

## The Aftermath of the Concept of 'Psychiatric Comorbidity'

Mario Maj

Department of Psychiatry, University of Naples SUN, Largo Madonna delle Grazie, Naples, Italy

The concept of 'psychiatric comorbidity' (i.e., coexistence of two or more psychiatric diagnoses) has become very popular in the last few decades. 'Psychiatric comorbidity' has been found to be very common both in the general population and in clinical settings. For instance, in the US National Comorbidity Survey [1], only 26% of patients with a DSM-III-R/DSM-IV diagnosis of major depression had no concomitant ('comorbid') mental disorder, while in a study carried out in a general psychiatric clinic [2] more than one third of patients presenting for admission had at least three concomitant ('comorbid') DSM-IV axis I disorders.

It has been repeatedly pointed out [e.g., 3, 4] that the term 'comorbidity' as originally defined by Feinstein [5] – i.e., the occurrence of a 'distinct additional clinical entity' during the clinical course of a patient having an index disease – should not be used to indicate the concomitance of two or more psychiatric diagnoses, because in most cases, due to our current very limited knowledge of the etiopathogenesis of mental disorders, it is unclear whether the concomitant psychiatric diagnoses actually reflect the presence of 'distinct clinical entities' or refer to multiple manifestations of a single clinical entity. 'Disorders' are different from 'diseases' [6], and even the term 'disorders' (rather than 'syndromes', i.e., constellations of symptoms) is probably inadequate to reflect the status of our current diagnostic categories [7]. Moreover, the emergence of the phenomenon of 'psychiatric comorbidity' has been to a large extent a by-product of some characteristics of our

current diagnostic systems, such as 'the rule laid down in the construction of DSM-III that the same symptoms could not appear in more than one disorder' [8], the proliferation of diagnostic categories, the limited number of hierarchical rules, and the fact itself that the current systems are based on operational diagnostic criteria, which may be less able than traditional clinical descriptions to convey the 'gestalt' of some diagnostic entities [4]. The recent debate on 'clinimetrics' vs. psychometrics in this journal [9, 10] is enlightening in this respect.

The main argument which has been put forward [e.g., 11] to respond to the above criticisms is that, exactly because our current knowledge of the etiopathogenesis of mental disorders is very limited, we should adopt an atheoretical and descriptive approach, allowing to record all the diagnoses whose criteria are fulfilled by each individual, with very few hierarchical rules. This would ensure the collection of a greater amount of clinical information, a more comprehensive and targeted approach to treatment and the exploration of the pathophysiological correlates of the individual 'comorbid' mental disorders.

Is this argument convincing? Not completely, as its proponents themselves recognize [e.g., 11, 12]. The assumption that encouraging multiple diagnoses allows the collection of a greater amount of information in clinical practice remains at present not proven by empirical research. What research evidence actually suggests is that clinicians tend not to record all the diagnoses that a given individual fulfils [2, 13]. Especially in very busy practices

**KARGER**

Fax +41 61 306 12 34  
E-Mail [karger@karger.ch](mailto:karger@karger.ch)  
[www.karger.com](http://www.karger.com)

© 2005 S. Karger AG, Basel  
0033-3190/05/0742-0067\$22.00/0

Accessible online at:  
[www.karger.com/pps](http://www.karger.com/pps)

Mario Maj

Department of Psychiatry, University of Naples SUN  
Largo Madonna delle Grazie  
IT-80138 Naples (Italy)

Tel. +39 081 5666502, Fax +39 081 5666523, E-Mail [majmario@tin.it](mailto:majmario@tin.it)

and in developing countries [14], usually only one diagnosis is made. Since this diagnosis often corresponds to just one 'piece' of a traditional diagnostic entity, the amount of information which is finally collected is sometimes less than the one obtained with traditional diagnostic systems. Moreover, the 'piece' that is recorded may not be the same when a given patient is seen by different psychiatrists, which may represent a new powerful source of diagnostic unreliability.

That the possibility to record multiple diagnoses implies a more comprehensive and targeted approach to treatment is also not documented by available research. The risk here is that splitting artificially a complex clinical condition into several 'pieces' may prevent a holistic approach to the individual patient, encouraging unwarranted polypharmacy (one drug for each diagnosed disorder) [4]. If each of the concomitant 'disorders' has its own pathophysiological correlates, it is logical to use a different medication for each of them. But, are we sure that the 'panic' of patients with agoraphobia, major depression and schizophrenia is exactly the same 'entity', which simply 'co-occurs' with the others, thus requiring an independent treatment which is the same in agoraphobic, depressed and psychotic patients? I am not aware of any empirical study dealing with this issue.

Finally, we all hope that the application of the concept of 'psychiatric comorbidity' will lead to a rearrangement and a refinement of our current classifications, which may either involve [4] a simplification (i.e., a single disease entity may underlie the apparent 'comorbidity' of several disorders), or a further complication (i.e., different dis-

ease entities may correspond to different patterns of 'comorbidity') or possibly a simplification in some areas of classification and a further complication in other areas. Recent research findings [e.g., 15] about the different biological correlates of bipolar disorder when it is 'comorbid' with panic disorder seem to encourage optimism in this respect. However, the fact is that most biological and pharmacological research is currently ignoring the phenomenon of 'psychiatric comorbidity'. Most biological studies are carried out in patients fulfilling diagnostic criteria for a given mental disorder, without any attention to other concomitant disorders. In most drug trials focusing on a given mental disorder, the presence of other 'comorbid' disorders is an exclusion criterion. Moreover, the current incomplete characterization of the 'new' psychopathology of some psychiatric syndromes seems to represent an important confounding factor in this area: for instance, the 'comorbidity' between anxiety disorders and bipolar disorder is reported to be very frequent, but the differentiation between some anxiety symptoms and some manifestations of 'nonclassical mania' or 'agitated depression' seems to be problematic [see, for instance, 16].

From the above discussion, it seems clear that the emergence of the phenomenon of 'psychiatric comorbidity' has generated a considerable debate, addressing the foundations of our current systems of classification of mental disorders. This should certainly be regarded as a positive development. However, continuous critical challenge seems to be vital in this area, in order to prevent dangerous oversimplifications and misunderstandings.

## References

- 1 Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen HU, Kendler KS: Lifetime and 12-month prevalence of DSM-III-R disorders in the United States: Results from the National Comorbidity Survey. *Arch Gen Psychiatry* 1994;51:8-19.
- 2 Zimmerman M, Mattia JJ: Psychiatric diagnosis in clinical practice: Is comorbidity being missed? *Compr Psychiatry* 1999;40:182-191.
- 3 Lilienfeld SO, Waldman ID, Israel AC: A critical examination of the use of the term and concept of comorbidity in psychopathology research. *Clin Psychol Sci Pract* 1994;1:71-83.
- 4 Maj M: 'Psychiatric comorbidity': An artefact of current diagnostic systems? *Br J Psychiatry*, in press.
- 5 Feinstein AR: The pre-therapeutic classification of co-morbidity in chronic diseases. *J Chronic Dis* 1970;23:455-468.
- 6 Cooper J: Disorders are different from diseases. *World Psychiatry* 2004;3:24.
- 7 Jablensky A: The syndrome - an antidote to spurious comorbidity? *World Psychiatry* 2004;3:24-25.
- 8 Robins L: How recognizing 'comorbidities' in psychopathology may lead to an improved research nosology. *Clin Psychol Sci Pract* 1994;1:93-95.
- 9 Fava GA, Ruini C, Rafanelli C: Psychometric theory is an obstacle to the progress of clinical research. *Psychother Psychosom* 2004;73:145-148.
- 10 Emmelkamp PMG: The additional value of clinimetrics needs to be established rather than assumed. *Psychother Psychosom* 2004;73:142-144.
- 11 Pincus HA, Tew JD Jr, First MB: Psychiatric comorbidity: Is more less? *World Psychiatry* 2004;3:18-23.
- 12 Regier DA: State-of-the-art psychiatric diagnosis. *World Psychiatry* 2004;3:25-26.
- 13 Basco MR, Bostic JQ, Davies D, Rush AJ, Witte B, Hendrickse W, Barnett V: Methods to improve diagnostic accuracy in a community mental health setting. *Am J Psychiatry* 2000;157:1599-1605.
- 14 Murthy RS: Psychiatric comorbidity presents special challenges in developing countries. *World Psychiatry* 2004;3:28-30.
- 15 MacKinnon DF, Xu J, McMahon FJ, Simpson SG, Stine OC, McInnis MG, DePaulo JR: Bipolar disorder and panic disorder in families: An analysis of chromosome 18 data. *Am J Psychiatry* 1998;155:829-831.
- 16 Maj M, Pirozzi R, Magliano L, Bartoli L: Agitated depression in bipolar I disorder: Prevalence, phenomenology, and outcome. *Am J Psychiatry* 2003;160:2134-2140.