Letter to the Editor

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In his interesting Editorial on Categories, continua and the growth of psychiatric knowledge, Paul Bebbington [1] slightly mis-states my earlier paper. I was not arguing that all common mental disorders can be reduced to “overarching anxious depression domain, together with single symptom qualifiers such as obsession or panic”, for two reasons: first, the additional symptoms are in the form of a multi-symptom sets of symptoms rather than a single symptom, and second it is possible to have a common mental disorder without being at all anxious—for example, non-anxious depression. As Wittchen et al. [2] argued, depression can result from anxious symptoms or by an independent pathway. Indeed, the nature of our present classification of common mental disorders encourages the practice of including quite heterogeneous disorders under the same label [3, 4].

My own position is that combinations of various common symptom complexes are more common than single sets of symptoms, and that the clinicians’ task is to establish which set of symptoms is distressing the patient the most, and to target interventions on those symptoms in the first instance. Another important difference between the categorical model presented and my own position is that categorical models with a single threshold are not always the best ones in general medicine: examples being

hypertension and anaemia. In the case of common mental disorders, we are not searching for a single threshold that will justify a single intervention, but for points along the underlying dimension that will justify particular interventions. In the case of anxious depression, the continuum of interventions starts at health advice for the mildest (but most common) cases, to simple behavioural and psychological interventions, to pharmacological treatments, and finally to life-threatening degrees of anxious depression for which admission to an in-patient unit is required. Similar arguments apply to different degrees of eating disorders.

References

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