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Editorials

Subthreshold Mental Disorders

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According to world health report (2001), 25% of the population, at sometime during their life are affected by mental and behavioral disorders. These disorders have great economic impact on societies and the quality of life of individuals and families. These problems are present at any point in time in about 10% of the adult population. Twenty percent of all patients seen by primary health care providers have one or more mental disorders. The common disorders causing severe disability include depressive disorders, substance use disorders, schizophrenia, epilepsy, Alzheimer's disease, mental retardation and disorders of childhood and adolescents.1

The ICD (International Classification of Diseases) and DSM (Diagnostic and Statistical Manual) classification have categorized mental disorders on certain criteria that include the time duration, symptomatology and disturbance in social and occupational functioning. If the criteria for respective illnesses are met, then the diagnosis is made and the patient becomes eligible for treatment. There are numerous instances where the diagnostic criteria is not fulfilled fully but there is a gross disturbance in personal, social and occupational functioning along with distressing symptoms of diseases for example anxiety and depression.

World over there is a talk about these incomplete disorders which are called subthreshold disorders. These are characterized by a variety of symptoms that do not conform to a formal diagnosis of mental disorder according to standard psychiatric classification. Information about the characteristics, development and outcome of these disorders is of considerable importance since they are frequent and cause distress and disability.2

Subthreshold psychiatric disorders are mild, masked, atypical, or intense but brief psychopathological syndromes below the threshold of standardized diagnosis. They indicate beginning, intermittent, or residual states of well known psychiatric disorders associated with other psychiatric and somatic disorders.3

Goldberg mentions about individuals with subthreshold disorders containing a small proportions of "true cases" which falls in the categorically disturbed population of patients while the dimensional category have the same basic disorder but in insufficient degree to warrant a diagnostic label.4

Depression is a serious but treatable disorder which is characterized by symptoms like: low mood, disturbed appetite, insomnia, loss of interest and energy, weeping tendencies and death wishes etc. with a duration of at least two weeks affecting social, personal and occupational life. There are many cases, which do not fulfill the duration and symptoms criteria but pose lot of distress in life. As mentioned in this context that frank mental disorders such as depression and panic disorders are prevalent in primary care and cause substantial suffering and interference in daily functions. Even subthreshold or subsyndromal conditions with fewer symptoms cause substantial morbidity.5

Nearly 50% of individuals in the community meet threshold and subthreshold diagnostic criteria for depression and anxiety, with depression being far more common, co-occurrence of anxiety and depression is common as the majority of individuals who experience anxiety also manifest threshold or subthreshold depression.6

In the outpatients, subthreshold depression appeared to be a variant of affective disorder and was treated as such in the mental health specialty sector but not in general medical sector.7 The findings emphasize the importance of treatment outcome studies of patients with subthreshold depression. It is described by the researchers that subthreshold depression does not carry mortality risk for men8 and less serious 12-month outcome than the threshold cases9.

Major depression is a serious diagnostic category but recent epidemiological research in general population and primary care demonstrated that a substantial proportion of disabling depressive syndromes do not meet the diagnostic criteria for major depression.10

Researchers have pointed out certain facts about other conditions for example; the presence of subthreshold anxiety disorders is influenced by age, gender and previous professional level.11 Adjustment disorder is one of the subthreshold disorders that is less well defined and shares characteristics of other diagnostic groups. Higher number of subthreshold PTSD (Post Traumatic Stress Disorder) symptoms were associated with greater impairment, co-morbidity and suicidal ideation.12

Subthreshold symptoms in schizophrenia can be prodromal signs of a psychotic relapse. In people without schizophrenia, similar symptoms may indicate the presence of disorders termed as 'schizophrenia spectrum disorders'. Subthreshold schizophrenia-like symptoms may indicate a genetically transmitted higher proneness to schizophrenia.13

In the local context since its independence, Pakistan has persistently been riddled by poor socioeconomic conditions, low literacy rate, political instability, and meager healthcare profile. The burning issues of recent times such as human right violations, corruption, unemployment, denial of justice, loosening of cohesion in society, discrimination and violence, have further aggravated the scenario which has culminated in upsurge of mental disorders both threshold and subthreshold. Some studies14,15 highlight the increase in prevalence of depression, psychosomatic disorders and substance abuse. The recent upsurge of suicide reported in the press is also worth mentioning. Epilepsy, speech problems and other behavioral problems constitute substantial proportion in child psychiatric disorders in Pakistan. Mental retardation constitutes another grave problem, and is estimated to affect some 0.5 to 1 per cent of the children.14
The fact file, based on available research data as compiled from various studies14,15, gives the prevalence figures as: 6% for depression, 1.5% for schizophrenia, 1-2% for epilepsy and 1% for Alzheimer's disease. Besides other social evils, these mental morbidities are responsible for the high suicide rate as noted recently. The prevalence of depressive disorders is the highest, followed by schizophrenia and substance abuse in that order.15
The data of a nationwide study15 based percentages of mental illnesses diagnosed by various participant psychiatrists across the country, has shown depression outnumbers all other illnesses followed by manic-depressive psychosis, schizophrenia, anxiety neurosis, psychosomatic disorders and substance abuse disorder. It is not known that how many of such cases fall in the subthreshold variants.

Concept of mental illness is believed to be the result of possession and 'Jinnic' influence and its recognition is barred because of the issue of stigma, the layman identifies it only if a person talks irrelevantly, becomes aggressive and exhibits disinhibition.16 Once it is understood, the treatment approach is through shamans (these are the alternate practitioners for mental health who claim to be in direct communication with spiritual world), general practitioners and physicians with only tiny minority reaching the psychiatrists. Though current literature gives the data on mental disorders but there is hardly any study depicting the magnitude of subthreshold disorders. Diagnosis does not remain a problem for many psychiatrists who use their own judgment and experience and would treat both disorders equally. Other practitioners face the dilemma of diagnosis and treatment.

Presentation and symptomatology may present a complex picture in clinical situations The doctors who endeavor to follow the classification system strictly, find it very difficult to reach a diagnosis, but at the same time they grasp the problem because of their familiarity with the surrounding culture and the local norms.

Under the existing circumstances, it is appropriate to start a debate on the need for revision of the existing classification system with accommodation of transcultural variation and to devise an appropriate protocol for such an action. There could be a possibility of devising a classification for the Asian region, which should incorporate many, identified culture-bound syndromes and "subthreshold mental disorders".

In Pakistan, as the magnitude of subthreshold disorders is not known and so no information whatsoever is about the treatment and its outcome. Future research needs to apply methodological and intellectual rigour and systematically consider a broader clinical and nosological context.17

The high prevalence of sub-threshold mental disorders, the significant psychosocial impairment associated with it and the chronicity of its course make the sub-syndromal mental disorder a matter for serious consideration by both clinicians and researchers.

Thus, there is a need to give research-based recognition to subthreshold mental disorders along with their associated repercussions and a comprehensive strategy including guidelines for addressing this matter from the management point of view.

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