The syndrome – an antidote to spurious comorbidity?

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Pincus et al identify correctly the proliferation of comorbid diagnoses in psychiatry as a by-product of the

current classification systems, especially since the abandonment of the hierarchical rules which had been introduced in DSM-III. If we adhere to the original definition of comorbidity as co-occurrence of clinically independent conditions, the reported prevalence of multiple comorbid psychiatric disorders - over a third of all cases in the population (1) - strains credibility and reflects adversely on the conceptual basis of the current classifications. Either the nature of psychiatric illnesses is such that they always tend to occur in clusters, or the diagnostic classification fails to discriminate between spurious comorbidity (mistaking facets of the same clinical entity for independent disorders) and true comorbidity.

The problem seems to be unique to psychiatry among the medical disciplines. An individual can, of course, harbour two or more diseases and, consequently, be a member of two or more categories in medical classifications, but such multiple membership can only be based on distinct and independent sets of characteristics. Current psychiatric classifications allow multiple category membership on the basis of the same set of data since their categories are not mutually exclusive. For example, an individual can meet the diagnostic criteria of both dysthymia and major depressive disorder on the basis of essentially the same symptoms, depending on their intensity, duration and sequence.

Part of the problem stems from the fact that DSM-IV and ICD-10 evade the difficult problem of defining the nature of the entities that are being classified, and instead adopt as the currency unit in psychiatric classification the term 'disorder' (first introduced in DSM-I in 1952), which has no clear correspondence with either the concept of disease or the concept of syndrome in medical classifications (2). The ambiguous status of the classificatory unit of 'disorder' has two corollaries which create conceptual confusion and hinder the advancement of knowledge: a) the 'reification fallacy' - the tendency to view the DSM-IV and ICD-10 'disorders' as quasi-disease entities; and b) the fragmentation of psychopathology into a large number of 'disorders', of which many are merely symptoms. This blurs the distinction between true and spurious comorbidity, and masks the presence of complex but essentially unitary *syndromes,* such as Bonhoeffer's "exogenous reaction types" (3) or the recently revived "general neurotic syndrome" (4). It is not surprising, therefore, that 'disorders', as defined in the current versions of DSM and ICD, have a strong tendency to co-occur, which suggests that "fundamental assumptions of the dominant diagnostic schemata may be incorrect" (5).

In contrast, syndromes are basic concepts for most clinicians, and much of their clinical knowledge is cognitively stored in this format. These are good reasons for reinstating the syndrome, as a "real-world correlational structure" in psychopathology (6), to its rightful place as the basic Axis I unit in future classifications.

References

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