we have become Psychiatric Technicians, treating symptoms and syndromes – as if symptoms and syndromes exist autonomously, independent of the *person* who is the patient. Perhaps in addition to honing our ability to use DSM diagnostic terms, we should adopt a paraphrasing of the political catch-phrase, “It’s the Patient, Stupid!”