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RESEARCH INTO PRACTICE

The Role of Clinical Judgment in Psychiatry

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ABSTRACT

Clinical judgment is currently perceived as an intuitive art that is going to be replaced by growing technology and artificial intelligence. Even though patients look for good clinical judgment when they seek medical attention and clinicians rely on it, the topic is seldom mentioned and discussed in the literature. In their everyday practice, psychiatrists use observation, description, and classification; test explanatory hypotheses; and formulate clinical decisions based on clinical judgment. The aim of this review was to examine the current role of clinical judgment in psychiatry. We first outline the importance of collecting information that supplements the use of diagnostic criteria (allostatic load, health attitudes and behavior, psychological well-being, personality and iatrogenic factors). Clinimetrics, the science of clinical measurements, provides an intellectual home for the reproduction and standardization of clinical intuitions. The clinimetric translation of clinical reasoning allows the organization of the material that has been collected (staging, building unitary concepts, subtyping, formulating pathophysiological links, and global judgments). Finally, we discuss how clinical judgment is the intermediate step between the general indications that derive from clinical trials and individualized treatment plans, encompassing patients' preferences, treatment articulation and selection, level of care, and interpretation of previous treatment response. Clinical judgment remains the basic method of medicine and psychiatry. Improving its features by clinimetric strategies is likely to yield a highly effective precision psychiatry that is available today to any practicing clinician.

1 | Introduction

In their everyday practice, psychiatrists use observation, description, and classification, test explanatory hypotheses, and formulate clinical decisions. In evaluating whether a patient needs admission to the hospital (or can be discharged from it), in deciding whether a patient needs treatment (and in case what type) and in planning the schedule of follow-up visits or interventions, the psychiatrist uses nothing more than the art and science of clinical judgment [1]. The sophisticated forms of clinical judgment that are suitable for clinical challenges, however, are not addressed by current research strategies [2, 3]. Little consideration has been given to the clinical process in psychiatry, that is, how clinical judgment leading to medical decisions is formulated [1]. The main emphasis has been given to the standardization of the assessment process by use of diagnostic criteria.

In 1967 Alvan Feinstein defined clinical judgment as a type of reasoning for making decisions about prognosis and therapy of patients [4]. "Clinical judgment depends not on a knowledge of causes, mechanisms, or names of diseases, but on a knowledge of patients. The background of clinical judgment is clinical experience: the things clinicians have learned at the bedside in the care of sick people" [4, p. 12]. The methods of acquiring evidence and of organizing clinical thoughts provide its distinctive features [2–4]. Feinstein introduced the term "clinimetrics" to indicate a domain concerned with indices, rating scales and other expressions that are used to describe or measure symptoms, physical signs, and other clinical phenomena [5]. The clinimetric

> **Summary**
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> - Clinical recommendations
>   - Clinical judgment remains the basic method for assessment and treatment planning in psychiatry.
>   - Clinical judgment is the intermediate step between general indications that derive from clinical trials and individualized treatment plans.
>   - Improving clinical judgment by clinimetric strategies allows the clinician to practice a highly effective precision psychiatry.
> - Limitations
>   - The findings that are discussed derive from a selective review of the relevant literature.
>   - The focus of the paper is on clinimetric evaluation and omits reference to psychometric methods.

perspective provides an intellectual home for the reproduction and standardization of clinical intuitions. It allows the clinician to make full use of the information that is available [6].

A review of the literature on clinical judgment in psychiatry was performed. It was based on a MEDLINE search from inception to May 2025 using the keywords "clinical judgment," "clinical reasoning," and "clinimetric" in relation to psychiatric illness. It was supplemented by a manual search of the literature. The aim of this state-of-the-art critical review [7] was to illustrate how the science of clinical judgment may be articulated in psychiatry, with reference to the importance of collecting information that supplements the use of diagnostic criteria, to clinical reasoning that may organize the material that has been collected, and to the formulation of individualized treatment plans.

2 | Gathering Clinical Information

The introduction of diagnostic criteria for the identification of psychiatric syndromes has considerably decreased the variance due to different assessors and the use of inferential criteria rather than direct observation. The customary clinical taxonomy in psychiatry does not include clinical distinctions that demarcate major prognostic and therapeutic differences among patients who otherwise seem to be deceptively similar since they share the same psychiatric diagnosis [1]. Indeed, in clinical practice, psychiatrists weigh factors such as the progression of disease, the overall severity of the disorder, the patient's social support and adaptation, resilience and reaction to stressful life circumstances, and response to previous treatment [8]. However, current formal strategies of assessment fail to capture most of the information that forms the basis of clinical judgment.

Clinical interviewing is the essential basic method of medicine and psychiatry [9]. From the very beginning of the contact with the patient, the clinician is looking for clues, key perceptions most likely to be interpreted as clinical inferences, which involve observation and general impressions [10]. Observations interact with the personal experience and knowledge of the clinician [9, 10]. Psychological testing, laboratory, and imaging methods have a limited role in psychiatric practice [11]. Time pressure has progressively reduced the aims and goals of the interview to ascertain the mere presence of certain symptoms in a checklist fashion [12]. As a result, the interview has been more and more conceived as a method to come to a diagnosis, while it is the basic method to understand how a person feels and what the presenting complaints are, obtain psychiatric history, evaluate personal attitudes and behavior related to health and disease, give the patient information about diagnosis, prognosis, and treatment, and establish a bond between patient and physician that is crucial for shared decision making and self-management [9, 11].

When Feinstein introduced the concept of comorbidity in 1970 [13] he referred to having disorders unrelated to the one of interest and to any "additional co-existing ailment" separate from the primary disease, even in the case this secondary phenomenon does not qualify as a disease per se. Indeed, in clinical medicine the many methods that are available for measuring comorbidity are not limited to disease entities [14]. Comorbidity in DSM-5 [15] is confined to psychiatric and medical diagnoses, while there are several clinical aspects that would qualify for it and have primary importance for clinical judgment (Figure 1).

2.1 | Allostatic Load

In psychiatric practice, the interpretation and evaluation of certain symptoms are different in highly stressful circumstances or grief reactions compared to what occurs in the absence of stress. The concept of allostatic load (the cost of chronic exposure to fluctuating or heightened physiological responses resulting from repeated or chronic stress) provides a characterization of the individual psychosocial environment [16, 17]. Such characterization is missing from current clinical diagnostic formulations [15]. The conceptual framework of allostatic load extends to work, unemployment, adverse living conditions, social and educational experiences, and income inequality throughout the lifespan [18]. This comprehensive model also includes the physiological consequences of the resulting health damaging behaviors, such as poor sleep and diet, smoking, alcohol consumption, and social isolation. When environmental challenges exceed the individual ability to cope, allostatic overload ensues [18]. There are clinimetric methods for assessing allostatic overload, in addition to the use of biomarkers [17, 18].

2.2 | Health Attitudes and Behavior

Individual attitudes and behavior related to health and disease are major components of clinical encounters both in medicine and psychiatry. These factors shape lifestyle, presentation of symptoms, access to patient care, interactions between patients and physicians, adherence to medical advice, and response to treatment [19]. Health attitudes and behavior may range from anxiety and worry about illness to various forms of denial, such as delay of seeking care and lack of adherence to treatment. Psychiatric symptoms may be emphasized or minimized according to specific clinical situations and types of interaction. Further, whether patients take an active attitude toward challenges and tasks posed by illness or disability, or their mode of coping is characterized by passivity and dependency, are coping strategies that may influence the prognostic judgment [20, 21].

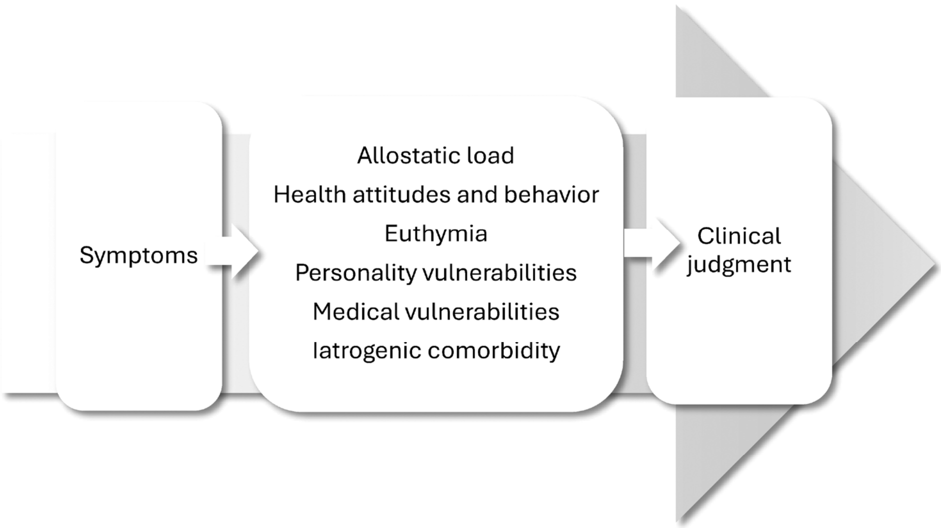

FIGURE 1 | Clinimetric integration of diagnostic criteria.

Finally, assessing health attitudes and behavior within the clinical interview and/or with clinimetric methods may provide important clues to phenomena such as lack of adherence or impaired response to treatment [19].

2.3 | Euthymia

There is extensive evidence on the protective role of psychological well-being as to development or relapse in psychiatric disorders [22]. In clinical psychiatry, it is important to identify strengths, particularly when the person is confronted with difficult environmental situations (allostatic load). Euthymia is an integrative concept characterized by lack of mood disturbances, presence of positive affect, balance of psychological well-being dimensions leading to flexibility, consistency, and resistance to stress [22]. Clinical assessment of euthymia requires a clinimetric approach that includes interview and/or self-rated methods. It may provide a framework for a renewed definition of recovery, for measuring treatment outcome and for targeting interventions [22]. Euthymia expresses the capacity of using allostasis optimally [23]. Promoting euthymia may improve flexibility of the individual response capacity, which may entail long-lasting remission from psychiatric disorders and more successful and enduring results in lifestyle medicine [21–23].

2.4 | Personality Vulnerabilities

If individual biography explored by clinical interviewing may help identify strengths, it is also a primary source of information for enduring modes of functioning and relating that determine vulnerabilities [1, 8, 10, 11]. In particular, persons may lack the characteristics that allow them to cope with environmental changes, and they are likely to succumb to almost any stress, provided it is sufficient in degree [24]. Such weaknesses refer to the concept of neurosis [24–26]. Tyrer [25] argued that the combination of mixed anxiety and depressive disorders together with a certain type of abnormal personality (excessive timidity, poor self-esteem, avoidance of anxiety provoking situations, and dependence on others) constitutes a single syndrome, the general neurotic syndrome. The syndrome was shown to be associated with a poor response to treatment, frequent symptoms throughout the neurotic diagnostic spectrum, and a tendency to relapse [25]. The clinimetric concept of dysthymia encompasses liability to demoralization and subjective incompetence; chronic worrying; mental pain; rigidity; and abnormal reactivity to environmental stimuli [27]. Dysthymia is conceptualized at the other end of a continuum with euthymia and is not synonymous with persistent depressive disorder as in the DSM-5 [15]. The concepts of neurosis and dysthymia connote characteristics of perceiving, thinking, and acting that may be important in the formulation of clinical judgment. They do not fall within the definitions of personality disorders according to DSM-5 criteria [15]. Dysthymia, however, is in line with the increasing body of literature pointing to the clinical value of the concept of frailty in older people [28].

2.5 | Medical Vulnerabilities

A large proportion of psychiatric patients have active medical illnesses, and many medical and surgical patients present with a psychiatric disorder [29]. Further, psychiatric medications may pose additional medical risks. A full understanding of the patient's medical condition is important not only to clarify the nature of psychiatric symptoms, but also to determine the need for general medical care and to choose psychiatric treatments that do not interact adversely with the medical illness and its treatment. The evaluation of psychiatric symptomatology in the setting of medical disease requires clinical judgment. Assessment should ascertain a number of issues: the potential etiological role of medical disorders and medications in producing psychiatric symptomatology; the differential diagnosis of psychiatric disorders in the setting of medical disease; and the relationship of psychiatric symptoms to the evolution and characteristics of medical disturbances over time [30].

2.6 | Treatment History and Iatrogenic Factors

History of previous treatments plays an important role in the formulation of clinical judgment in relation to ascertaining responsiveness, the nature and severity of side effects, and the presence of iatrogenic factors [1, 31]. Current diagnostic methods in psychiatry, however, essentially refer to patients who are drug free and do not take the issue of iatrogenic effects into adequate consideration. They are suited for a patient who no longer exists: most of the psychiatric cases that are seen in clinical practice already receive some forms of psychotropic drug treatment at the time of the first psychiatric or psychological assessment and require evaluation of iatrogenic factors [31]. The term "iatrogenic comorbidity" refers to the unfavorable modifications in the course, characteristics, and responsiveness to treatment of an illness that may be related to previously administered therapies [31]. Such vulnerabilities may manifest themselves during treatment administration and/or after its discontinuation (Table 1) These iatrogenic effects may be caused by medications, psychotherapy and their interaction [31, 32].

3 | Clinical Reasoning

When data that supplement diagnostic criteria are collected (Figure 1), a first problem is concerned with their organization and translation in clinical hypotheses. Macro-analysis is a clinimetric technique, originally developed by Emmelkamp et al. [33] for cognitive behavioral assessment, that is based on the main elements and problematic areas that are collected during the interview [1, 34]. It includes psychiatric and medical disorders, as well as complaints that are not part of diagnostic criteria but are perceived by the clinician as important in the life of the patient. Macro-analysis selects problematic areas (e.g., interpersonal conflicts, difficulties at work, family frictions), functional impairments, stressful environmental circumstances, health attitudes and behavior, health-damaging lifestyle, and use of medications. It is not limited to negative aspects of functioning but may also include some areas of euthymia that stand despite the presence of distress, thus providing a picture of the balance between strengths and weaknesses of the individual patient [1, 34]. All these elements are simply collected on a sheet of paper and lend themselves to clinical reasoning in terms of their relationships and priorities. Macro-analysis is always tentative and needs to be updated and verified in subsequent encounters (for instance, after a first course of treatment), as illustrated in the case depicted in Figure 2. At initial assessment, a patient may present with a major depressive disorder, social avoidance, and family conflicts. In terms of macro-analysis, the clinician, after a thorough interview with the patient, could place into a hierarchy the syndromes and symptoms of comorbidity by considering also the patient's needs. The clinician could thus give priority to the pharmacological treatment of the current major depressive episode (time 1). After successful response to first-course treatment, a second assessment is warranted (time 2). The clinician could decide to intervene on the residual symptoms by using cognitive-behavioral treatment (CBT) for social avoidance, followed by well-being therapy (WBT) for low levels of autonomy and self-acceptance [22]. If the clinical decision of tackling one syndrome may be taken during the initial assessment, the subsequent steps of macro-analysis require a reassessment after the first line of treatment has terminated. The hierarchical organization that is chosen may depend on a variety of factors (e.g., urgency, time of onset, availability of treatment tools), including also the patient's preferences and priorities. Macro-analysis is not only a tool for the therapist but can also be used to inform the patient about the relationship between different problem areas and motivate the patient for changing [21].

Currently, clinical reasoning in psychiatry tends to end with the identification of a diagnosis that generates the prognostic and therapeutic evaluation of the clinician [1, 12]. The focus on DSM-5 [15] is in line with the classical medical approach that aims to find the best diagnostic match for the patient's condition [35]. Clinical decisions may then be automatically protracted for years. A much more sophisticated clinical reasoning, in line with what occurs in medicine, is, however, frequently performed in psychiatric practice [8, 34]. Selecting the elements to be included in macro-analysis requires broad assessment and stringent lines of clinical priorities. Establishing links among the elements of macro-analysis and interpreting their role require the formulation of tentative hypotheses. The value of each interpretation is that it provides a framework within which clinical decisions can be applied to the individual case. Clinical reasoning occurs within the context of patient–clinician interaction (in this sense it can never be substituted by artificial intelligence). The patient may or may not confirm clinical hypotheses and intuitions, and interviewing is continuously testing assumptions.

Feinstein [36] remarked that, when making a diagnosis, thoughtful clinicians seldom leap from a clinical manifestation to a diagnostic endpoint. The clinical reasoning goes through a series of "transfer stations" where potential connections between presenting symptoms and pathophysiological processes are drawn. These stations are a pause for verification or change to another direction [36]. This particularly applies to psychiatric disorders [1]. For instance, an initial state of generalized anxiety may assume phobic connotations at some later point in time. If major depression then ensues, mood symptomatology may overshadow the previous anxiety

TABLE 1 | Common examples of iatrogenic factors in psychiatry.

- Withdrawal syndromes after psychotropic drug discontinuation
- Persistent post-withdrawal disorders
- Persistent side effects during and/or after medication discontinuation
- Paradoxical effects (e.g., deepening of depression with antidepressants)
- Switching (onset of mania or hypomania with antidepressant treatment)
- Loss of clinical effects during maintenance treatment
- Lack of response to a previously effective treatment when it is started again after a drug-free period
- Supersensitivity psychosis

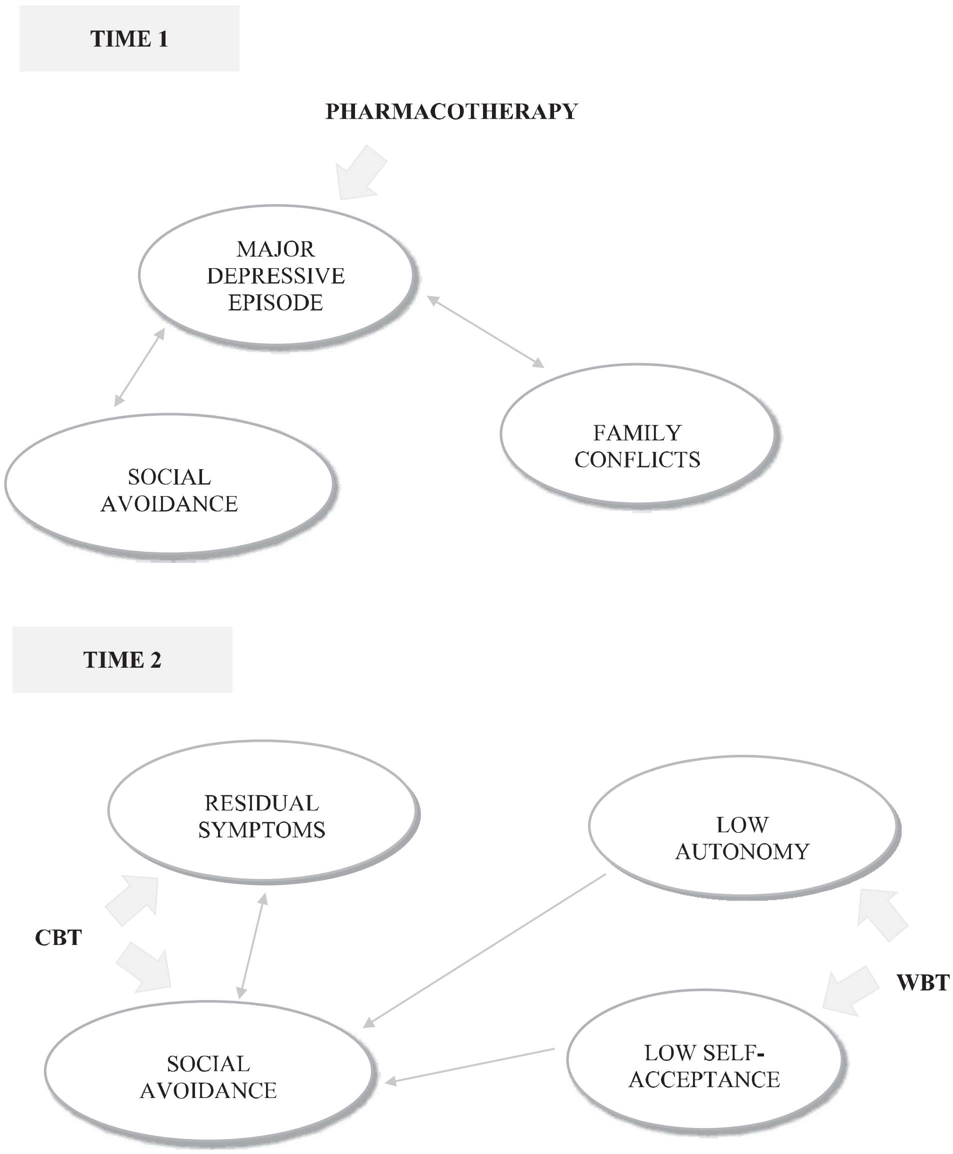

FIGURE 2 | Example of macro-analysis. CBT, cognitive-behavioral treatment; WBT, well-being therapy.

disturbances, but the diagnosis of depression is only a transfer from prodromal to residual anxiety.

There are several clinical strategies that may facilitate the organization of data that have been collected.

3.1 | Setting a Longitudinal Perspective (Staging)

The DSM-5 [15] provides a cross-sectional, flat view of mental disorders, with little attention to their longitudinal course [1]. However, disorders that may appear as simply comorbid at a first evaluation may have different times of onset. A longitudinal perspective may provide room for the primary/secondary distinction of mental disorders. Such distinction has been operationalized in depression (i.e., an episode of depression is defined as secondary when it was superimposed on a pre-existing psychiatric or medical disease) [37], but it may apply to any psychiatric disorder. In medicine, staging is a conceptual and practical framework for monitoring disease longitudinal course [5, 6]. Such clinimetric approach was first applied to psychiatry three decades ago [38]. The model was based on differentiating the prodromal, acute, and residual phases in the first three stages, followed by subsequent stage(s) indicating recurrence or chronicity and their progression in terms of severity and complications [1, 38]. The same symptoms may achieve a different meaning if they are viewed as residual of a psychiatric disorder [38]. For instance, in patients with a diagnosis of chronic fatigue syndrome, fatigue may be viewed as a residual symptom of depression, and such recognition could have important therapeutic implications [39].

3.2 | Building Unitary Concepts

Symptoms may be grouped together according to the clinical formulation of mental disorders in diagnostic systems [15]. However, clinimetrics offers the opportunity of building unitary concepts that are articulated in heterogeneous components and that emphasize the importance of global judgment. Examples of such unitary concepts are allostatic overload, euthymia, dysthymia, and iatrogenic comorbidity [6].

3.3 | Subtyping

When psychiatric diagnoses are too broad to yield meaningful treatment implications (e.g., depression), there is the need for subtyping them [1, 40]. The aim is to increase the amount of clinical information that is conveyed by a diagnosis. Clinical reasoning may thus lead to the subtyping of a psychiatric condition, such as depression [1]. The basic assumption is that clinical manifestations that are subsumed under the diagnosis of major depressive disorder may display substantial differences in prognostic and therapeutic terms [40].

3.4 | Selecting Elements of Macro-Analysis and Interpreting Links

The selection of the elements that constitute the macro-analysis of the individual patient entirely relies on clinical perception, that is, what the clinician regards as most important and meaningful in an individual story. As a result, macro-analysis may consist of a highly variable number of elements; other elements may be added or discarded in subsequent encounters, which underscores the importance of repeated assessments. Once the elements of a macro-analysis have been established, one needs to set their relationships and to interpret their links. Hypotheses should be evaluated not as to whether they are right or wrong, but as to how useful they are and whether they may apply or not to the individual narrative of the patient. Each person's unique biography (life experience) is in fact likely to exert major influences on health, disease development, and response to treatment [41] and one needs to link a diagnosis to the level of functioning and quality of life of an individual. Tentative hypotheses (transfer stations) can be tested in the dialogue between the patient and the clinician, and new hypotheses and configurations may be formulated until a satisfactory interpretation of the clinical situation is achieved [34]. At times, hypotheses often derive from clinical intuitions that are based on clinicians' perceptions (flavors, feelings, hunches) more than precise data [8].

3.5 | Global Judgments

Clinical reasoning applied to the individual case may help formulate global judgments about the patient's condition, as it is typical of the clinimetric approach [6]. Global judgments do not derive from the sum of the parts (e.g., the sum of the individual item scores of a rating scale) but from an overall evaluation. Global judgments may involve key clinical issues such as severity and/or complexity of illness, prognosis (e.g., suicidal risk and dangerousness), and urgency of treatment (e.g., need for inpatient admission). Evaluation may be categorical (present/absent), such as in determining whether the overall severity of depressive illness reaches a diagnostic threshold, or dimensional, such as in a 0–100 index [42]. Table 2 displays a staging formulation of global judgment concerned with prognosis that a clinician is likely to take into consideration when evaluating a case that presents with affective disturbances. The clinician estimates the likelihood of a particular outcome over a specific time period and discloses and discusses the formulated prognosis with the patient and/or family [43]. The formulation of a prognosis involves integrating clinical judgment with patient-, disease-, and environment-related factors to suggest treatment options [43]. Even though in psychiatry diagnoses may be good predictors of the course and outcome of mental disorders, such information needs to be integrated with the developmental, biographic, and personality characteristics, that may represent an additional source of vulnerability [26].

Clinical reasoning in psychiatry is liable to a number of biases that occur in clinical medicine [35, 44]: anchoring bias (the tendency of the clinician to concentrate on certain aspects of the case identified early in the work-up, ignoring other elements); confirmation bias (selectively searching for evidence to confirm an initial impression); diagnostic momentum (failure to revisit diagnostic labels once they are attached to the patient); framing effect (organizing a case in a particular way to fit with the initial orientation of the clinician); premature closure (finalizing a diagnosis before having all the data); availability bias (the

TABLE 2 | Prognosis in the evaluation of mood and anxiety disturbances.

Stage 1. Sadness, anxiety or irritable mood are experienced occasionally, but they tend to be short-lived, related to specific situations and do not significantly affect everyday life. There is no history of previous psychiatric disorder and/or treatment. High likelihood of spontaneous remission, particularly with removal of allostatic load, if present.
Stage 2. Psychiatric symptoms that do not meet the diagnostic criteria for a mental disorder according to DSM-5, but are persistent and affect everyday life. No previous psychiatric disorder and treatment. Likelihood of spontaneous remission is low if the current situation and individual attitudes persist.
Stage 3. First episode of a single mental disorder according to DSM-5, with decreased level of functioning and impaired quality of life. No previous psychiatric disorder and treatment. Appropriate and adequate treatment is likely to yield full remission.
Stage 4. Recurrent and/or chronic occurrence of a mental disorder according to DSM-5, with decreased level of functioning and impaired quality of life. Unstable individual adjustment. A single course of treatment is unlikely to yield remission.
Stage 5. Recurrent and/or chronic occurrence of a mental disorder according to DSM-5, with decreased level of functioning and impaired quality of life and history of resistance or partial response to treatment. Allostatic load and/or dysthymia and/or suicidal risk may be present. Iatrogenic factors and/or counterproductive health attitudes may be involved. Remission appears to be complex and difficult.

tendency to over rely on recently encountered cases). In psychiatry, in particular, in the initial interview the patient may not disclose some important information and/or the clinician may limit the assessment to symptomatic areas with a checklist attitude [12]. Eliciting an insightful history of present illness [9, 45] and obtaining a reliable past psychiatric and medical history [9, 46] are basic requirements for adequate clinical judgment and are part of the art of interviewing in psychiatry [11]. Lack of clinical information due to inadequate interviewing may be a major source of errors in diagnostic, prognostic, and therapeutic formulations. Symptoms are not the whole disease [26].

4 | Formulating a Treatment Plan

Once a diagnostic assessment has been performed, guidelines purport the automatic application of a therapy listed among the options that have shown to be effective in randomized controlled trials (RCTs) and were supported by meta-analytic methods [47, 48]. However, results of RCTs may show comparative efficacy of treatments for the average randomized patient, but not for those whose characteristics such as severity of symptoms, comorbidity, and other clinical features depart from standard presentations [47, 48]. Further, guidelines are focused on single diseases, despite the frequent occurrence of multi-morbidity [1, 49]. Clinical judgment has thus an essential role for a number of decisions as the intermediate step from general research findings to their application to individual patients.

4.1 | Therapeutic Targets

Clinical reasoning, through macro-analysis or equivalent procedures, identifies the comorbidities that characterize the clinical picture and sets them according to priorities and the patient's preferences. Such comorbidities may be translated into treatment targets. In many cases that are encountered in clinical practice, it is wishful thinking to believe that one course of treatment aimed at a single component of the illness may "cure" the disease. Indeed, a treatment plan that includes the most important comorbidities in the individual case is warranted.

4.2 | Articulation of Treatment

Clinical judgment may set the modalities of the treatment plan (monotherapy vs. combined therapies, simultaneously or in sequential order). The sequential model is an intensive, two-stage approach, where one type of treatment (e.g., pharmacotherapy) is employed in the initial phase and is followed by another therapy (e.g., psychotherapy) to improve symptoms that the first treatment was unable to affect [50]. In psychiatry, there are four modalities of sequential integration of pharmacotherapy and psychotherapy: pharmacotherapy followed by psychotherapy; psychotherapy followed by pharmacotherapy; one drug treatment following the other; and one psychotherapeutic technique following another [50]. Psychotherapy following drug treatment was found to entail significant benefits in relapse rate in depression [51]. Clinical judgment may determine whether the approach of adding one therapeutic element at a time is necessary or therapeutic elements can be combined at the same time. There are advantages and disadvantages with each approach. Combining pharmacotherapy and psychotherapy simultaneously does not necessarily yield superior outcomes [52]. Reasons for administering two treatments in sequential order instead of simultaneously may include differential response to a particular treatment in different stages of the disease (e.g., acute/residual), occurrence of side effects, greater treatment adherence with monotherapy, and antagonistic effects of two concurrent treatments [50, 51].

4.3 | Treatment Selection

Clinical judgment ultimately allows the clinician to evaluate treatment options in a balance among potential benefits, likelihood of responsiveness, and vulnerabilities to adverse effects applied to the individual patient [48, 53]. The concept of vulnerability is not limited to side effects, but it is extended to iatrogenic factors [31, 32]. It makes full use of the potential of clinimetrics and of the clinician's individual experience [6]. For instance, in a case of anxious depression associated with iatrogenic comorbidity, the low likelihood of responsiveness and the potential vulnerabilities may prevail over the potential benefits.

4.4 | Level of Care

Clinical judgment, matched with the availability of the resources and the patient's preferences, suggests the level of care and the extent of personnel involved in treatment: outpatient treatment conducted by one or more clinicians; use of consultants for part of the therapy (e.g., medical treatment); hospitalization (either voluntary or involuntary) for acute emergencies (e.g., high suicidal risk); long-term inpatient stays (e.g., personality disorders); rehabilitation units (e.g., alcohol dependence); alternatives to hospitalization (e.g., use of communities).

TABLE 3 | Discovering the key features of a case of resistance/refractoriness by clinical judgment.

A. Failure of at least two adequate therapeutic trials. One of these trials should have involved psychotherapy (alone or in combination with drug treatment). The duration of each trial should range from 4 to 8 weeks for medications, from 20 to 52 weeks for psychotherapy. Drugs should have been used at appropriate dosages.
B. Therapeutic trials should have been appropriate in terms of evidence-based indications and should have addressed the clinical complexity of the case (e.g., extensive comorbidities).
C. Clinimetric assessment related to the patient (e.g., lifestyle, euthymia, health behavior), the therapy (e.g., clinician's attitude, iatrogenic factors), and the environment (e.g., allostatic load/overload, family and interpersonal relationships).
D. The patient has been provided with an adequate appraisal of the psychiatric situation, with opportunity for discussion, clarification and shared decision.

4.5 | Treatment Response

The customary clinical approach to evaluating response to treatment primarily relies on counting episodes that fulfill specific criteria [54]. For instance, a commonly accepted definition of treatment-resistant depression (TRD) consists of the failure to respond to two or more antidepressant medications despite adequate dose, duration of treatment, and adherence [54]. However, neglect of clinical judgment in evaluating treatment response disregards the treatment process [55]. How the patient experiences the treatment process, his/her interaction with the physician/therapist and significant others, and the patient's role in the treatment plan (self-management) are all essential therapeutic components. A broader evaluation of factors related to the patient, the treatment, the environment, and morbidity (Table 3) may shed light on individual responses and pave the way for targeted therapeutic efforts.

5 | Conclusions

Clinical judgment may be perceived as an intuitive art that is going to be replaced by growing technology and artificial intelligence. Even though patients look for good clinical judgment when they seek medical attention and clinicians rely on it, the topic is seldom mentioned and discussed in the literature. However, it remains the basic method of medicine and psychiatry. Clinical judgment is the result of observation, interpretation, and reasoning that takes place within the patient–doctor interaction. It is the intermediate step between the general indications that derive from clinical trials and specific clinical situations and settings.

In 1967 Feinstein [4] urged clinicians to develop a "basic science" of their own, to study the clinical phenomena directly, to specify the importance of different types of clinical data, to create appropriate systems of taxonomy for classifying the information, and to develop intellectual models and pragmatic methods that would articulate the clinical process and use the results for quantified analyses. The clinimetric perspective provides an intellectual home for the reproduction and standardization of clinical intuitions [5, 6]. It allows the clinician to make full use of the clinical information that is available [6]. The lack of a biopsychosocial perspective [56], as is often the case in current psychiatry, deprives the clinical process of a number of important variables and pathophysiological links. Framing patient's symptoms in a more meaningful context than that provided by diagnostic criteria of a single psychiatric disorder is in line with the major transformations in health care needs that have occurred in the past decades [57]. The implications of such an approach extend beyond individual treatment strategies, reaching the broader domains of public health and socioeconomic sustainability. Improving the features of clinical judgment by clinimetric strategies is likely to yield a highly effective precision psychiatry that is available today to any practicing clinician.

Author Contributions

G.A.F. and J.G. have equally contributed to the manuscript and have agreed on the final submitted version.

Conflicts of Interest

The authors declare no conflicts of interest, except book royalties (G.A.F.).

Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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