

Psychiatry and Neuropsychiatry as a Craft

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Consider motorcycle repair:

".... it frequently requires complex thinking. In fixing motorcycles you come up with several imagined trains of cause and effect for manifest symptoms, and you judge their likelihood before tearing anything down. This imagining relies on a mental library that you develop. An internal combustion engine can work in any number of ways, and different manufacturers have tried different approaches. Each has its own proclivities for failure. You also develop a library of sounds and smells and feels..."

"Some diagnostic situations contain a lot of variables. Any given symptom may have several possible causes, and further, these causes may interact with one another and therefore be difficult to isolate. In deciding how to proceed, there often comes a point where you have to step back and get a larger gestalt..."

"There is always a risk of introducing new complications when working on old motorcycles, and this enters the diagnostic logic. Measured in likelihood of screw-ups, the cost is not identical for all avenues of inquiry when deciding which hypothesis to pursue."¹

In the quote above, replace "motorcycles" and "internal combustion engine" with "people with psychiatric and neuropsychiatric disorders" and these words about work ring true for our profession. The quote also reflects Alan Schatzberg's 2009 American Psychiatric Association presiden-

tial address calling for a return of professional pride in the practice and craft of psychiatry.

Psychiatric work is complex, difficult, challenging, and ever changing. Psychiatry requires mastering a large body of knowledge about the manifestations of the most complex object that we know exists—the human brain. On top of this large body of knowledge, psychiatrists have to learn the skills of how to integrate and apply that knowledge, and how to treat people whose psychiatric disorders can make it difficult for them to collaborate with their doctors.

To obtain the necessary psychiatric skills, as with any medical specialty, one must transition from book learning to apprenticeship to mastery. But mastery is never permanent because the psychiatric field is constantly evolving with new insights from neuroscience, cognitive science, efficacy and effectiveness clinical trials, and genetics. Psychiatry has the additional burdens of stigma, discrimination, controversy about diagnoses and treatments, and internal professional conflicts with roots in philosophical differences in understanding causes and explanations of psychiatric disorders. Plus each person with a psychiatric or neuropsychiatric disorder presents a different set of challenges. Their brains and minds (a manifestation of brains with complex gene-environment interactions overlaid with interpretations and the

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salience and meaning of events) are a bit more complicated than a motorcycle engine.

Just as with the challenge of mastering any complex skill, psychiatrists have to build on a foundation of knowledge, get supervised by those who have mastered the skills, practice the skills that we learn, and most important, constantly find ways to improve what we do.

"To do good work means to be curious about, to investigate, and to learn from ambiguity...[it] negotiates a liminal zone between problem solving and problem finding...listening...can glean clues about... ailments that might escape a diagnostic checklist."²

We should take pride in our skills in systematic diagnosis. Psychiatric diagnosis, as with motorcycle repair, is the first step towards helping our patients. *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*³ has its limits and will change in the future with additional information about genes, circuits, brain development and the behavioral manifestations that result from abnormalities in brain development or psychiatric trauma, neuronal plasticity and neurogenesis, and resilience or lack of resilience to stress.⁴ Nevertheless, the *DSM-IV* has been a reasonable approach to clarify clinical patterns that reveal familial heritability, pathophysiology, clinical course, and practical treatments. If we view the *DSM-IV* as an evolving tool, then we can take pride in our skillful use of diagnostic criteria.

How psychiatrists actually diagnose⁵ patients, however, may require some attention. Should structured interviews, such as the Structured Clinical Interview for the *DSM-IV*⁶ or the Mini International Neuropsychiatric Interview⁶ be used in routine

clinical care? Are they too burdensome? Should diagnosis be made with an unstructured interview? How can we diagnose our patients in a way that increases precision and decreases errors of omission? How do we ensure quality of diagnosis in everyday practice? How can we be systematic and, at the same time, listen empathically and carefully to our patients' stories? When done well, we obtain the necessary clinical information for psychiatric diagnoses with careful listening, semi-systematic inquiry, along with an ability to weigh and interpret the importance of symptoms.

After we make a diagnosis, we sift the information to find psychosocial and plausible biological explanations that contribute to the diagnosis. Then we formulate a treatment plan, initiate treatment, and track our patients' outcomes, changing treatment as needed. And at the heart of our work in caring for our patients and their families is our hard-earned clinical judgment⁷ that blends the best of evidence with clinical experience. While there is always room for improvements in how we make diagnoses, it is time we retake pride in our craft of psychiatric and neuropsychiatric work. **CNS**

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