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

Professor Goldberg’s suggestion1 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.

will take any account of the arguments put forward – but at least the issues have been aired. Our suggestions were intended to provoke discussion, in the hope that we might make a little progress towards a still distant goal.


Suffrage or suffering? Voting rights for psychiatric in-patients

Before the Representation of the People Act 1949, in-patients in psychiatric settings were usually denied the right to vote in the UK General Elections; instead they were considered unsuitable and labelled (by common law) as ‘idiots’ or ‘lunatics’. Furthermore, the 1949 Act disenfranchised those with mental disorders by refusing to allow patients to register to vote while under the care of psychiatric institutions. This ruling was not revoked until the advent of ‘universal suffrage’ in the UK. Currently, patients on psychiatric wards. I asked 19 staff members whether or not they believe psychiatric in-patients have the right to vote and whether they had been asked to consider patients’ voting rights. More than half (n = 11, 58%) of those interviewed (including all three psychiatric trainees) reported that this was the first time that they had been asked to consider patients’ voting rights.

These findings, albeit from an investigation with clear limitations, demonstrates that knowledge of voting rights is lacking among those working in psychiatric units. I believe this criticism is a reflection of lack of clear guidance, and a deficiency in undergraduate/postgraduate psychiatric training. This is not a new issue – similar concerns raised in previous research appear to have been overlooked.2,3

I believe psychiatric in-patients and their interests remain underrepresented by our political system and that lack of clarity in this area is inadequate justification for care providers to take a laissez-faire approach. I am not proposing that healthcare professionals should be encouraging in-patients to vote, but rather that we should be proactive in making them aware that they can vote.


2 Smith H, Humphreys M. Changes in laws are necessary to allow patients detained under Mental Health Act to vote. BMJ 1997; 315: 431.


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