Review of: "Is psychopathology a bit rusty? A critical essay"

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Potential competing interests: No potential competing interests to declare.

I found myself addressing number of issues as I engaged in exploration of the theme of this paper, disagreeing with the content, and the way content was presented from the onset. As I engaged in additional reading, I found myself lost for the purpose.

As a basic and clinical researcher as well as clinician on the front lines of work with afflicted patients. I found sections related to appropriate use of terminology in defining symptoms that may originate from variety of neurobiological difficulties and yet presenting with common symptomology, quite wasteful. I appreciate historical perspectives and how far we've come in our understanding of psychiatric presentations. We are nowhere near being able to establish gold standards for any psychiatric conditions which would respond predicably to specific therapeutic approaches. There is so much that we need to do moving forward.

It would be appropriate to state the purpose of the paper upfront by presenting how this effort enhances our understanding of complex human conditions that are referred to as psychiatric disorders, and how this writing could be helpful to move the field in forward direction.

This paper also suffers from linguistic issues which translate int a difficult read.

Specific comments related to the reading of the first part of the paper.

In medical specialties not only basic science but also clinical sciences play a significant role in defining the disease processes. Without specific clinical question there would be no reason to study mechanisms of pathology. In addition, example of cardiac infarct is lacking because the infarct may not be exclusively driven by atherosclerosis, this example is generally appropriate however not specific enough for an informed reader.

It is true that in most psychiatric practices are based on diagnostic interview and this approach plays a significant role in defining psychopathology, however with advances in neuroscience/ imaging/pharmacology/genetics this subjectively driven process is losing ground quickly.

The statement or presumption that empathic assessment of the patient's behavior is sufficient enough to generate proper diagnosis and develop appropriate therapeutic plan seems to be quite archaic. It is true that looking at the brain as a chemical soup with a goal l of developing appropriate molecules to treat the specific psychiatric disorders is very hindered by the therapeutic outcome studies of pharmacological efficacy studies. Basic problem of this approach is that there are no gold standards that define any psychiatric conditions. For example, 2 individuals with a similar clinical presentation may have very different underlying brain dysfunctions that respond to two different therapeutic approaches. In such case where

is the commonality? Is it in subjective clinical diagnosis? Or is it in underlying neurobiological conditions?

The issue of historical terminology addressing symptom clusters can be quite confusing based on cultural and educational variability, as pointed out by the author. How could we know that what we see and what we label is addressing the same clinical presentation? Th only way to eliminate this subjective process is to go back to biological substrates and talk about brain networks, structures, neurotransmitters, genetics, early developmental processes etc. as related to clinically presenting behavioral sequences.