



# Comorbidity in psychiatry

Philosophy of Medicine Roundtable  
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# Comorbidity

In psychiatry it often occurs that patients suffer from multiple disorders at the same time.

	Country	N	12 mth any dx (in%)	1 dx	2 dx	3 dx	> 3 dx	% pts > 1dx
Bijl 1998	NL	7076	23,3	15,3	4,4	1,9	1,9	35
Jacobi 2004	BRD	4181	31,1	18,8	6,3	2,8	3,2	40
Kessler 2005	USA	9282	26,2	14,4	5,8	6,0		45



# Why study comorbidity?

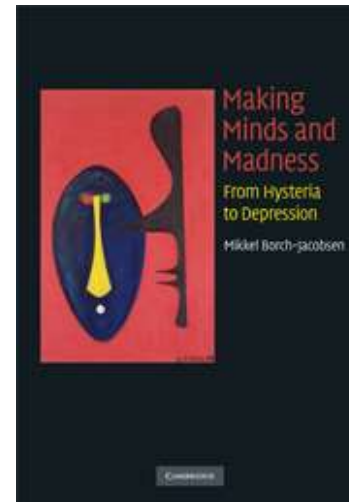
Understanding this phenomenon is important, both practically and theoretically.

- › Patients with comorbidity have more functional disability and react less well to treatment.
- › A better understanding of comorbidity will contribute to a sensible debate over many issues surrounding the DSM.



# Theoretical controversy

Two opposing views on comorbidity dominate the debate: realism and constructivism.





# Disorders as conventions

We aim to escape this opposition and argue for *conventionalism*.





# Plan of talk

- ① Discussion on comorbidity
- ② Illustration of conventionalist perspective
- ③ Philosophical benefits
- ④ Implications for practice
- ⑤ Future work



# ① Comorbidity

The discussion on comorbidity has focused on what it might tell us.

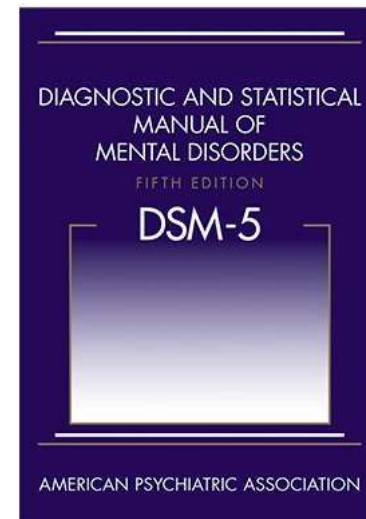
- › Some argue that it results from definitional choices (constructivist).
- › Others maintain that it signals real relations among diseases (realist).



# Example: MDD

At least 5 out of (items 1 or 2 necessary):

1. Depressed mood
2. Loss of interest
3. Appetite disturbance
4. Sleep disturbance
5. Psychomotor disturbance
6. Fatigue
7. Worthlessness
8. Trouble concentrating
9. Suicidal thoughts







# Comorbidity as artificial

It may be an artefact of the DSM that some people are diagnosed with multiple disorders, e.g. MDD and GAD.

	A	$\neg A$	
B	2	3	2
$\neg B$	3	4	3
	2	3	2
	1	2	1

$\neg C$        $C$        $\neg C$

$\neg D$   
|  
D  
|  
 $\neg D$

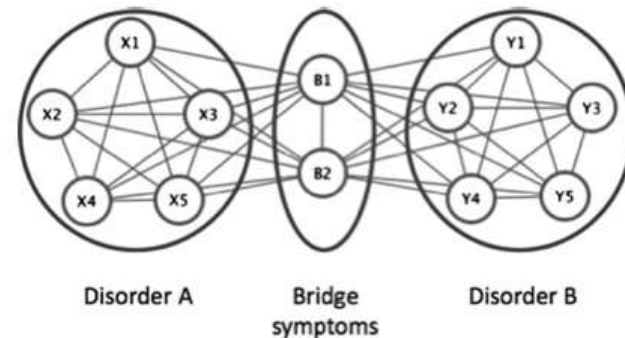
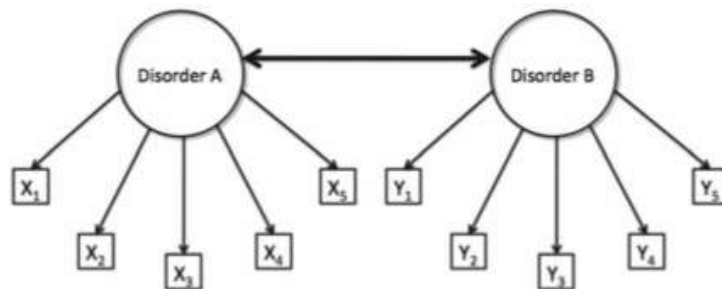
	A	$\neg A$	
B			
$\neg B$		*	

$\neg C$        $C$        $\neg C$

$\neg D$   
|  
D  
|  
 $\neg D$

# Comorbidity as causal

The co-occurrence of two disorders may also signal that they promote each other causally.

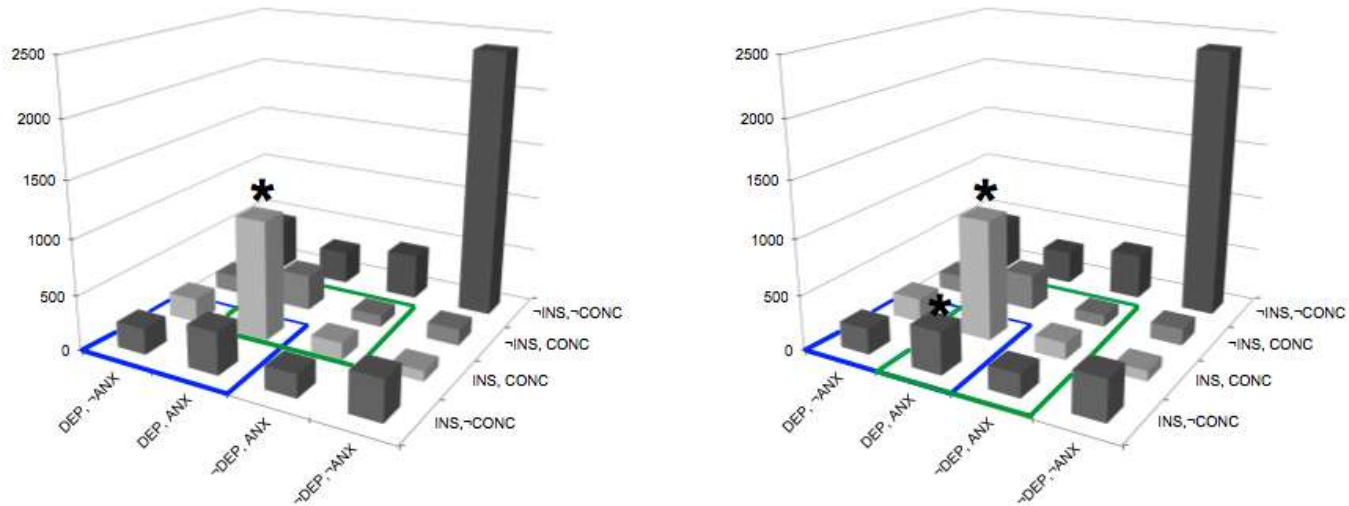


(Figures from Cramer *et al*, BBS 2010)



## ② Conventional choices

There is undeniably a subjective element to comorbidity.

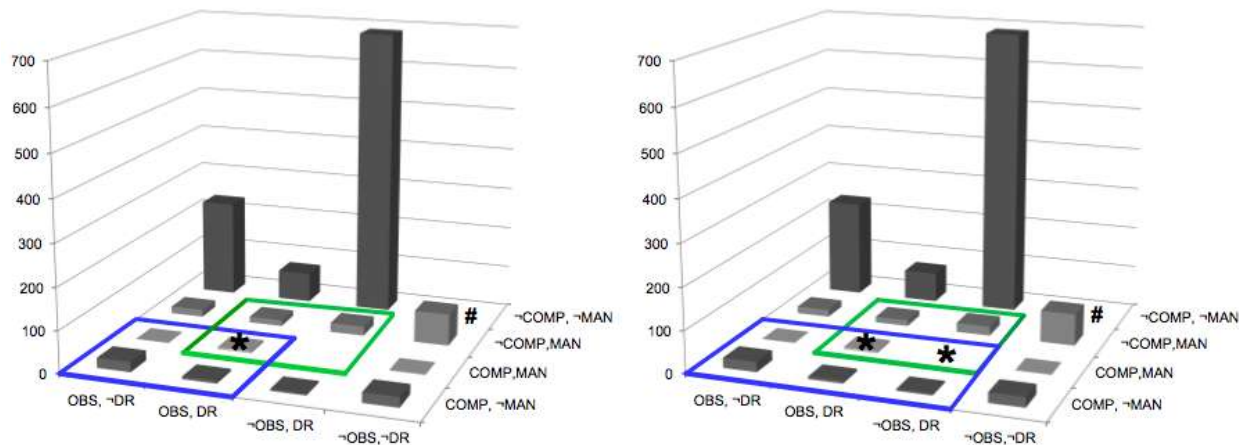


(Data from NEMESIS study n=7076)



# Objective representations

Relative to conventions, the comorbidity rates indicate robust aspects of symptom distribution.



(Data from NEMESIS study n=7076)



# Conventionalism

The DSM has the role of a convention that occasions substantive claims about mental disorders.





# Coordinative definitions

Mental disorders obtain the role of “coordinative definitions”.





## ③ Philosophical benefits

Conventionalism can clarify a number of conceptual problems in psychiatry.

- › The DSM performs two functions: diagnostic tool and theoretical structure. Does psychiatry suffer from vicious circularity?
- › Psychiatric disorders from the DSM are man-made and hence seem arbitrary. How can they be carriers of causal power?



# Virtuous circularity

The structure of the DSM establishes the relation between theory and data but is not itself a substantive claim.

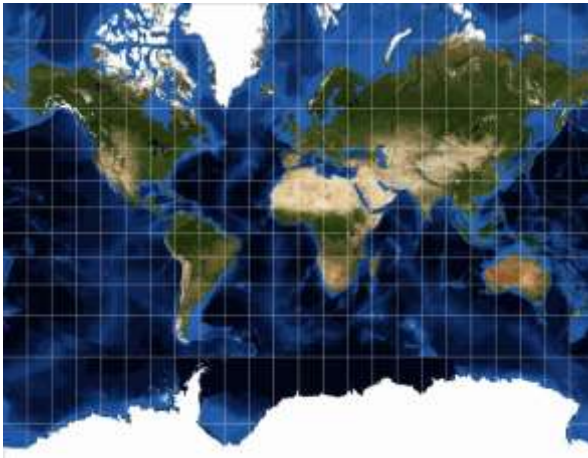






# Non-arbitrariness

The structure of the classification must be such that substantive claims, made by means of it, can be expressed conveniently.





## ④ Impact on practice

The appropriate response to conceptual problems in psychiatry is the one that is most conducive to successful psychiatric practice.





# Psychiatry: fake?

Constructivists views on the DSM have adverse effects on health policy.

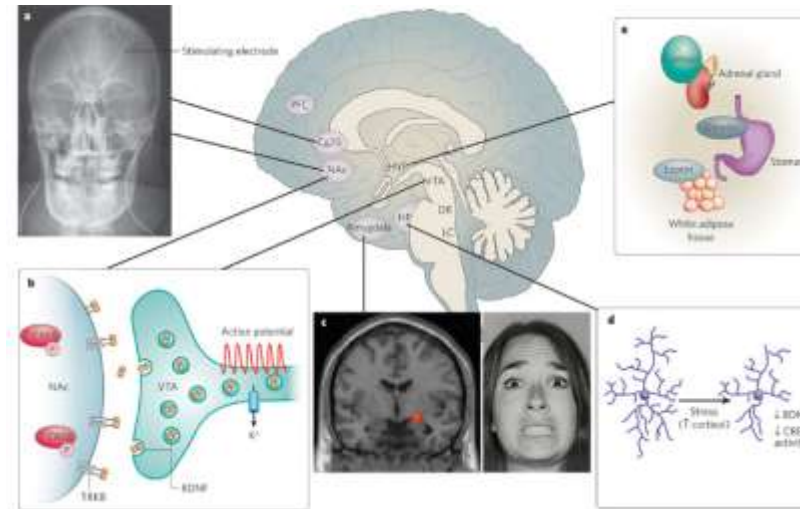
Minister Edith Schippers: “Psychiatrische diagnoses zijn geen echte ziekten”,

Datum: 6 september 2011, 11:18 ~ Bronnen: [De Volkskrant](#), [NOS Nieuws](#)



# Excesses of realism?

The idea that MDD is real possibly misdirects major research efforts.

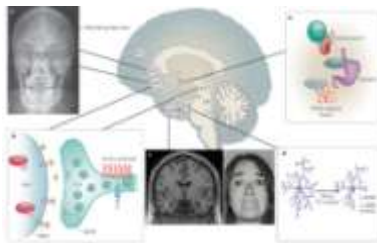


(Figure from Krishnan & Nestler. Nature 2008)



# Moving forward

Debates over the DSM5, comorbidity and so on do not benefit from the strong opposition between real and artificial.



[Minister Edith Schippers: “Psychiatrische diagnoses zijn geen echte ziekten”](#),

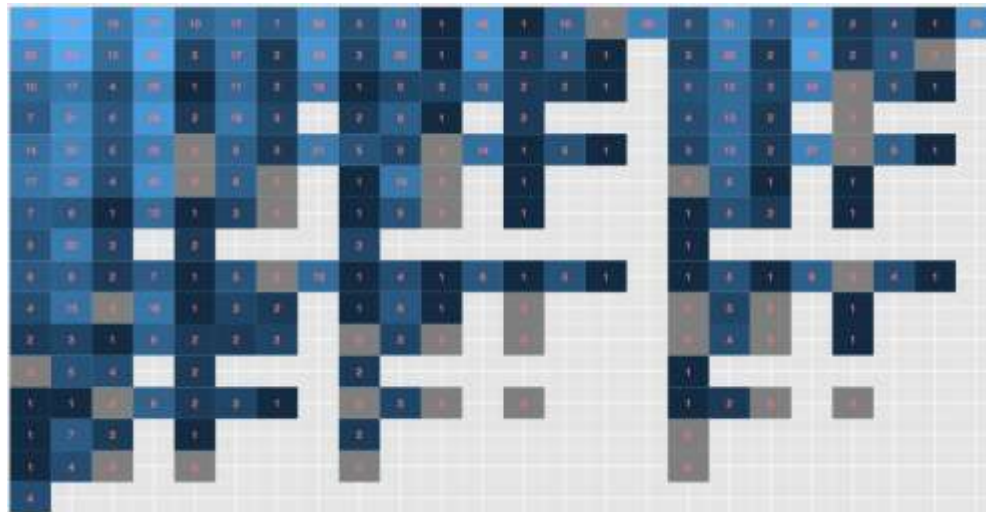
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## ⑤ Future work

More fine-grained analyses may suggest subtypes of depression that relate directly to treatment profiles.





# Conventions: whence?

The conventions find their ultimate basis in a situated practice (cf. van Fraassen).



The *use* of the DSM defines the conventions that fix its theoretical content.



# Thanks for your attention

For questions and remarks please email:

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