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Data and clinical utility should be the drivers of changes to psychiatric classification

Professor Goldberg's suggestion[1] that our psychiatric classification should have a few major groupings of disorders that have common properties is very appealing and it is surely the direction in which psychiatry must aim to progress. This would help in the teaching of psychiatry, in reassuring those outside the discipline of its logical and scientific foundation and it would be of great benefit in clinical practice. However, although the specific categories he suggests have some clinical plausibility, they do not seem to be grounded in sufficient empirical evidence to justify their introduction. For example, a great deal of work is ongoing to understand the complex relationship between mood disturbance and psychosis. Much remains to be discovered but there is already substantial evidence for a complex overlap in the underlying pathogenesis of major mood and psychotic syndromes.[2] Thus, it does not seem like a very good idea to draw what is likely to be an arbitrary distinction between 'emotional disorders' and 'psychoses'. Similarly, if schizophrenia is shown to be a 'neuro-developmental disorder', which category does it go in? It seems too early to set out broad categories, which may actually hamper progress over the coming years.

What about dimensions? At least for mood and psychotic disorders, we already know that there is a major overlap between underlying biology and we also know that dimensional approaches can provide useful clinical information over and above current diagnostic categories.[3] Hence, it is likely to be useful to encourage use of dimensional descriptions of psychopathology alongside the current categories.

The neuroscientific understanding of major psychiatric illness is advancing rapidly and can be expected to provide a rational basis for future psychiatric classifications that will have greatly increased clinical usefulness.[4] All changes come at substantial costs to the users of the classification – be they clinicians, patients, researchers, managers, administrators or politicians. Apart from the time and money expenditures required for training, there is the potential for confusion and for communication difficulty leading to problems in making comparisons across time. Thus, it is desirable that an appropriately high threshold is set when judging the advance in knowledge that is deemed necessary to justify each change. In this regard, it is important to be dispassionate and cautious in evaluating the strength and relevance of the increment in knowledge since previous classifications. We need to be fully aware of the problems and limitations with our current classification and start thinking in earnest about the future – but we are not there yet. Major changes should be justified by robust evidence and proven clinical utility.

While we await the evidence over the coming decade or two, we should be cautious in any changes that are made and realistic in our evaluation of the current evidence.[5] Introducing descriptive dimensions alongside categories makes sense. Wholesale change of categories does not.

1 Goldberg D. Should our major classifications of mental disorders be revised? *Br J Psychiatry* 2010; **196**: 255–6.

2 Craddock N, Owen MJ. The Kraepelinian dichotomy – going, going . . . but still not gone. *Br J Psychiatry* 2010; **196**: 92–5.

3 Dikeos DG, Wickham H, McDonald C, Walshe M, Sigmundsson T, Bramon E, et al. Distribution of symptom dimensions across Kraepelinian divisions. *Br J Psychiatry* 2006; **189**: 346–53.

4 Bullmore E, Fletcher P, Jones PB. Why psychiatry can't afford to be neurophobic. *Br J Psychiatry* 2009; **194**: 293–5.

5 Craddock N. Robust empirical data and clinical utility: the only drivers of change. Commentary on . . . The classification of mental disorder. *Adv Psychiatr Treat* 2010; **16**: 20–2.

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Author's reply: Craddock & Owen are certainly right in drawing attention to the 'complex overlap' between psychotic and mood disorders, but the same can be said for most other sets of psychiatric symptoms. The neat, mutually exclusive categories described by our present classifications do not exist in nature, and classifications must necessarily draw a line somewhere between the major groups of symptoms. But are these lines at present drawn in the right places, and are there perhaps too many lines already? Their letter is very welcome, and it is to be hoped that many others will join this debate and express their views on what is an important matter.

My main research interest has been in those psychological disorders seen by generalists in primary care and general hospital practice, and here the overlap between symptoms is particularly marked.[1] In this broad group, the reasons for suspecting common ground between the various syndromes are set out at length elsewhere,[2] and the arguments considered most certainly included both data and clinical utility. It seems to my colleagues[3] that if we are to make at least gradual progress towards a more rational system of classification there are other peculiar features that need attention. What sense does it make to classify similar disorders in different chapters of the ICD? Not only is there overlap between adult and child disorders, but the fact that anxiety disorders, mood disorders and somatoform disorders occur in separate chapters make multiple 'comorbidity' inevitable for many patients. Craddock & Owen welcome dimensions (without mentioning the problems that are associated with them) but appear to want the chapter structure of the classifications to remain as it is. It is difficult to see the advantage in doing this, and we cannot wait until 'neuroscientific' research has allowed us to cross the last frontier before improving it. It is not clear whether epidemiological or psychological research may also be allowed to be considered relevant – they are both respectably scientific, but do not qualify for the prefix 'neuro-'.

The problem of where to put bipolar disorder is a difficult one to resolve, and for the time being the balance of evidence probably favours a cowardly approach, with bipolar disorders being separate from both schizophrenias on the one hand, and emotional disorders on the other.[4] It is clear that further modifications will inevitably be made in our classifications as knowledge increases, and that changes suggested now can only be provisional. It remains to be seen whether either classification