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## Letter to the Editor

### Co-morbidity and the concept of ‘emotional disorders’

In his thoughtful comments on our paper (Goldberg *et al.* 2009), Jablensky (2009) writes ‘much of the progress towards understanding the biology of mental disorders has so far been achieved by splitting rather than lumping’. Not only would I agree with this, but I would argue that the process has not gone far enough, and we are obliged to conjure up the spectre of ‘co-morbidity’ to account for the fact that the patient has symptoms listed in several different chapters of the DSM. Having a single cluster of ‘Emotional Disorders’ would allow researchers to study the various combinations of disorders, to elucidate which are distinctive in terms of the validators we have used. Thus, in addition to ‘major depressive disorder’ we could distinguish between anxious depression and pure depression, and within the depressive spectrum we could describe a patient as having ‘depression with panic disorder’, ‘depression with somatic symptoms’, ‘depression with somatic over-concern’ and so on. Few psychiatrists seriously think that the concept of ‘major depression’ refers to a single entity, yet our classification imposes tunnel vision upon us, and discourages research from elucidating differences between the common syndromes of psychological distress.

It will be argued that such changes are merely cosmetic, and that postulating ‘co-morbidity’ in any case allows such research. But progress so far has been disappointing, and in the rest of medicine it is unusual to tell the patient that he/she has unfortunately developed several quite different disorders at the same time.

### Declaration of Interest

None.

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**The author replies**

Professor Goldberg's comment on co-morbidity puts into sharp focus the *reductio ad absurdum* resulting from the excessive fragmentation of psychopathology and scattering of congeneric conditions in the present DSM. The practice of coding in a single patient multiple 'disorders' listed in various chapters of the classification easily generates spurious co-morbidity, is clinically counterintuitive and scientifically counter-productive. It is regrettable that research into clinical psychopathology, the core of the discipline of psychiatry, has been back-staged by the 'atheoretical' approach of current classifications. In the context of the ongoing debate about the future shapes of DSM and ICD, it may be of interest to revisit some half-forgotten earlier concepts, such as Kraepelin's idea of strata ('registers') of psychopathology (Kraepelin, 1920), or the hierarchical 'classes of personal illness' proposed by Foulds (1976). Without advocating their 're-make', we can perhaps extract from the

perspective of such models biometrically testable propositions about the ways in which syndromes and symptoms segregate and recombine with each other to form patterns of *personal illness*, rather than an assemblage of unrelated 'disorders'.

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