

How Recognizing "Comorbidities" in Psychopathology May Lead to an Improved Research Nosology

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A short history of the roots of DSM-III and the politics of its creation help to explain the extensive occasions it offers for fulfilling criteria for multiple diagnoses. With use of standardized interviews, it becomes possible to discover all the diagnoses a single person can qualify for. This should prompt rethinking how diagnoses are selected and what rules for preemptions accord with the nature of psychopathology.

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The paper by Lilienfeld et al. in this issue has as its goal getting people to drop the use of the term *comorbidity* when they refer to the presence of more than one psychiatric disorder in the same person. The authors prefer terms such as *co-occurrence* or *overlapping diagnoses*. I've generally used *co-occurrence* (Robins and Regier, 1991) because I too was uneasy about the term *comorbidity*. Like the authors of this paper, I suspect that it is not the case that every disorder in DSM-III and DSM-III-R reflects a distinct underlying reality (the authors' "latent taxon"). Instead, disorders are sometimes the product of three factors—tradition, politics, and a rule laid down in the construction of DSM-III that the same symptom could not appear in more than one disorder.

I don't know whether Lilienfeld et al. are aware of that rule, but it does explain in part why DSM-III became a "splitting" rather than a "lumping" diagnostic system. I thought then, as I still do, that the rule was not a good one, because it deviates from practice in the rest of medicine, where many diseases share symptoms—aching joints and fever, for example. Its role in creating "comorbidities" can perhaps be best seen in somatization disorder. The symptoms of somatization disorder in DSM-III are generally identical with those of Briquet's syndrome,

a disorder resurrected from the French literature at Washington University because it so much resembled the diagnosis of hysteria in the Feighner criteria (1972), but DSM-III deleted the symptoms overlapping with depression and anxiety disorders. Not surprisingly, when we looked at the Epidemiologic Catchment Area data, we found that every one of the somatization disorder cases had at least one other disorder—with risks most elevated for panic disorder, but greatly elevated as well for affective disorders, schizophrenia, and organic brain syndrome (Robins and Regier, 1991).

Politics also played a major role in making DSM-III a splitting rather than a lumping system, particularly in the child psychiatry area. There was a meeting in St. Louis soon after Robert Spitzer took over the leadership of the DSM-III Task Force, which nearly brought the construction of DSM-III to a halt because the proponents of the then new field of adolescent psychiatry, many of whom had training in psychoanalysis, felt that their concepts were being ignored. A solution required adding the diagnoses they were supporting, such as identity disorder, post-traumatic stress disorder, and the various adjustment disorders.

The consequences of these forces can be seen simply by counting the number of diagnoses in DSM-III compared with its progenitors, the Feighner criteria (1972) and the Research Diagnostic Criteria (Spitzer, 1975). It was Robert Spitzer's decision to give DSM-III the explicit diagnostic criteria that had impressed him in Washington University's "Feighner criteria." The Feighner criteria listed only 15 diagnoses in all, plus a category for patients who fit none of them, "undiagnosed." The first step toward DSM-III was R. Spitzer's, J. Endicott's, and E. Robins's elaboration of the Feighner criteria into the Research Diagnostic Criteria (RDC) (Spitzer et al., 1975). In this earliest version of the RDC, the number of diagnoses grew to 22. Its only substantive additions to the Feighner criteria were two personality disorders—cyclothymic and depressive. The rest of the increase resulted from splitting the Feighner categories. Even the "undiagnosed" category was split into unspecified psychosis, other psychiatric disorder, and borderline features. The creation of new categories was most remarkable between publication of RDC criteria and publication of DSM-III. DSM-III, published in 1980, contained more than 200 diagnoses. Lilienfeld et al. call attention in particular to its multiplicity of children's disorders. Note that

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neither the Feighner criteria nor the RDC included any diagnoses specific to children. Thus in constructing DSM-III it was the child area which, lacking a map for reform, was most subject to contest.

Although DSM-III's criteria were much more specific than DSM-II's, the proliferation of diagnoses made it possible to give a patient several different diagnoses *even when all of his symptoms fit within one of them*. As a result, even with conscientious use of DSM-III criteria, psychiatrists could express different diagnostic styles. At Washington University, for instance, there are sections of DSM-III and DSM-III-R that remain virtually unused because every patient can fit into that subset of diagnoses that local psychiatrists have been trained to use. When diagnosticians do *not* discard parts of the Manual, they can legitimately give multiple diagnoses *without* multiple syndromes, as Lilienfeld et al. suggest in protesting the provision of personality disorder diagnoses that are very like Axis I disorders.

Lilienfeld et al. also credit the creation of standardized interviews with a role in the explosion of interest in multiple diagnoses. While they may deplore this, I would argue that this was a useful function of standardized interviews. Their use prevents a researcher from doing what the Washington University psychiatrists did—simply ignoring available diagnoses that do not fit one view of the field. Instead, the output from a fully standardized interview notes all the diagnoses that the Manual allows a patient or research subject to qualify for. These interviews do not create the multiplicity of diagnoses; they try to be true to what the diagnostic manual *says*, even when its authors may have *meant* something a bit different. When standardized interviews demonstrate that a single patient qualifies for an unreasonable number of diagnoses, that should motivate the field to rethink this proliferation of categories.

Lilienfeld et al. recommend adoption of Kazdin's definitions of syndrome, disorder, and disease. They are less bothered by multiple *disorders* or *syndromes* in the same individual than multiple *diseases*. But a problem remains in practice even if the *idea* of multiple disorders or syndromes is more acceptable, because of inconsistencies in the current system. As Lilienfeld et al. note, the DSM avoids some overlapping diagnoses by using preemptive rules. But its preemptive rules are inconsistent in whether multiple syndromes are combined or suppressed to create single disorders. For example, the diagnosis of a patient who is depressed but previously had a manic epi-

sode is given as *Bipolar Disorder, Depressed*, a diagnosis that simultaneously represents both current and past syndromes, while ruling out the diagnosis of *Major Depression*. Lilienfeld et al. cite a contrasting example: If a patient has both phobias and obsessions, whether simultaneously or consecutively, the phobia syndrome is completely suppressed in the diagnosis.

DSM-III and its subsequent versions give advice in the text of individual disorders about when to use preemptions and when to give multiple diagnoses, but they do not discuss basic principles that have determined what advice is given. Principles for exclusion were a lively topic in the pre-DSM-III 1960s and 1970s. An influential proposal was to implement a distinction between "primary" and "secondary" disorders (Robins and Guze, 1972). This principle was simple to operationalize—the disorder that appeared first was the primary diagnosis. The choice was a logical one: if the reason for giving only one diagnosis is that there is assumed to be only a single disease (and here I believe the term *disease* is appropriate), then it must be the earlier disorder that causes the later-appearing one, because temporal priority is a basic requirement for causation. But this principle ran into trouble with the practitioner, who wanted to describe the patient in terms of his current complaint, not a past syndrome. It ran into trouble with researchers as well when long symptom-free intervals made the one-disorder rule implausible. Could a depressive disorder beginning at age 50 be viewed as part of alcohol abuse present only in the 20s or of hyperkinesis present from age 5 to 10?

When the one-diagnosis rule was abandoned by DSM-III, no general rules were offered with respect to when multiple diagnoses were appropriate. Even the listing of preempting diagnoses, DSM-III's main tool for limiting multiple diagnoses, lacked the explicitness of its positive diagnostic criteria. One was to apply the preemptions if a disorder was "due to" another listed disorder, but no criteria for deciding causation were provided. Often it was not even clear which disorders were to be considered as possibly preemptive; typically, one or two were listed, preceded by "such as" or followed by "etc.," suggesting that there were also unlisted ones. It was probably as much the criticisms of the lack of clarity of the preemptive rules as Boyd's analysis (cited by Lilienfeld et al.) of ECA data showing that diagnoses listed as preemptive were not uniquely closely associated with the disorders they were to preempt that led to dropping some preemptions in DSM-III-R.

It is easy to fault DSM-III and its successors, DSM-III-R and DSM-IV, for vagueness in their decision-making instructions. But one has to remember that these manuals were written to serve many purposes, and were the product of compromises between representatives of different schools of psychiatric thought. What surprises us is how well, despite all this tug-of-war between interested parties, the diagnoses survive psychometric tests for internal consistency (George et al., 1989).

Meanwhile, encouraging the observation of whatever you want to call them—comorbidities, co-occurrences, or overlapping diagnoses—rather than asking the clinician to choose a single diagnosis among the many candidates in some undisclosed way, brings into the open the many instances in which people's psychiatric symptoms suffice to fill multiple diagnostic categories. Having to acknowledge the problem and having the standardized assessment instruments that chart all the component signs and symptoms that go to meet these criteria can occasion a variety of explorations to see whether the syndromes can be reassembled to better fit the underlying realities. Grove and Andreasen (1989) enumerate many strategies that could be undertaken to reduce and reconstruct the current plethora of diagnoses into a set more likely to reflect underlying disease.

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