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Guest Editorial

Symptom-oriented clinical psychiatry

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Summary

This Guest Editorial argues that symptoms, rather than syndromic diagnoses alone, function as the practical units of psychiatric care. To render implicit symptom-oriented reasoning explicit, symptom-oriented clinical psychiatry offers a structured framework for analysing symptom roles, guiding treatment priorities and sequence and reducing reactive polypharmacy while remaining fully compatible with established diagnostic systems.

Keywords

Symptom-oriented psychiatry; clinical decision-making; subjective experience; unit of clinical attention; phenomenology.

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Patients seek psychiatric care because they suffer from specific experiences: insomnia, panic, intrusive thoughts or overwhelming sadness. Clinical psychiatry treats these experiences, not syndromes, yet the conceptual frameworks structuring the field remain largely syndromic. Diagnostic systems such as DSM and ICD provide an indispensable language for research and communication, but their limitations in guiding individualised treatment are increasingly evident. Diagnostic heterogeneity, rising polypharmacy and the demand for personalised care[1–3] reveal a widening gap between how psychiatric illness is classified and how it is treated in everyday practice. In reality, syndromic classifications serve important purposes but psychiatric care itself is inevitably symptom-oriented.

The hidden symptom-oriented pattern of practice

In daily clinical practice, treatment decisions are rarely guided only by diagnosis. Clinicians respond to the symptoms that most shape the patient's condition: those that define the diagnosis, those that cause significant suffering and dysfunction or those that appear to drive other aspects of the presentation. Medications are adjusted according to symptom response, additional treatments are introduced to address residual symptoms, and interventions are withdrawn if they do not improve particular complaints. In effect, symptom-oriented reasoning has long been widespread in clinical practice, even if our formal frameworks remain syndromic.[4]

In everyday clinical work, while establishing a diagnosis, clinicians examine symptoms in detail. They ask whether sadness is constant or episodic, whether sleep disturbance involves difficulty falling asleep or early awakening and whether anxiety arises spontaneously or is triggered by intrusive memories. These questions reflect an intuitive understanding that symptoms are the most practical units through which mental illness is experienced and recognised. Treatment selection often follows the same logic: a sedating antidepressant may be chosen for depression with prominent insomnia, an activating medication for anergia or a serotonergic agent for anxiety. Such decisions are routinely framed within diagnostic categories, yet they are guided primarily by symptom profiles.

This implicit symptom-oriented reasoning is deeply embedded in clinical culture. It develops through accumulated clinical experience and is transmitted through supervision and case discussion. Experienced clinicians learn that certain symptoms give rise to or sustain others, that some symptoms are strategically more important than others and that the most distressing complaint is not always the most effective initial treatment target. Over time, clinicians develop heuristics for matching symptom patterns to therapeutic strategies.

Elements of symptom-oriented thinking also appear implicitly in the psychiatric literature: diagnostic criteria in DSM and ICD emphasise core symptoms whereas textbooks and clinical guidelines often describe treatments directed at particular symptoms.[5] Nonetheless, these ideas are rarely articulated as a coherent framework, with recommendations instead organised primarily around syndromic categories. As a result, symptom-oriented reasoning is seldom conveyed through explicit and systematic instruction. The absence of such a framework can lead to inconsistent training, uncertainty in treatment prioritisation and reactive prescribing patterns, including unnecessary polypharmacy when multiple symptoms are addressed sequentially without an organising framework.[2,4]

Making this implicit reasoning explicit may therefore help refine clinical decision-making. Symptom-oriented clinical psychiatry (SOCP) proposes a framework that recognises symptoms as the practical units of clinical reasoning while remaining compatible with syndromic diagnosis. It offers a structured approach to the analysis of relationships among symptoms, clarifying their roles within a clinical presentation, prioritising treatment targets and guiding therapeutic planning and monitoring.

Symptom roles in clinical reasoning

If symptoms are the practical units through which psychiatric illness is experienced and treated, an important question follows: do all symptoms carry the same clinical significance? In routine practice, clinicians intuitively recognise that they do not. SOCP examines relationships among symptoms by analysing their dynamics (temporal and causal patterns), configuration (structural organisation) and hierarchy (relative priority within the symptom system). This analysis helps clarify the provisional and heuristic roles of primary, core and prominent symptoms within a clinical presentation, thereby structuring clinical reasoning and guiding more strategic treatment planning.

Primary symptoms are those that appear, within the patient's meaning-world, to generate, maintain or organise other aspects of the symptom presentation. They function as drivers within the symptom system. For example, a fixed persecutory belief may generate and sustain anxiety, social withdrawal and defensive behaviour whereas rumination may precipitate depressed mood, anxiety and insomnia. When such relationships are identified, targeting the primary symptom may produce downstream improvement across multiple associated symptoms.

Core symptoms are those required for diagnosis within established syndromic systems such as DSM or ICD. They define

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Table 1 Roles of symptoms in clinical reasoning and treatment planning

Symptom role	Definition	Strategic value	Example
Primary	Generates, maintains or organises other symptoms at the phenomenological level of the patient's experience	Most strategic starting point for intervention	Fixed persecutory belief driving social withdrawal, insomnia and anger
Core	Required for formal syndromic diagnosis, and often carries biological and prognostic significance	Guides initial evidence-based treatment selection	Anhedonia or depressed mood in major depressive disorder
Prominent	Causes great subjective distress/functional impairment, often requiring urgent clinical attention	May require urgent targeted relief	Panic attacks or overwhelming agitation leading to emergency room visit

Any symptom may assume one or more of these roles simultaneously, and the same symptom may assume different roles across individuals.

diagnostic categories and often carry biological and prognostic significance. Anhedonia or depressed mood, for example, are defining features of major depressive disorder and guide initial treatment selection according to evidence derived from diagnostic categories. Core symptoms largely determine the clinical significance and treatment direction of a diagnosis, even though additional symptoms may shape the patient's broader lived experience.[5]

Prominent symptoms, by contrast, are those that cause significant subjective distress or functional impairment. These are often the symptoms that motivate patients to seek care: the agitation that disrupts daily functioning, the panic that confines someone to their home or the voices that overwhelm perception. Prominent symptoms frequently require targeted interventions whether or not a formal diagnosis has been established.

Importantly, any symptom may assume one or more of these roles yet these roles do not always align. A primary symptom may simultaneously be core and prominent – or neither – and similar divergences occur between core and prominent symptoms. A core diagnostic symptom may not function as the primary driver within the patient's subjective meaning-world, even though it may occupy an influential position within the broader biological or clinical expression of the disorder. Likewise, the most prominent symptom is not always the most strategic treatment target. In some cases, neither primary nor core symptoms are prominent in the patient's presenting complaints. Because symptom dynamics and configuration vary across individuals, the roles that symptoms assume can differ from patient to patient. For example, rumination may appear both primary and prominent in one depressed patient, mild in another and absent in a third. Likewise, nightmares may be highly prominent for one patient with post-traumatic stress disorder yet minimally troubling for another (see Table 1).

Clinical implications for treatment planning

Understanding the functional roles of symptoms provides a guide for clinical reasoning and treatment planning. Treatment targets should be selected not only on the basis of diagnosis or subjective distress, but also according to the roles played by symptoms within the broader symptom system. Often, identifying a primary symptom offers the most strategic starting point for intervention. Improvement of primary symptoms may produce cascading benefits across multiple domains. For example, addressing persistent derogatory voices may alleviate associated depressed mood, self-blame, anger and sleep disturbance. Recognising such relationships encourages clinicians to focus first on symptoms that exert broader influence rather than addressing each complaint separately.

When primary symptoms cannot be clearly identified, core symptoms often guide initial treatment decisions. For example, treatment of depressed mood – a core symptom of major depressive disorder – is the standard initial approach and may improve psychomotor retardation, poor appetite and excessive guilt, reflecting evidence-informed practice within existing clinical frameworks.

Prominent symptoms, such as disabling insomnia, panic attacks or agitation, often require direct intervention, not because they are diagnostically central or causally primary but because they dominate the patient's lived experience and impair their capacity to engage in treatment. Effectively relieving these symptoms early can build trust and create conditions for subsequent clinical engagement.

This perspective also helps structure medication adjustments and augmentation strategies. Rather than sequentially adding treatments for residual symptoms without a clear framework, clinicians can evaluate which symptom roles remain insufficiently addressed. When adjustments or augmentation are required, these should be guided by analysis of symptom roles. Interventions are introduced to address clearly defined symptoms through plausible mechanisms of action, rather than to non-specifically augment treatment for a loosely defined diagnosis. For example, augmentation may target persistent rumination or intrusive thoughts when these sustain broader mood or anxiety symptoms.

The following real-world clinical vignette illustrates this approach.

A 49-year-old man presented with major depressive disorder characterised by prominent symptoms including depressed mood, anxiety and insomnia, and he had failed multiple medication trials over 2 years. An in-depth interview with symptom analysis identified persistent rumination about a work-related situation as the primary symptom driving the presentation. Although not itself a prominent symptom, the rumination appeared to generate and sustain the remaining symptoms, with depressed mood serving as the core diagnostic symptom. Prioritising rumination through low-dose, off-label risperidone augmentation produced rapid and broad clinical improvement and led to reduction of other medications.

Such an approach encourages greater parsimony in prescribing, by prioritising and sequencing interventions based on symptom analysis. Medications are introduced only when clinically necessary, targeted towards specific symptoms according to their proposed roles and discontinued when they fail to produce meaningful benefit at the symptom level. By explicitly linking treatment decisions to well-defined symptom targets, clinicians can more readily reconsider or withdraw ineffective medications. This approach may help avoid the reactive accumulation of treatments directed towards broad, heterogeneous and biologically limited diagnostic constructs, a pattern that may contribute to non-evidence-based polypharmacy.[2,4]

Scope, limits and relationship to diagnosis

This hybrid approach is not intended as a replacement for established diagnostic systems such as DSM and ICD. Syndromic classifications continue to support the study, communication and

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treatment of mental illness. Decades of observation have identified typical patterns of symptom co-occurrence, longitudinal trajectories and general treatment responses. These insights support finer-grained, symptom-level subtyping, an area for further research. For example, depressed mood has unipolar and bipolar variants; anhedonia differs in schizophrenic and depressive presentations; and specific fears may include subtypes centred on heights, animals or sharp objects.

Importantly, SOCP does not add extra clinical work. Rather, it increases the awareness of implicit symptom-oriented logic by redirecting clinical attention from diagnoses to the finer level of symptoms. SOCP supports closer observation of patients' subjective experiences, more person-centred care, greater constructive patient–clinician engagement and more precise and personalised treatment selection.[3] In emphasising symptoms, SOCP echoes earlier traditions in psychopathological phenomenology that paid close attention to subjective experience at the centre of clinical reasoning.[6] In this sense, SOCP is not a departure from psychiatric tradition but a recovery of its most valuable clinical discipline.

Crucially, symptom-oriented reasoning does not assume that symptoms exist in isolation from a patient's developmental history, social context or broader psychopathological structure. Nor does it imply that clear symptom hierarchies can always be confidently established: many clinical presentations remain complex and partially indeterminate. The aim is to encourage systematic reflection on symptom dynamics and configuration when meaningful relationships can be discerned. By anchoring clinical attention closer to the experiential units of illness, clinicians can clarify treatment priorities and navigate complexities with greater granularity and finer resolution.

The challenges confronting modern psychiatry make the limits of purely syndromic thinking impossible to overlook. Diagnosis remains essential, but it cannot by itself adequately guide personalised treatment planning. For decades, nuanced symptom-level reasoning has been ubiquitous yet it has never been articulated as a systematic framework for clinical decision-making. Recognition of symptoms as the practical units of clinical attention is therefore not merely an academic exercise but a clinical necessity.

As the field faces rising rates of non-evidence-based polypharmacy and persistent diagnostic heterogeneity, the symptom-oriented framework proposed here warrants serious consideration across psychiatric education, clinical practice and research. Future work should include outcome-based research designed to evaluate the validity, utility, reproducibility and limitations of symptom-oriented approaches.

Making our implicit clinical reasoning explicit may represent an important step in the evolution of psychiatric methodology. By distinguishing among symptoms that define a disorder, drive a clinical presentation and generate the most acute distress, clinicians can move from reactive, additive prescribing towards more strategic and parsimonious intervention. In this respect, SOCP shares a conceptual logic with emerging transdiagnostic and dimensional frameworks such as Research Domain Criteria, Hierarchical Taxonomy of Psychopathology and network theory,[7–9] within broader contemporary discussions surrounding categorical versus dimensional classification, hierarchical models and symptom-focused approaches, while remaining firmly grounded in everyday clinical practice. The promise of precision psychiatry lies not only in advances in genetics or neuroimaging but also in greater clarity of symptom-level reasoning at the bedside, where subjective experience is met with individual and humane attention.

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References

1 Allsopp K, Read J, Corcoran R, Kinderman P. Heterogeneity in psychiatric diagnostic classification. *Psychiatry Res* 2019; **279**: 15–22.

2 Correll CU, Gallego JA. Antipsychotic polypharmacy: a comprehensive evaluation of relevant correlates of a long-standing clinical practice. *Psychiatr Clin N Am* 2012; **35**: 661–81.

3 Comai S, Manchia M, Bosia M, Miola A, Poletti S, Benedetti F, et al. Moving toward precision and personalized treatment strategies in psychiatry. *Int J Neuropsychopharmacol* 2025; **28**: pyaf025.

4 Waszczuk MA, Zimmerman M, Ruggero C, Li K, MacNamara A, Weinberg A, et al. What do clinicians treat: diagnoses or symptoms? The incremental validity of a symptom-based, dimensional characterization of emotional disorders in predicting medication prescription patterns. *Compr Psychiatry* 2017; **79**: 80–8.

5 APA. *American Psychiatric Association Publishing Textbook of Psychiatry* 7th ed. APA, 2019 (https://www.appi.org/American_Psychiatric_Association_Publishing_Textbook_of_Psychiatry_Seventh_Edition [cited 18 Mar 2026]).

6 Jaspers K. The phenomenological approach in psychopathology. *Br J Psychiatry* 1968; **114**: 1313–23.

7 Insel T, Cuthbert B, Garvey M, Heinssen R, Pine DS, Quinn K, et al. Research domain criteria (RDOC): toward a new classification framework for research on mental disorders. *Am J Psychiatry* 2010; **167**: 748–51.

8 Kotov R, Krueger RF, Watson D, Achenbach TM, Althoff RR, Bagby RM, et al. The Hierarchical Taxonomy of Psychopathology (HiTOP): a dimensional alternative to traditional nosologies. *J Abnorm Psychol* 2017; **126**: 454–77.

9 Borsboom D. A network theory of mental disorders. *World Psychiatry* 2017; **16**: 5–13.

https://doi.org/10.1192/bjp.2026.10711 Published online by Cambridge University Press