action, it is common for the bull to be stimulated by feeding it alcohol, and by irritating its mucous membranes with chilli powder in the eyes and the nose. A crazed bull can also injure itself by running into obstacles and stumbling awkwardly, and who can gauge the psychological stress the poor animal must undergo?

In 2008, the Animal Welfare Board of India approached the Supreme Court in an effort to get jallikattu banned. The Board claimed that the practice violated the Prevention of Cruelty to Animals Act. The Government of Tamil Nadu countered that this was an old tradition with religious overtones, and promised that no animal and no person would be injured. Medical and veterinary facilities would be made available wherever jallikattu took place. The Court permitted jallikattu to continue.

However, the Board did not take this reverse lying down. The following year, they produced photographic evidence to the Court that the practice continued unchanged. People and animals were injured. Twenty-one people died and 1614 were injured during the jallikattu season in 2008. The Court agreed that this was indeed cruelty to animals, and banned the sport, but reversed itself within 2 weeks on an appeal submitted by the government. The Court wanted Doordarshan and officials of the Board to be permitted to take videos of the event in different places. Organizers would have to make a deposit in advance to cover the treatment of injuries to man and animal, and to provide compensation to the families of people who died.

While these restrictions had some effect, they were inadequate. Official government records state that during 2010, 12 persons died and more than 1600 persons were injured in this activity. It seems odd to me that a government should support any activity that kills so many and maims thousands, while being cruel to animals. The plot gets ever more murky. A resident of a village where jallikattu was planned approached the Madras High Court to appoint an official to see that political parties were not permitted to take over the running of jallikattu. He says they vied with each other to distribute towels and *banians* (vests) with the imprint of the party. The court has not yet pronounced on this plea.

In my youth, the people of Madras (present Chennai) were known for their courteous manners, and were by and large gentle folk. No longer. Citizens of Chennai are now aggressive and rude. Much of the change may be related to the film culture that dominates our lives. I do not know what the Censor Board of Film Certification does. Tamil films and television programmes are full of mindless and extreme violence, and no Indian film is restricted to adults only, or even cautions that parental guidance is needed. Our children are exposed to these images. And our government is now making matters worse by encouraging cruelty to animals, and by introducing them to the worst aspects of Tamil tradition in schools.

The newspapers of 17 January 2011 have reported on the first day of this year's jallikattu season. A posse of police was on duty to ensure that the event was held in compliance with the Tamil Nadu Regulation of Jallikattu Act, 2009. The result: 1 killed, gored to death by a bull, 68 injured.

M. K. MANI

Letter from the UK

CARVING NATURE AT ITS JOINTS: THE CHALLENGES OF CLASSIFYING MENTAL DISORDERS

Clinical assessments would be much easier if patients presented with symptoms exactly as described in textbooks. Unfortunately, they do not. Attaining clinical wisdom to distinguish health from disease and normal from abnormal usually involves much more than just learning the descriptions of diseases in classification manuals or textbooks. This is a particular challenge when assessing people presenting with mental health problems, since (at least so far) diagnoses are largely based on clinical history and mental state examination; there are no laboratory results or biological markers for clinicians to base their decisions on.

Classification systems such as the WHO's International Classification of Diseases (currently ICD-10) and the American Psychiatric Association's Diagnostic and Statistical Manual (currently DSM-IV) form the basis of psychiatric training and influence clinical practice. The complex and precise rules for making each diagnosis are often seen as gospel truth (at least by trainees—and they make great questions for examinations). But as these two widely used major classification systems of mental disorders get reorganized and revised in the coming years, there is a growing debate on the limitations of the concepts enshrined in these classification manuals. The eminent psychiatrist, Sir David Goldberg states that an ideal classification system for even common mental disorders has eluded psychiatry over the past 100 years, and we seem to be 'merely drawing lines in the fog, not carving nature at its joints'.[1] The editor of the *British Journal of Psychiatry*, Professor Peter Tyrer, provocatively wishes that classification systems would 'revise the nosology … in such a way that the current labels can be cast into oblivion'.[2] What is wrong with the current classification of mental disorders that it invokes such strong statements, and what is to come?

Most clinicians would agree that symptoms of diseases are usually distributed on a continuum of severity, with no clear or definite boundaries between normal and abnormal. However, despite this knowledge, everyday clinical decisions require dichotomous thinking—whether to give the patient a diagnosis or not, whether to treat or not, and so on. Research populations, too, are often divided into 2 categories, i.e. those who have a disorder (the cases under study) and those who do not (the 'non-cases' who are often implied as being normal for the purpose of that study). Thus, there are 2 major approaches—dichotomous categories on the one hand (one can either be pregnant or not), and continuous dimensions on the other (continuously distributed symptoms). On the face of it, these appear straightforward and both appear to have their place in practice. In psychiatric nosology, however, the

categorical approach has been historically favoured by the major classification systems. Both the DSM and ICD provide an important framework for making these categorical diagnoses. They provide lists of symptoms and a set of rules whereby patients presenting with these would either qualify for a diagnosis or not. One central area of criticism is that these largely ignore the concepts of dimensionality of symptoms and instead, reify (consider as real entities) constructs such as diagnostic labels.

In the preamble to the DSM-IV, it is cautiously pointed out that 'there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder' (DSM-IV, p. xxii). However, this small print is often forgotten in the real world and these diagnoses are often reified instead of being seen merely as useful heuristics that provides a common language with good inter-rater reliability.[3] Hyman begins his insightful review of this issue with an apt quote by John Stuart Mill: 'The tendency has always been strong to believe that whatever received a name must be an entity or being, having an independent existence of its own.' Hyman argues that reification is probably reinforced by the fact that these official categories have such precise and complex rules and definitions.[3] A vicious cycle then ensues. Grant funding bodies, journal editors and reviewers and scientific bodies expect researchers to follow these rules in research. Learning these explicit diagnostic rules is often a requirement for trainees in psychiatry and medical students. These eventually hamper advancement of science by becoming 'epistemic blinders impeding scientific progress', since the current systems do not allow for alternative approaches to be investigated, or even imagined.[3] By default, therefore, the system is extremely resistant to change.

There is also a feeling that the current systems are based on old and archaic concepts. Psychiatric classification is hugely influenced by historical descriptions and categorization of mental illnesses. For instance, Emil Kraeplin's dichotomization of major psychotic and mood disorders, currently termed as schizophrenia and bipolar disorder, respectively, has heavily influenced the thinking on these conditions for over a century, and forms the basis of the present classification of these disorders.[4] A fair amount of evidence has amassed over the years that does not support this dichotomy, and the usefulness of these concepts in the twenty-first century has been questioned.[4,5] Even the validity of the use of the term 'schizophrenia', probably the most reified concept in psychiatry, has been debated.[5] Likewise, the stability of diagnoses of common mental disorders such as depressive and anxiety disorders is questionable. Despite the number of anxiety and depressive disorders defined in the DSM-IV and ICD-10, a fairly robust body of evidence exists on the common co-occurrence of these presentations, in continua of severity as well as time.[1,3] In other words, they do not breed true. Co-morbidity is the law rather than exception, begging the question whether attempts to define them as salient categories have been successful.[2] Another major problem that commonly arises with the use of categorical diagnoses is that of sub-threshold cases. Categorical systems require the use of thresholds below which people are not considered 'ill'. However, the boundaries between the defined thresholds are usually blurred and many people below established thresholds are often also significantly impaired as compared to those above the threshold.[6,7] How do classification systems then cope with people below the (often arbitrary) thresholds that are defined in current systems? If they were included in further categories of 'milder than mild', classification manuals would just get bulkier than they already are and a larger number of people in society would be labelled unwell.

Despite the knowledge of the above limitations, it is often necessary to use a categorical approach leading to a 'yes' or 'no' decision. Categorical labels are an easier and more intuitive concept to grasp than, for instance, quantitative scores on a number of dimensions. Categorical diagnoses are required not only in individual clinician–patient encounters (where, for example, the clinician has to make dichotomous decisions such as whether treatment is indicated or not), but often also by policy-makers to estimate the burden of particular disorders in society to allocate resources and plan services. They form the basis of many research questions, facilitating the search for causes and examination of the consequences of disorders, and are important for developing interventions and treatments. They may also have legal (including being classified as ill or disabled) and insurance (such as qualifying for benefits) implications. In their classic paper, Kendell and Jablensky identify some distinct advantages of the current versions of rule-based categorical classification systems.[8] Importantly, these provide a common language in a standardized framework, to be used in teaching and clinical practice, and provide for better communication among professionals, patients and other stakeholders. They offer reliability of diagnoses across clinical practice and research.

Major changes to current categories will lead to confusion, restrict comparability over time, lead to overnight changes in the prevalence of disorders, and render much previous evidence (such as for the efficacy of treatments) meaningless.[3] It is, therefore, inconceivable that despite the arguments against the current categorical concepts of psychiatric disorders, revised versions of classification systems will be able to avoid the status quo to a large extent. For a long time, the categorical versus dimensional debates have assumed that these are 2 mutually exclusive concepts.[9] However, more recently, pragmatic solutions have been proposed—keep the current categories largely unchanged and complement them with validated dimensional measures, whereby the symptoms forming these categories could be studied in the natural continua they exist in.[9] That may offer a middle path, a 'best of both worlds' solution. It is a challenging and exciting time for psychiatric nosology, a time for reflection and debate. What will be the outcome, only time will tell.

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DHEERAJ RAI
Academic Unit of Psychiatry
University of Bristol
Oakfield House
Oakfield Grove
Bristol, UK
dheeraj.rai@bristol.ac.uk