How to avoid 'checklist' psychiatry

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To determine whether a patient meets the criteria for a DSM-5 diagnosis, we rely on objective data, direct observations, and individual biopsychosocial factors as well as our patient's subjective report of symptoms. However, because the line differentiating normal from abnormal emotional responses can sometimes be blurred, we should be prudent when establishing a diagnosis. Specifically, we need to avoid falling into the trap of "checklist" psychiatry—relegating diagnostic assessments to robotic statements about whether patients meet DSM criteria—because this can lead to making diagnoses too quickly or inaccurately.[1] Potential consequences of checklist psychiatry include[1,2]:

- becoming so "married" to a particular diagnosis that you don't consider alternative diagnoses
- labeling patients with a diagnosis that many clinicians may view as pejorative (eg, antisocial personality disorder), which might affect their ability to receive future treatment
- developing ineffective treatment plans based on an incorrect diagnosis, including exposing patients to medications that could have serious adverse effects
- performing suicide or violence risk assessments based on inaccurate diagnoses, thereby over- or underestimating the possible risk for an adverse outcome
- leading patients to assume the identity of the inaccurate diagnosis and possibly viewing themselves as dysfunctional or impaired.

When you are uncertain whether your patient has a diagnosable condition, it can be useful to use the terms "no diagnosis" or "diagnosis deferred." However, many insurance companies will not reimburse without an actual diagnosis. Therefore, the following tips may be helpful in establishing an accurate diagnosis while avoiding checklist psychiatry.[1,2]

Ask patients about the degree and duration of impairment in functioning. Although impairment in functioning is a criterion of almost all DSM-5 diagnoses, not all endorsed symptoms warrant a diagnosis. Mild symptoms often resolve spontaneously over time without the need for diagnostic labels or interventions.

Make longitudinal observations. Interviewing patients over a long period of time and on multiple occasions can provide data on the consistency of reported symptoms, the presence or absence of behavioral correlates to reported symptomatology, the degree of impairment from the reported symptoms, and the evolution of symptoms.

Collect collateral information. Although we often rely on our patients' reports of symptoms to establish a diagnosis, this

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information should not be the sole source. We can obtain a more complete picture if we approach a patient's family members for their input, including asking about a family history of mental illness or substance use disorders. We can also review prior treatment records and gather observations from clinic or inpatient staff for additional information.

Order laboratory studies. Serum studies and urine toxicology screens provide information that can help form an accurate diagnosis. This information is helpful because certain medical conditions, substance intoxication, and substance withdrawal can mimic psychiatric symptoms.

Continuously re-evaluate your diagnoses. As clinicians, we'd like to provide an accurate diagnosis at the onset of treatment; however, this may not be realistic because the patient's presentation might change over time. It is paramount that we view diagnoses as evolving, so that we can more readily adjust our approach to treatment, especially when the patient is not benefitting from a well-formulated and comprehensive treatment plan.

Our patients are best served when we take the necessary time to use all resources to conceptualize them as more than a checklist of symptoms.

To avoid falling into the trap of 'checklist' psychiatry, make longitudinal observations and collect collateral information

References

1. Kontos N, Freudenreich O, Querques J. Thoughtful diagnoses: not 'checklist' psychiatry. Current Psychiatry. 2007;6(3):112.
2. Frances A. My 12 best tips on psychiatric diagnosis. Psychiatric Times. http://www.psychiatrictimes.com/dsm-5/my-12-best-tips-psychiatric-diagnosis. Published June 17, 2013. Accessed July 19, 2019.