Correspondence

EDITED BY MATTHEW HOTOPF

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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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