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Editorial

Is it time for case formulation to outweigh the classical diagnostic classification in child and adolescent psychiatry?

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How does the clinician weigh, sort and summarize all the information gained during the clinical assessment? How does the clinician ensure that the amount of information is summarized in a way that makes sense for the child and family while providing a basis for planning treatment?

Most clinicians will probably agree that information gained from standardized testing – as such testing focuses mainly on symptoms and results in diagnostic categories – can only be complementary to the overall clinical assessment. However, the more common and general clinical assessment and clinical reflection is not well described and systemized. It requires time and experience. An important overall question is, whether the needs of the families are truly elucidated if in the future we are relying mainly on standardized testing? One can certainly worry that clinical reflections and diagnostic decisions increasingly become premature due to structural changes. The field of child and adolescent psychiatry in Denmark has in recent years been burdened by political decisions to increase efficiency, which in effect results in less time for the individual patient. This means there is less time for the general clinical assessment and for interdisciplinary reflection. To name one current issue, it is hardly meaningful from a professional perspective to have "fast track" diagnostic processes, as we know the symptomatology of children and adolescents can change significantly over a short time period. It may be more important to recognize the patient as a person – and consider the patient's perspective – than to immediately decide upon a diagnosis. The diagnostic and treatment planning process is heterogeneous as different children with the same main diagnosis have different treatment needs. Further, the categorical nature of classical diagnostic classification is potentially excluding important information on the patient and the patient's family. Hence, the diagnosis in itself does not constitute an adequate basis for individual treatment planning (1,2).

The humble clinicians dare to give time (although nearly impossible) to be doubtful and discuss uncertainties with colleagues in an interdisciplinary field – all in order to consider information from multiple perspectives. They do not blindly trust in standardized testing, but consider their validity critically and in the context of supplementary information on the patient. However, one also has to recognize the sociological phenomena in humans that makes us pull away from uncertainty and complexity, and search for a solution to the current problem (3). Hence, what happens when time is of the essence? We think it may further result in moving away from diagnostic precision – and from the real issues of importance to the patient – when time becomes a limited luxury.

Developmental psychopathology is a research field with particular focus on the processes that contribute or protect against the development of psychopathology. In order to capture the "specificity of the individual's life" and guide decision making in planning treatment, "case formulation" has been suggested by several researchers (4). The method in detail will not be described here. However, in overall terms, it is a theory embracing diverse hypotheses and perspectives on why current difficulties have arisen. These hypotheses are considered in the context of the child's developmental trajectory and include information on vulnerability and risk factors as well as protective factors. The idea is to allow the clinician in an interdisciplinary framework, to weigh, sort and summarize all information in a manner that makes sense for each family. This is a more systemized way of carrying out clinical assessment, which provides a basis for treatment planning that can be adjusted continuously when needed. The obvious strength of this mindset is that it provides a

supporting framework to the process of comparing clinical data to empirical knowledge.

In our opinion, today's psychiatry is facing two problems: first of all we do not know the actual real worth of the "general clinical assessment" as a concept due to great variability in clinician experience and time spent. On the other hand, we do not know the consequences if this information – as part in the overall information gathering – is gradually excluded from the diagnostic process due to the well-known pressure of time and resources. What is the result if this development is in favor of standardized testing? To name one example, we know that the validity of the Autism Diagnostic Observation Schedule (ADOS) depends on the clinician' experience (5). This puts the validity of at least some standardized measures into question. This may very well also be the case for clinical assessment and reflection.

Hence, case formulation may prove to be an example of evidence-based "clinical practice". However, despite the potential importance of case-formulation in clinical practice, the method is still placed next and secondary (if considered at all) to the more classical diagnostic classification systems. There is a need for research focusing on how to improve the clinical practice through the use of case formulation methods. Three important aspects of evidence-based psychiatry include: 1) external evidence; 2) patient/family preference; and 3) clinician experience and clinical practice(6).

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