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Thoughtful diagnoses
Not 'checklist' psychiatry

In our experience, psychiatry residents often are encouraged to present rich psychodynamic or biopsychosocial formulations,[1] while diagnostic assessments are relegated to robotic statements about whether patients meet DSM-IV-TR criteria. This practice can lead to "checklist psychiatry."[2]

However, thoughtfully invoking DSM criteria can enhance clinical acumen if the following conclusions are chosen and justified during patient assessments.

"This person meets diagnostic criteria, *and* I believe this is the correct diagnosis."

Ask the resident to back up his or her conclusion that symptoms are "not due to another condition" and cause "significant distress or impairment" as required by DSM. Emphasize differential diagnosis and understanding illness impact and illness behaviors. Also ask the resident to explain why the patient is considered a reliable reporter of his or her experience.

"This person seems to meet criteria, *but* I do not believe the diagnosis is correct."

Seeming to meet criteria is not the same as "having" a psychiatric diagnosis. Ask the resident to discuss alternate diagnoses and confounding factors in the patient's presentation. Some patients overreport psychological distress to pursue secondary gain or because of idiosyncratic ways of experiencing distress. Likewise, some clinicians interpret too narrowly patients' endorsements of symptoms and assume that patients share their definitions of terms such as depression and panic.[3]

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"This person does not meet criteria, *but* I believe the disorder is present."

This scenario often leads to a rapid "not otherwise specified" (NOS) diagnosis. However, if a patient has an incomplete yet longitudinally consistent and sufficiently severe version of a known syndrome, an NOS diagnosis is not clinically useful (research settings are a different story). Encourage the trainee to justify the diagnosis that he or she plans to treat.

"This person does not meet criteria, *and* I believe no disorder is present."

Some people are not mentally ill; in fact, most are not. Yet most residents we supervise cannot recall the last time they diagnosed "no mental illness" or saw a supervisor do so. Adopt this practice, and give trainees overt permission to make this assessment.

References

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