Correspondence

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The case for cothymia: an open verdict?

Tyrer's (2001) perspicacious editorial argues cogently for the recognition of a syndromal diagnosis of mixed anxiety and depression, collating supportive evidence from various fields of study. A 'combined anxiety and depressive disorder' model that extends beyond ICD–10's (World Health Organization, 1992) sub-syndromal mixed anxiety and depressive disorder (MADD), in terms of severity, seems to be a reasonable proposition and one that clearly has salience in terms of classification, epidemiology, clinical practice and treatment. To denote this 'distinct syndrome' the author resurrects the term cothymia, explaining that it represents 'two moods of equal significance occurring together' and that it perhaps provides the desired diagnostic differentiation.

However, the diagnosis of MADD was created to better understand the emergence of anxiety and depressive disorders and to determine whether the two groups of disorders arise from a common pool of biological abnormalities or whether mixed presentations reflect the overlap of essentially separate pathologies. This has clearly not yet been achieved and the assignment of a 'diagnosis' is perhaps somewhat premature. Indeed, Tyrer notes the significant degree of association between anxiety and depression and suggests that this does not invalidate separate or comorbid disorders. A DSM–IV Task Force (Frances *et al*, 1992) suggested four models for associations between anxiety and depression: (a) distinct but sometimes coexistent syndromes; (b) symptoms of anxiety and depression denoting similar external manifestations of a single underlying cause; (c) anxiety predisposing to depression; and (d) the converse, depression predisposing to anxiety. Tyrer (2001) asserts that the term cothymia 'implies that anxiety and depression are equal partners in its presentation', a message that, while clear, may not be completely accurate (Malhi *et al*, 2002). In terms of pathogenesis, several studies have demonstrated that, in practice, anxiety most often precedes depression (model 3) and that it probably plays an important role in its aetiology (Breslau *et al*, 1995; Parker *et al*, 1999). Furthermore, comorbid anxiety and depression show considerable variation clinically, and thus for the purposes of diagnosis and management it is perhaps more useful to retain recognition of their discrete contributions.

It is evident that greater clarity is urgently required with respect to the classification of anxiety and depressive disorders. To this end, the editorial is a welcome re-evaluation of a common diagnostic problem and may generate the necessary impetus for further investigation and research.

Breslau, N., Schultz, L. & Peterson, E. (1995) Sex differences in depression: a role for preexisting anxiety. *Psychiatry Research*, **58**, 1–12.

Frances, A., Manning, D., Marin, D., *et al* (1992) Relationship of anxiety and depression. *Psychopharmacology*, **106** (suppl.), 82–86.

Malhi, G. S., Parker, G. B., Gladstone, G., *et al* (2002) Recognizing the anxious face of depression. *Journal of Nervous and Mental Disease*, in press.

Parker, G., Wilhelm, K., Mitchell, P., *et al* (1999) The influence of anxiety as a risk to early onset major depression. *Journal of Affective Disorders*, **52**, 11–17.

Tyrer, P. (2001) The case for cothymia: mixed anxiety and depression as a single diagnosis. *British Journal of Psychiatry*, **179**, 191–193.

World Health Organization (1992) *Tenth Revision of the International Classification of Diseases and Related Health Problems* (ICD–10). Geneva: WHO.

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I was pleased to read Tyrer's (2001) editorial arguing for the creation of a mixed category of anxiety and depression as a single diagnostic entity. Over two decades ago a paper of mine was published in the *Journal* reporting that attenders at a Maudsley Hospital out-patient clinic, when asked to check the symptoms experienced when they were depressed and when anxious, showed a correlation between the two mood states of 0.62. By contrast, ten experienced Maudsley psychiatrists, when asked to check the symptoms of a typical patient with a neurotic disorder, recorded a correlation of zero between anxiety and depression (Leff, 1978). While current diagnostic classifications perpetuate the problem, its origins would seem to lie in psychiatrists' training, with the promotion of textbook descriptions of mood states as ideal entities, bearing little relationship to the experiences of real-life patients.

Leff, J. P. (1978) Psychiatrists' versus patients' concepts of unpleasant emotions. *British Journal of Psychiatry*, **133**, 306–313.

Tyrer, P. (2001) The case for cothymia: mixed anxiety and depression as a single diagnosis. *British Journal of Psychiatry*, **179**, 191–193.

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Author's reply: In my editorial (Tyrer, 2001) I argued that 'diagnoses that have face validity should at least be tested in the classification arena before being accepted or rejected'. In fact, 'cothymia' has more than face validity in its favour. We have just completed a further study (Tyrer *et al*, 2001) that shows that its long-term outcome (12 years) with regard to clinical symptoms, service contact and social function is nearly 50% worse than that of single mood disorders and it is as powerful a predictor as personality disorder (Seivewright *et al*, 1998) in indicating the prognosis of common neurotic disorders. If we persist in regarding this association as yet another example of comorbidity, we are unlikely to make progress in the treatment of what appears to be a very morbid condition. Grant-giving bodies are very reluctant to provide funding for treatment interventions for conditions that have no formal existence.

Dr Malhi's argument for retaining the separate diagnoses of anxiety and depression, pending further investigation and research into its chronology, is somewhat recondite and would carry more weight if

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the jury had not been sitting on this case for over 30 years (Woodruff *et al*, 1967) before coming to a verdict. Leff's early work (1978) identifies the heart of the problem: joining anxiety and depression upsets the epidemiologists, pharmacologists and researchers who would like anxiety and depression to stay apart, but for patients and clinicians these emotions are often joined together intimately. Let them at least have a trial marriage before condemning them indefinitely to live in nosological sin.

Leff, J. P. (1978) Psychiatrists' versus patients' concepts of unpleasant emotions. *British Journal of Psychiatry*, **133**, 306–313.

Seivewright, H., Tyrer, P. & Johnson, T. (1998) Prediction of outcome in neurotic disorder: a 5-year prospective study. *Psychological Medicine*, **28**, 1149–1157.

Tyrer, P. (2001) The case for cothymia: mixed anxiety and depression as a single diagnosis. *British Journal of Psychiatry*, **179**, 191–193.

—, Seivewright, H., Simmonds, S. *et al* (2001) Prospective studies of cothymia (mixed anxiety–depression): how do they inform clinical practice? *European Archives of Psychiatry and Neuroscience*, in press.

Woodruff, R., Murphy, G. & Herjanic, M. (1967) The natural history of affective disorders: I. Symptoms of 72 patients at the time of index hospital admission. *Journal of Psychiatric Research*, **5**, 255–263.

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Cross-cultural training in psychiatry

Farooq (2001) has highlighted some inadequacies in the psychiatric training imparted in developing countries. He has suggested the need for a total paradigm shift in training to address these problems. As a psychiatric trainee having initially trained in a developing country and now undergoing training in the UK, I cannot agree more with this suggestion. However, I wish to make some further points.

Some doubts are expressed about the suitability of training in developed countries for psychiatrists who will ultimately work in developing countries. There may be some disparities between training needs and the training obtained, but this is only to be expected, given the nature and extent of the differences in psychiatric practice. But cross-cultural training exchange helps develop the insight into both worlds that is required to be able, one hopes, to make some contribution towards changing psychiatric practice in the developing world.

Conversely, Britain is a multicultural society with many ethnic groups, some members of which formerly lived in the developing world, which in turn might influence their current customs and practices. It might be a good idea for British psychiatric trainees (and indeed trainees from other developed countries) to obtain some training in the developing world. This would give greater insight into the cultural variations in psychiatry. I am sure many would find this an exciting and rewarding prospect. After all, one of the best ways of learning about other cultures is to be among them and to partake of the local customs and traditions.

Farooq, S. (2001) Psychiatric training in developing countries (letter). *British Journal of Psychiatry*, **179**, 464.

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Substance misuse among people with schizophrenia: similarities and differences between the UK and France

We read with interest the paper by Duke *et al* (2001) reporting on non-alcohol substance misuse among people with schizophrenia. We recently conducted a study addressing that question among patients with schizophrenia from the Parisian suburbs, using the Composite International Diagnostic Interview for DSM–III–R diagnoses of substance abuse or dependence (Dervaux *et al*, 2001). We found that 41% of the patients had a lifetime history of substance abuse or dependence, including 30% on a drug other than alcohol (*v.* 16% in the Duke *et al* study). As in Duke *et al*'s study, in our study the patients with substance abuse were younger than non-abusers. We also found no difference in respect of psychiatric symptoms using the Positive and Negative Syndrome Scale, mean age of first psychiatric treatment or mean number of previous hospitalisations. The patterns of consumption were slightly different for cannabis (27% of the patients in Paris *v.* 18.7% in London) and opiates (7% *v.* 5.3%, respectively). The main difference concerned the misuse of cocaine and crack, less common in France (1%) than in the UK (8.7%), and considerably less than in North American studies (ranging from 20 to 30%; Cantor-Graae *et al*, 2001). Although methodological issues could explain some of these differences (e.g. the use of different assessment instruments; mean age of the subjects was 34.7 years in our study *v.* 50.3 years in the English study), these patterns most probably reflect the different availability of drugs in these countries. Taken together, these observations do not argue in favour of the self-medication hypothesis but instead emphasise the role of alternative, and probably multiple, factors leading to substance misuse in schizophrenia.

Cantor-Graae, E., Nordström, L. G. & McNeil, T. E. (2001) Substance abuse in schizophrenia: a review of the literature and a study of correlates in Sweden. *Schizophrenia Research*, **48**, 69–82.

Dervaux, A., Bayle, F.-J., Laqueille, X., *et al* (2001) Is substance abuse in schizophrenia related to impulsivity, sensation seeking or anhedonia? *American Journal of Psychiatry*, **158**, 492–494.

Duke, P. J., Pantelis C., McPhillips, M. A., *et al* (2001) Comorbid non-alcohol substance misuse among people with schizophrenia. Epidemiological study in central London. *British Journal of Psychiatry*, **179**, 509–513.

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