6 Nemeroff CB, Heim CM, Thase ME, Klein DN, Rush AJ, Schatzberg AF, Ninan PT, McCullough JP Jr, Weiss PM, Dunner DL, Rothbaum BO, Kornstein S, Keitner G, Keller MB. Differential responses to psychotherapy versus pharmacotherapy in patients with chronic forms of major depression and childhood trauma. *Proc Natl Acad Sci USA* 2003; **100**: 14293–6.

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Author's reply: Pattanayak & Pattanayak assert that I am dismissive of biological advancements. Not true (my hay fever benefits from them every summer). I'm simply trying to identify their relevance to psychiatric practice. If such advancements in understanding 'putative biological mechanisms of mental disorders' proved of concrete value to clinical psychiatry I would be delighted, but no single example has yet been given in these letters or the original debate which demonstrates this to be the case. Pattanayak & Pattanayak also say that genetic research helps in counselling patients but what they are describing is the relevance of discussing and providing evidence about the influence of family history. Any genetic component may relate to mental disorder but could it simply be the mediating effects of the genetics of vulnerability factors such as temperament?

Hill speculates on the interaction of biology and social circumstances and the former's possible role in conveying vulnerability to depression. Hypothalamic–pituitary–adrenocortical reactivity may be theoretically interesting but how does assessment of it contribute to clinical interactions? Also, how exactly, in the management of childhood maltreatment are 'the presence [sic] of structural differences in the brain . . . highly relevant to clinical practice'?

If, after decades of watching the 'new dawn', the sun still does not appear to have risen, could I suggest to Dr Al-Adwani and his colleagues that they turn round and look in a different direction? They may find that it has been rising behind them, providing illumination of the way forward. Such a reorientation by psychiatry, to use psychosocial research as the foundation from which to address the major issues that exist, could transform our fundamentally flawed classification system,[1] appallingly stigmatising terminology[2,3] and manifestly confusing and ineffective explanations of mental conditions.[4]

1 McHugh PR. Striving for coherence: psychiatry's efforts over classification. *JAMA* 2005; **293**: 2526–8.

2 Kingdon D. DSPD or 'Don't Stigmatise People in Distress'. Invited commentary on: Challenges in the treatment of dangerous and severe personality disorder. *Advan Psychiatr Treat* 2007; **13**: 333–5.

3 Kingdon D. Down with schizophrenia. *New Scientist* 2007; **196**: 22.

4 Read J, Haslam N, Sayce L, Davies E. Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other' approach. *Acta Psychiatr Scand* 2006; **114**: 303–18.

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