The confusion of psychiatric comorbidity

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For me, the concept of comorbidity as it has been applied in psychiatry always has been difficult to comprehend. Theoretically, a patient could suffer from schizophrenia, persistent depressive disorder, agoraphobia, Cannabis use disorder, mild neurocognitive disorder, and perhaps a few more diagnostic entities. Yes, this example may be a bit of an exaggeration, but is possible. We often see a similar host of psychiatric diagnoses in patients’ charts for a variety of reasons, such as a string of treating psychiatrists who use or see different diagnoses or insurance payment issues. However, I believe there are 3 main reasons in the present era that explain this phenomenon: lack of attention to careful descriptive psychopathology, lack of symptom and syndrome hierarchy, and the inappropriate use of the term “comorbidity.” In a way, comorbidity is a product of DSM-IV and DSM-5 because DSM-III kept a certain hierarchy of psychopathology.

The term *comorbidity* was introduced to medicine by Feinstein in 1970. As he wrote, "For the purpose of the discussion here, the term *comorbidity* will refer to any distinct additional entity that has existed or that may occur during the clinical course of a patient who has the index disease under the study." He further expounded using toponymy: “The toponymy of an event refers to its anatomic location and purported mechanism in relation to the index disease under scrutiny. A primary event is attributable to the main pathological derangement of the index disease; a secondary event arises from an auxiliary problem or complication.... In relationship to such an index disease, a co-morbid disease can be regarded as ancestral, supervening, or derivative. An ancestral disease is one that caused, or was converted into, the index disease. Thus, an old pneumonia is often regarded as ancestral for a pulmonary ‘scar’ carcinoma, and ulcerative colitis may sometimes be ancestral for carcinoma of the colon. A supervening disease is caused by a new pathologic process that was predisposed by anatomic events of the index disease at the primary site. For example, an acute pneumococcal pneumonia or lung abscess may super-
A derivative disease is caused by dissemination of the same pathologic process present in the index disease. The dissemination may be produced either by actual anatomic spread, or by systemic ‘secretion’ of hormones or toxins. Thus a cancer of the lung may metastatically destroy the adrenal glands, producing Addison’s disease; or the focal cancer may hormonally create hypertrophic osteoarthropathy or the endocrinopathies of Cushing’s syndrome, hypercalcemia, or inappropriate secretion of vasopressin. A co-morbid disease that has none of the dependent relations just described may be regarded as independent, or unrelated to the index disease.¹⁴

As defined by Feinstein,⁴ comorbidity clearly does not apply to psychiatry and should not be used in psychiatry. First, in the case I described at the beginning of this editorial, we usually cannot ascertain ancestral, supervening, or derivative relationships between entities such as schizophrenia and agoraphobia. We simply do not know. We also cannot establish whether these are 2 or more distinct entities. We have started to address this confusion by introducing new terminology in DSM-5, eg, panic attack specifier,² which allows us to avoid using a “comorbid” coexisting diagnosis of panic disorder by saying that there are panic attacks occurring during the course of a specific other disorder, such as major depressive disorder. That brings back another issue—the hierarchy of psychopathology, symptoms, and syndromes—a matter beyond the scope of this editorial.

More than a decade ago Maj² suggested that “Because ‘the use of imprecise language may lead to correspondingly imprecise thinking’ … this usage of the term ‘comorbidity’ should probably be avoided.” He was right. The question remains, “Why are we still using it?”

REFERENCES