The Position of Anxiety Disorders in Structural Models of Mental Disorders

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"Comorbidity" among mental disorders is commonly observed in both clinical and epidemiological samples. The robustness of this observation is rarely questioned; however, what is at issue is its meaning. Is comorbidity "noise"—nuisance covariance that researchers should eliminate by seeking "pure" cases for their studies—or a "signal"—an indication that current diagnostic systems are lacking in parsimony and are not "carving nature at its joints?"

(Krueger, p. 921).[1]

With these words, Krueger[1] started a discussion on the structure of mental disorders, which suggested that a 3-factor model of common mental disorders existed in the community. These common factors were labeled "anxious-misery," "fear" (constituting facets of a higher-order internalizing factor), and "externalizing." Along with similar evidence from personality research and psychometric explorations[2–4] and selective evidence from genetic and psychopharmacologic studies,[5–10] Krueger[1] suggested that this model might not only be phenotypically relevant, but might actually improve our understanding of core processes underlying psychopathology. Since then, this suggestion has become an influential, yet also controversial topic in the scientific community, and has received attention particularly in the context of the current revision process of the Manual of Mental Disorders (Fifth Edition) (DSM-V) and the International Classification of Diseases, 11th Revision (ICD-11).[11,12]

Focusing on anxiety disorders, this article critically discusses the methods and findings of this work, calls into question the model's developmental stability and utility for

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clinical use and clinical research, and challenges the wide-ranging implications that have been linked to the findings of this type of exploration. This critical appraisal is intended to flag several significant concerns about the method. In particular, the concerns center around the tendency to attach wide-ranging implications (eg, in terms of clinical research, clinical practice, public health, diagnostic nomenclature) to the undoubtedly interesting statistical explorations.[11–13]

INTERNALIZING AND EXTERNALIZING AS CORE DIMENSIONS OF THE STRUCTURE OF MENTAL DISORDERS

The Approach

Krueger[1] used the epidemiological diagnostic data from the US National Comorbidity Survey (NCS)[14] to analyze patterns of comorbidity among DSM-III-R mental disorders. Ten diagnoses were selected for this analysis from a wider set of all diagnoses in the NCS, namely: major depressive episode (MDE), dysthymia (DYS), panic disorder (PD), agoraphobia (AGPH), social phobia (SOP), simple phobia (SIP), generalized anxiety disorder (GAD), alcohol dependence (AD), drug dependence (DD), and antisocial personality disorder (APD). All 10 disorders were submitted to confirmatory factor analysis (CFA), a formal statistical means of evaluating dimensional accounts of comorbidity among mental disorders. Four competing models, positing from 1 latent factor to 4 latent factors, were evaluated to determine their fit in the entire NCS sample and various subsamples (**Fig. 1**).

Krueger's[1] main findings were noteworthy. For the entire NCS sample, across sexes, and across random halves, a 3-factor model provided the best fit to the correlations among the 10 disorders. These factors were labeled "anxious-misery," "fear," and
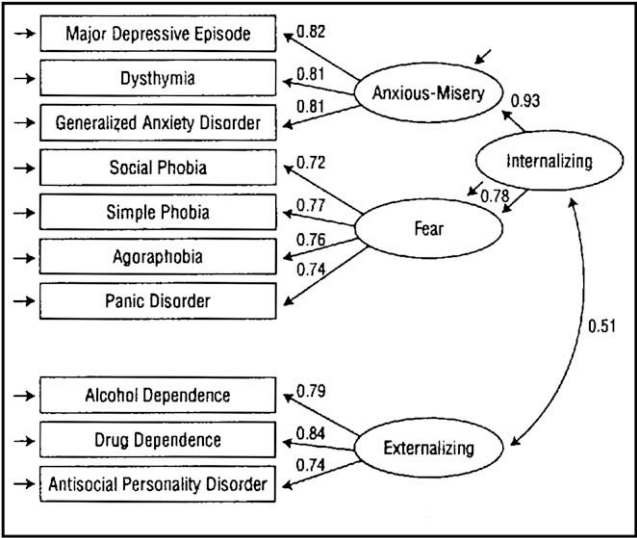
Best-fitting model for the entire National Comorbidity Survey, a 3-factor variant of the 2-factor internalizing/externalizing model. All parameter estimates are standardized and significant at P<.05.

Fig. 1. Krueger's 3-factor model based on 10 lifetime disorders (NCS-Data). (*From* Krueger RF. The structure of common mental disorders. Arch General Psychiatry 1999;56:921–6; with permission.)