



Reflections on Co-occurring Conditions

by Peter S. Jensen, M.D.

WITH THE ADVENT of new diagnostic systems over the last 20 years, including DSM-III (1980), DSM-III-R (1987), and DSM-IV (1994), the issue of co-occurring disorders has become more highly identified. Sometimes referred to as “comorbidity,” this simply means that descriptively, in terms of outward manifestations, a child or adult exhibits signs and symptoms of more than one disorder. For some scientists, clinicians and even parents, this poses a problem because it leads them to ask, “But what is the *real* disorder?” This concern, while understandable, is misplaced and based on the *confusion of the ends and means*. Earlier diagnostic systems made certain assumptions concerning the nature of a given diagnosis, and to a significant extent, the diagnosis was an end unto itself. If a person had a specific diagnosis, he or she just had “it,” and all parties acted as if they knew what “it” was. The diagnostic label even carried assumptions about etiology or the cause(s) of the condition.

Beginning in 1980, however, our diagnostic approach changed significantly—for the better, to my mind. These new diagnostic systems became a way for the patient to clearly communicate with scientists and clinicians about the outward, indisputable symptoms he or she experienced, so new research could eventually shed light on the causes of specific conditions. Implicit in these new diagnostic systems are the twin assumptions that: 1) a fuller understanding of “it” will emerge and change as research sheds light on the underlying causes and processes of specific symptom patterns, and consequently, 2) diagnostic labels are more likely to be temporary and change as our understanding increases.

To illustrate the temporary nature of diagnostic systems and how they are intertwined with “co-occurring conditions,” consider the differences in how the American versus European diagnostic systems deal with the issue of AD/HD complicated by other problems.

Unlike the American diagnostic (DSM-IV) system, the European diagnostic system (ICD-10) specifies that if a child has both severe AD/HD and conduct disorder, “it” is not really two different yet co-occurring conditions; rather, “it” is viewed as a single but different type of condition altogether called “Hyperkinetic Conduct Disorder.” Similarly, if a child has AD/HD and depression, “it” is not AD/HD and Major Depressive Disorder, but is identified as a new condition altogether, “Hyperkinetic Affective Disorder.”

So who is correct, the Europeans or the Americans? Even this question assumes that we really know what “it” is. Instead, we must understand that our diagnostic labels and systems (and the problems of comorbidity) will change over time as we learn more about the underlying processes of specific patterns of signs and symptoms. But if the label conveys specific information about a child or adult’s likely response to treatment, it serves a useful communication process among scientists, providers, parents and patients. It doesn’t matter whether we call a given set of problems co-occurring AD/HD and Anxiety Disorder (DSM-IV), or simply Hyperkinetic Affective Disorder (ICD-10), as long as we have research to guide how we should treat that more complex set of problems.

If a child or youth has both AD/HD and a substance use disorder or AD/HD and anxiety disorder, should that child be treated differently than a child with only one of these conditions? Can a doctor make meaningful clinical predictions about the outcomes for a child with two conditions versus a child with just one? Hopefully—but if this process is not accompanied by rigorous research to demonstrate the meaning and value of the dual labels, it is essentially a hollow victory for the child and family. However, short-term relief sometimes comes by having a name (or several names, in the case of co-occurring conditions) for the child’s problems.

Our current psychiatric classification systems are now mostly based on external descriptions—so-called “signs and symptoms” observable by the doctor or other health care professional. But as our research advances, our mental health diagnoses will eventually be based on understanding the inner workings and development of the brain and all of its attendant components—emotional tone, thought processes, temperament, self-esteem or sociability. This means that diagnoses, as well as the problems of comorbidity, can and should change as our understanding advances.

This is not a cause for despair; merely caution. We must all understand that investigators will often quibble over diagnoses—one diagnosis or two, or even a different diagnosis altogether. But these are arguments more about scientific uncertainties, rather than whether a given child has a severe set of problems or not.

Despite considerable scientific uncertainty about causes and the exact nature of an AD/HD diagnosis, we can still do much about treatment and early intervention. Knowing how to prevent and treat many

illnesses often occurs before the causes are identified. While we don’t know the causes of various forms of cancer and heart disease, we do know that various interventions clearly reduce the likelihood of these devastating diseases.

Understand the temporary nature of current diagnostic systems. Don’t become confused if your child has several diagnostic labels, or if they shift over time. If a child has several co-occurring conditions, ask yourself (and the health care providers) how this should affect the treatment and outcomes. Sometimes it may mean that the treatments used for each of the two disorders alone must now be combined; in other instances, it may mean that one treatment should precede another. In still others, the relevance of the co-occurring conditions could signify a better or worse outcome, and suggest a need to change the intensity of the interventions. ■

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