# to use diagnosis effectively as a tool for communication and decision-making. For example:

'Good psychiatric practice involves providing the best level of clinical care that is commensurate with training, experience and the resources available. It involves the ability to formulate a diagnosis and management plan based on often complex evidence from a variety of sources.' (p. 9)

'In making the diagnosis and differential diagnosis, a psychiatrist should use a widely accepted diagnostic system.' (p.10)

This is not an issue of personal choice for a practitioner. It is a professional responsibility to the patient.

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First received 30 May 2013, final revision 3 Oct 2013, accepted 10 Oct 2013

### **Acknowledgements**

The authors are grateful to many colleagues for helpful discussions that have informed the views expressed in this article.

#### References

- 1 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (5th edn) (DSM-5).* APA, 2013.
- 2 Gornall J. DSM-5: a fatal diagnosis? BMJ 2013; 346: f3256.
- **3** Davies J. Cracked. Why Psychiatry is Doing More Harm Than Good. Icon Books, 2013.
- 4 Spence D. Bad medicine: bipolar II disorder. BMJ 2011; 342: d2767.
- 5 Wykes T, Callard F. Diagnosis, diagnosis, diagnosis: towards DSM-5. J Ment Health 2010; 19: 301–4.

- 6 Timimi S. "No more psychiatric labels" petition. BMJ 2012; 344: e3534.
- 7 Kendell RE. *The Role of Diagnosis in Psychiatry*: 176. Blackwell Scientific Publications.
- 8 Kupfer DJ, First MB, Regier DA. A Research Agenda for DSM-V. American Psychiatric Association, 2002.
- 9 Craddock N, Owen MJ. Rethinking psychosis: the disadvantages of a dichotomous classification now outweigh the advantages. *World Psychiatry* 2007; 6: 84–91.
- **10** Maj M. Psychiatric diagnosis: pros and cons of prototypes vs. operational criteria. *World Psychiatry* 2011; **10**: 81–2.
- 11 Insel T, Cuthbert B, Garvey M, Heinssen R, Pine DS, Quinn K, et al. Research domain criteria (RDoC): toward a new classification framework for research on mental disorders. *Am J Psychiatry* 2010; 167: 748–51.
- 12 Aldhous P, Coghlan A. A revolution in mental health. New Sci 2013; 2916: 8–9.
- 13 Craddock N, Owen MJ. The Kraepelinian dichotomy going, going . . . but still not gone. *Br J Psychiatry* 2010; **196**: 92–5.
- 14 Craddock N, Kerr M, Thapar A. The right call. Open Mind 2010; 163: 6-7.
- 15 Rethink Mental Illness. *The Abandoned Illness: A Report by the Schizophrenia Commission*. Rethink Mental Illness, 2012.
- Farmer AE, Williams J, Jones I. Phenotypic definitions of psychotic illness for molecular genetic research. Am J Med Genet (Neuropsychiatr Genet) 1994;
  54: 365–71.
- 17 Leucht S, Hierl S, Kissling W, Dold M, Davis JM. Putting the efficacy of psychiatric and general medicine medication into perspective: review of meta-analyses. Br J Psychiatry 2012; 200: 97–106.
- 18 Casey BJ, Craddock N, Cuthbert BN, Hyman SE, Lee FS, Ressler KJ. DSM-5 and RDoC: progress in psychiatry research? *Nat Rev Neurosci* 2013; 14: 810–4.
- 19 Insel T. NIMH Director's Blog: Transforming Diagnosis, 29 April 2013. NIMH, 2013 (http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis. shtml).
- 20 White PD, Rickards H, Zeman AZ. Time to end the distinction between mental and neurological illnesses. *BMJ* 2012; 344: e3454.
- 21 Royal College of Psychiatrists. *Good Psychiatric Practice (3rd edn)*. (College Report CR154). Royal College of Psychiatrists, 2009.



## Body dysmorphic disorder

#### **David Veale**

Body dysmorphic disorder (BDD) consists of a preoccupation with a perceived defect or ugliness, usually around the face. The 'flaw(s)' is not noticeable to others, or appears only slight, yet causes enormous shame, depression, or interference in life and there is a high risk of suicide. Often at the core of BDD is a distorted image from an 'observer perspective' and there is a high degree of self-consciousness. People with BDD often avoid public situations and spend hours mirror gazing. BDD is treatable by specialised cognitive behaviour therapy or SSRI antidepressants in maximum dose (not by antipsychotics or cosmetic procedures).

The British Journal of Psychiatry (2014) 204, 95. doi: 10.1192/bjp.bp.112.123448