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Advances Volume 16, 2010 (six issues)
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Printed by Henry Ling Ltd, 23 High East Street, Dorchester, Dorset DT1 1HD.

ISSN 1355-5146

Classification

FROM THE EDITOR

By Joe Bouch

The science of psychiatric diagnosis and classification has its critics. Seligman (2005), the father of positive psychology, has even suggested that we 'develop a nosology of human strengths – the "unDSM–1", the opposite of DSM–IV'. Nevertheless, as 'diagnosis is intended to be one of the strongest assets of a psychiatrist' (Tyrer 2009), clinicians need to think about and be involved in the forthcoming revisions and harmonisation of the two major classifications ICD and DSM. Sartorius (pp. 2–9) gives a behind-the-scenes view of the revision process. There are many vested interests: not just clinicians, but governments and NGOs, lawyers, researchers, public health practitioners, Big Pharma and patient groups. Vast sums are at stake – everything from welfare benefits and compensation claims to research budgets. Concerns include the use of national classifications to facilitate political abuse and of diagnostic labels that are seen as stigmatising or are used to stigmatise. Like Sartorius, Thornicroft (pp. 53–59) singles out chronic fatigue syndrome, 'bitterly contested in terms of its status as a physical, psychiatric or psychosomatic condition' and viewed by healthcare staff as a 'less deserving' category.

Should the classifications use categories or dimensions? A dimensional approach seems impractical, although dimensions could be used to augment categorical definitions, as with severity of depression in ICD–10. If categories, should revision involve lumping or splitting and on what basis? Goldberg (pp. 14–19) is critical of the proliferation of diagnoses necessitating 'a diagnostic paella' of multiple comorbidities. He tantalises us with his proposal of a small number of large groups of disorders, each group based on aetiologically related criteria. But there are difficulties. For example, should bipolar disorder be considered a mood disorder, a psychotic disorder or separate from both? Craddock (pp. 20–22) is not convinced that there is (yet) sufficient evidence for Goldberg's categories, believing that it will take at least 5–10 years before our understanding of brain dysfunctions will justify major change in classification. The complexities involved in clarifying neurobiological mechanisms are well illustrated in a robust exchange in our Correspondence (pp. 76–80). Gillman stresses the importance of understanding the pharmacodynamics and pharmacokinetics of interactions of antidepressants. Palanniyappan *et al* agree, but reach an only too familiar conclusion: insufficient clinical data and a lack of biological markers of pharmacological mechanisms.

CBT with children and families

For the clinician, 'a diagnosis is no substitute for a full formulation, where cause should be addressed' (Scott 2002). Dummett (pp. 23–36) explores the use of a collaborative therapeutic approach to formulation in her article, which is my Editor's Pick. Causative and maintaining factors, present and past life contexts, and systemic and developmental factors are all considered and thoughtfully illustrated in a series of clinical vignettes. Her article should be read not just by CBT practitioners and those working with children.

Seligman M (2005) Positive psychology, positive prevention and positive therapy. In *Handbook of Positive Psychology* (eds CR Snyder, SJ Lopez): 3–9. Oxford University Press.

Scott S (2002) Classification of psychiatric disorders in children and adolescents: building castles in the sand. *Advances in Psychiatric Treatment*, **8**: 205–13.

Tyrer P (2009) From the Editor's desk. *British Journal of Psychiatry*, **195**: 470.