# Let's eliminate these imprecisions in chart notes of psychiatric evaluations

**Lorraine S. Roth, MD**

In private practice, government, and (especially) academically affiliated settings, chart notations that are *neither erroneous nor accurate but just imprecise* are seen regularly. Academic supervisors may overlook these ambiguous notations by medical students and residents because of their regularity; others may be actively taught by supervisors who use ambiguous notations themselves.

In my experience, the most frequently seen imprecisions are in diagnoses of personality disorders: for example, the terms "clusters" and "deferred," and the symptomatic overlap between antisocial personality disorder (APD) and substance abuse. Least helpful are qualifying phrases added to substance abuse diagnoses, along with an abundance of abbreviations. The latter occurs despite efforts by the U.S. Department of Veteran Affairs and other agencies to standardize acceptable lists of abbreviations. Many imprecisions could qualify for highlighting; here are 5 of the most unhelpful:

**Clusters.** Personality disorders are grouped into 3 "clusters," according to similar characteristics (eg, Cluster A includes paranoid, schizoid, and schizotypal personality disorders and focuses on patients' oddities and eccentricities). The need for identifying "clusters" could be debated, but a "cluster" is *not* a diagnosis. A psychiatric evaluation that notes "Cluster B traits" in lieu of a specific personality disorder is not informative, especially to a nonpsychiatric clinician. Which Cluster B traits apply? Is the patient unstable? Self-absorbed? Needy? Dramatic? Criminal? Assaultive?

In complicated or ambiguous cases, the diagnosis of a personality disorder not otherwise specified is appropriate, indicating that traits need to be clarified.

**Deferred.** This notation frequently is seen under axis II, and often is carried through the medical record for months or years. Psychiatrists are reluctant to diagnose a personality disorder because of the pejorative nature a diagnosis conveys. Nevertheless, by the second or third visit—after two or three hours of interview contact—it should be evident whether a personality disorder exists. If none does, "no diagnosis" should be documented. This notation can be adjusted if such evidence comes to light.

**APD (or APD traits).** This diagnosis often is made mistakenly when the root problem is in fact a substance abuse disorder. A multidecade study of alcoholism and antisocial personality attributes in university students illustrated this phenomenon.[1]

To be a successful substance abuser—that is, to satisfy the overwhelming urge to drink or use drugs—it's essential to lie, cheat, and steal. Substance abusers might become belligerent when intoxicated. They might be arrested in bar fights, drive while intoxicated, and buy illegal substances. The result is incarceration, a common consequence of substance abuse *and* of APD. The latter diagnosis should be made only if the patient has exhibited a pattern of criminal behavior—often starting in adolescence—irrespective of substance abuse, such as breaking and entering, robbery, or assault with a deadly weapon.

Substance abusers often feel guilt and self-loathing for their "weakness," and cannot

Dr. Roth is a member of the Department of Defense Medical Evaluation Board, Fort Belvoir, Virginia.

**Disclosure**

Dr. Roth reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

gain control over their addiction; the APD patient, on the other hand, feels entitled to plunder and often justifies his (her) actions by attributing fault to the victim.

Keep in mind that many APD patients also are substance abusers; both diagnoses should be listed in the chart when that is the determination. Recognize that substance abuse and APD are distinct entities that should not be confused by the common denominator of having spent time in jail.

**An APD diagnosis should be made only if the patient has exhibited a pattern of criminal behavior, irrespective of substance abuse**

**Early, late, full remission.** These qualifiers often are appended to substance abuse disorders, but they do not convey useful information. How early is "early"? How late is "late"? Perhaps the most misleading term is "full" or "partial" remission, because there is no clear definition of either.

If one is referring to length of time sober or a reduction in volume consumed, noting the date of the last use is more helpful—eg, "alcohol abuse in remission since summer of 2012." If "partial" remission means the patient has reduced his intake, then that is not remission. The reduction can be specified—eg, "alcohol abuse, reduced to one or two beers per weekend."

**Abbreviations.** Psychiatric evaluations should contain only standard, well-known medical shorthand (such as MSE for mental status exam). The military may be the biggest offender, devising acronyms and abbreviations for everything.

Two examples of abbreviations that I see in military psychiatric progress notes are AEB ("as evidenced by") and LLGD ("linear, logical, and goal-directed"). Psychiatrists have a leg up on deciphering abbreviations in psychiatric notes; other providers might be compelled to resort to consultation. That wastes more time than typing out the words and results in frustration and lost productivity.

**Reference**

1. Vaillant GE. The natural history of alcoholism. Cambridge, MA: Harvard University Press; 1983.