

## Comorbidity in psychiatry

Presentation for UJ seminar

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## Comorbidity

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

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

## Why study comorbidity?

Understanding this phenomenon is important, both practically and theoretically.

- > Patients with comorbid disorders have disproportional 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 determine the debate: realism and constructivism.



## Disorders as conventions

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



## Plan of talk

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

## ① Comorbidity

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

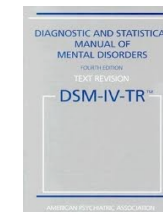
- > Some argue that it results from definitional choices (constructivist).
- > Others maintain that it signals real relations among diseases (realist).

The camps agree that comorbidity reveals the need for causal disease definitions.

## Example: MDD

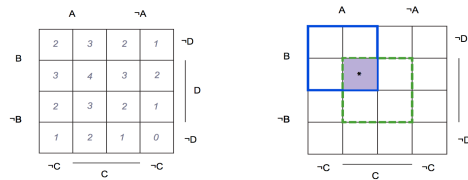
At least 5 out of (items 1 or 2 necessary):

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



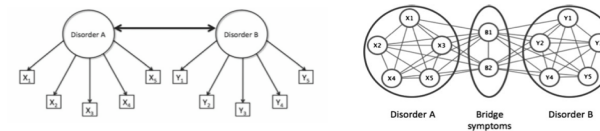
## Comorbidity as overlap

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



## Comorbidity as causal

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



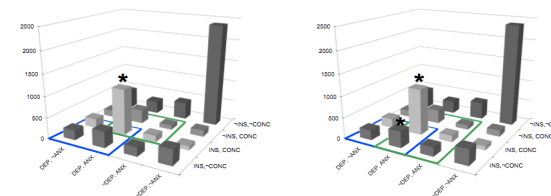
(Figures from Cramer et al, BBS 2010)

## ② Conventional choices

- We consider two cases of disease overlap.
- > Squaring {depression  $\wedge$  insomnia} with
    - {anxiety  $\wedge$  low concentration} and
    - {anxiety  $\wedge$  (insomnia  $\vee$  low concentration)}.
  - > Squaring {drug use  $\wedge$  being manic} with
    - {compulsions  $\wedge$  obsessions} and
    - {compulsions  $\wedge$  ( drug use  $\vee$  obsessions)}.

## It all depends...

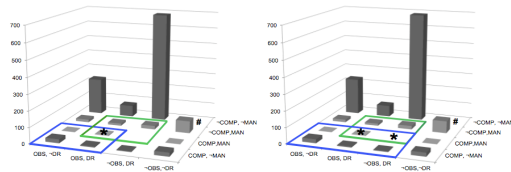
In the first case, comorbidity increases from 43% to 54% when widening disease definition.



(Data from NEMESIS study n=7076)

## ...on definition and distribution

But in the second case, comorbidity decreases from 7% to 6% with a widened definition.



(Data from NEMESIS study n=7076)

## Oversimplification?

The foregoing is a strong simplification of actual practice in psychiatric disease definition.

- > Symptoms are by no means the clean units of analysis portrayed here.
- > Clustering methods focus on far more intricate empirical patterns.

Nevertheless we maintain that the above insights apply in general.

## 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?

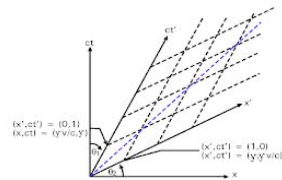
### Virtuous circularity

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.



### Scientific representation

In short, conventionalism allows us to escape old-hat oppositions between constructivist and re(presentation)alist views.



## ④ Impact on practice

The appropriate response to conceptual problems in psychiatry is the one that is most conducive to succesful 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



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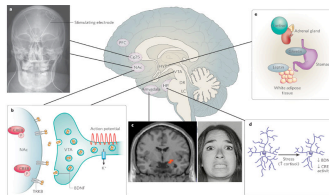
'Farmaceuten bedenken constant nieuwe aandoeningen'



In deze rubriek wordt aandacht gegeven aan de relatie van de wetenschap met de maatschappij. Het gaat om de relatie tussen wetenschap en de maatschappij. Het gaat om de relatie tussen wetenschap en de maatschappij. Het gaat om de relatie tussen wetenschap en de maatschappij.

## Excesses of realism?

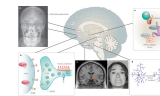
The idea that e.g. MDD is a causal unit or natural kind might misdirect major research efforts.



(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.



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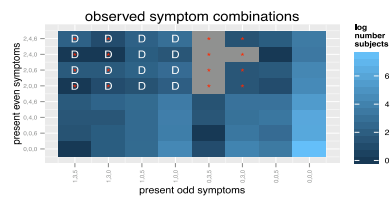
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## ⑤ Future work

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 should define the conventions that fix theoretical content.

## Externalist operationalism

Conventions serve as the point of contact between mental disease classifications and hands-on empirical reality.



## Thanks for your attention

This presentation will be made available on:

<http://www.philos.rug.nl/~romeyn/>

For questions and remarks please email:

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