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From the Editor's desk

By Peter Tyrer

Classification in the dock

'Dr Nosology, you are charged with bringing the science of classification into disrepute in your handling of psychiatric disorders. Specifically, you have developed a set of spurious categories that have no independent standing and which have led to confusion, doubt and error. How do you plead?' It would take a tough-minded psychiatrist with a capacity for psychopathic dissociation to plead anything but 'guilty as charged' to this accusation, and we have admitted as much in our pages many times recently.[1–4] This is sad, as diagnosis is intended to be one of the strongest assets of the psychiatrist. I have worked in many multidisciplinary psychiatric settings over the years and in some the hierarchy of management had become almost as flat as a pancake, but even in these the exercise of diagnosis was regarded as a skill that was the special province of the psychiatrist. So now is it really a false prospectus, exercised by an interpreter who pretends to be fluent in languages but in practice picks up only the odd word? Not yet, but in this issue Frances (pp. 391–392) reminds us that psychiatry is still only on the margins of diagnostic credibility. In the UK the initial part of medical training is called the first MB and so it is entirely appropriate that our bottom-line starter is by an author of the same title (First, pp. 382–390). This includes the worrying statistic that 21% of current diagnoses in the ICD and DSM classifications have conceptual differences, but as Jablensky (pp. 379–381) points out it would be quite bizarre if there was good agreement – it would almost represent scientific fraud. The search for validity as a long-term goal may seem to be a mirage, but at least we should try for clinical utility.[5]

In practice we have to work with the imperfect systems we already have and yet we are always trying to refine and improve them in research. So the AUDIT scale is used by Drummond *et al* (pp. 448–456) to give a better assessment of alcohol dependence, refined statistical combination of data used by Fergusson *et al* (pp. 420–426) to categorise mental ill health more exactly, and, the ultimate aim of biological psychiatry, an independent biomarker, examined by Radua & Mataix-Cols (pp. 393–402) in their imaging study of obsessive–compulsive disorder. The problem with all studies of classification is the absence of an independent yardstick of a specific 'illness', whatever that might mean. Although medical diagnoses have somewhat similar problems they can always rely on a quantitative measure to act as an important back-up. We in psychiatry are still too reliant on clinical observation alone; stuck in the same warp as medicine until Thomas Sydenham first showed evidence of independent pathology linking to clinical description. So until this time comes we can never be sure whether we should classify by clinical presentation, such as the antisocial behaviour of conduct disorder, or by something with at least a smell of independent quantification, such as callous–unemotional traits (Viding *et al*, pp. 414–419), which are getting a ground swell of support from genetic studies.[6,7]

In this Sisyphean task we should be grateful to all our contributors that, despite our discipline's consistent record of failure, they do not give up in this long-running quest to find a psychiatric classification that truly does cut nature at its joints. Until they do we will hear the echoing words of Samuel Beckett, 'Fail again, fail better'.

The Psychiatrist beckons

The new name of our long-standing journal, *Psychiatric Bulletin,* has now been announced. *The Psychiatrist* is a neat replacement, but is in some danger of being interpreted too literally by some as a single-profession journal. I hope by now all our readers, which I know includes psychologists, nurses, social workers, physicians, general practitioners, occupational therapists, pharmacists, carers and patients themselves, will realise from our columns that our profession is a very broad church indeed[8] and we are keen on making it even broader. It gives me no pleasure to have to reject dozens of highly competent papers submitted to the *British Journal of Psychiatry* that could be of great help to those working in clinical practice, just because we do not have sufficient space to include them all. There may have been a mistaken impression that *Psychiatric Bulletin* is just a house journal of the College and is of local interest only; this was never the case, but we now have expansion plans that will remove this notion completely. And for *The Psychiatrist* we do want more relevant papers from all interested professions, so do not be inhibited. We have moved far beyond the turf wars that used to prevent good interdisciplinary research from flourishing, and we should now feel sufficiently confident in our own spheres to feel comfortable in being both challenged and stimulated by others. We need the bottom-up developments from those working on the ground as much as the top-down science pointing to our errors and successes, and with both between the covers of *The Psychiatrist* we expect a bumper harvest.

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2 Tyrer P, Coombs N, Ibrahimi F, Mathilakath A, Bajaj P, Ranger M, et al. Critical developments in the assessment of personality disorder. *Br J Psychiatry* 2007; **190** (suppl 49): s51–9.

3 Cole J, McGuffin P, Farmer AE. The classification of depression: are we still confused? *Br J Psychiatry* 2008; **192**: 83–5.

4 Das-Munshi J, Goldberg D, Bebbington PE, Bhugra DK, Brugha TS, Dewey ME, et al. Public health significance of mixed anxiety and depression: beyond current classification. *Br J Psychiatry* 2008; **192**: 171–7.

5 Kendell R, Jablensky A. Distinguishing between the validity and utility of psychiatric diagnoses. *Am J Psychiatry* 2003; **160**: 4–12.

6 Viding E, Frick PJ, Plomin R. Aetiology of the relationship between callous–unemotional traits and conduct problems in childhood. *Br J Psychiatry* 2007; **190** (suppl 49): s33–8.

7 Frick PJ, White SF. Research review of the importance of callous–unemotional traits for development models of aggressive and antisocial behaviour. *J Child Psychol Psychiatry* 2008; **49**: 359–75.

8 Craddock N, Antebi D, Attenburrow M-J, Bailey A, Carson A, Cowen P, et al. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.