The psychiatric consultation reconsidered

David Hartman and Leon Rozewicz

We have subjected the current structure of the psychiatric consultation to critical examination, and we propose that the concepts of 'history', 'mental state' and 'formulation' should be abandoned. In their place we propose the more carefully defined concepts of 'narrative', 'interaction', 'examination' and 'inferences'. The clinician should make a clear distinction between information that is reported, observed or inferred, as these sources of knowledge are qualitatively different, and subject to psychodynamic, systemic and cultural influences. We propose that this approach would facilitate a clearer and more comprehensive understanding of the patient, and lead to a more creative therapeutic relationship.

As undergraduates and later as psychiatric trainees, we are trained in the consistent use of a standard clinical method. When presenting the 'case' we are trained to describe the patient's 'history', describe their 'mental state', and then to postulate a diagnosis, substantiating this with the information that we have obtained (Maguire, 1993). 'History' is supposedly factual information obtained from the patient or from informants. This includes the presenting complaint, the family history, medical and psychiatric history, an account of the patient's childhood and development, and the premorbid personality. On the other hand 'mental state' is supposedly an objective description of the observed clinical material. This consists of a description of the patient's appearance, behaviour and speech, an account of mood, affect, abnormal experiences, and a simple neuropsychiatric examination.

As teachers of psychiatry we were concerned that we were mechanically reproducing this approach in our teaching, but as practising clinicians we had evolved our own approach that was substantially different. Our widely divergent areas of interest, psychotherapy and neuropsychiatry respectively, have brought us to this question for different reasons. One of us (DH) wished to understand patients' problems as existing within relationships and social networks, rather than merely in an abstracted individual, while the other (LR) saw a need for logic and conceptual clarity in the way that patients are described. In this paper we attempt to bring these concerns together by describing an alternative approach which is more in keeping with some developments in psychiatric thought. We examine the factual status of the information derived from the clinical interview, considering what is historical narrative derived from the patient or the family, what is observed 'fact', what occurs within the unique interaction between the psychiatrist and patient, and what has been inferred from these channels of communication. We distinguish between four levels of 'fact': 'narrative', 'interaction', 'examination', and finally 'inference'. These levels bear a resemblance to the familiar history, mental state and formulation, but the conceptual basis is quite distinct.

The narrative

We have borrowed this term from a current development in the family therapy domain, known as narrative therapy (White & Epston, 1990; Hoffman, 1993). It is recognised that the interaction between the professional and the patient centres around the telling of a 'story', in which the information elicited has much in common with creative literature and autobiography: it is subject to revisions, editing and embellishments according to the state of mind of the patient and the nature of the relationship with the professional. This information relates to the development of the presenting symptom or problem, the patient's circumstances and relationships, and the patient's personal background and development. It is derived from the patient and from family or other informants: there may be both overt and covert information from both the patient and the family, and these may or may not agree. We should recognise that this narrative is only 'factual' to the extent that it reflects the opinions and memories of the patient or the family, which are influenced by a range of psychodynamic and systemic factors. These may include family myths and secrets, or the repression or denial of painful memories. Furthermore, sociological considerations such as the race, social class and gender of the patient and doctor influence the degree of trust in the consultation and therefore what the patient/family *choose* to

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convey to the psychiatrist. The narrative is therefore clearly not fact in the empiricist sense, nor is it likely to be stable over time.

The focus of the narrative will often be abnormal mental states including mood changes, experiences such as hallucinations, delusions, obsessions/compulsions, dissociative states, and religious or paranormal experiences. These experiences may be encapsulated in the term 'sense of self'. We would likewise include a longitudinal account of disturbed appetite, body image, sleep disturbance, sexual and health concerns under the heading of 'sense of body'. It is useful to relate these internal states to events in the patient's external reality, and use a life chart to this end (Sharpe, 1990). We should specifically record the patients' own perception of their ethnic identity, religious orientation and social class, together with the explanatory model employed by the patient or the family, which is likely to be culturally determined. Our understanding of these explanatory models will have considerable influence on whether we can engage them in a mutually understood therapeutic process (Kleinman, 1978; Al-Issa, 1995). When the explanatory model of the patient differs from that of the psychiatrist, the implications for the therapeutic relationship should be noted and adherence to the proposed management plan should be discussed. DSM–IV (American Psychiatric Association, 1994) requires a formulation of 'psychosocial and environmental problems', and we would elaborate this into a description of the 'social state' as suggested by Campbell & Szmukler (1993).

We recognise that information flows in both directions during the consultation process. While the psychiatrist is gathering information about the patient, the patient is gathering information about the psychiatrist's hypotheses and values, and adjusting her history accordingly. All history taking is therefore potentially a collaborative therapeutic process as the patient and clinician co-construct the story of the patient's illness (White & Epston, 1990; Hoffman, 1993).

The interaction

The unreliability of psychiatric examination in clinical practice has long been recognised, particularly with regard to current symptomatology. Kreitman (1961) found that only pervasive mood states such as depression were reliably elicited, whereas thought disorder and phenomena such as delusions and depersonalisation were subject to profound interrater disagreements. We would abandon the term 'mental state examination' which has spurious connotations with physical examination and positivist science, and deceptively suggests that we can in fact examine the patient's subjective experience. We prefer the terms 'interaction' to refer to what takes place in the context of the consultation, and 'examination' to refer to those phenomena, both physical and psychological, which can be measured.

The 'interaction' includes the patient's appearance, movement, speech and attitude as is customary in the mental state examination. We would describe the observed mood during the interview, but only describe experiences such as delusions or hallucinations if we can observe evidence of their presence during the assessment. Conversely, we would record past experiences, even earlier in the day, as part of the narrative. Formal thought disorder is an inference rather than an observation, and we would restrict ourselves to a description or verbatim sample of communication, rather than using a term that may presuppose a diagnosis. Similarly, we may record expressions or communications of mood as part of the interaction, but descriptions of sustained mood states should form part of the narrative, where they would be related to life experiences, treatment or changes in the environment.

It is important to record the subjective position of the psychiatrist within the interview. We would note the nature and quality of the interaction within the consultation, one's emotional reaction to the patient, and what one brings to this interaction from one's own personal and social background (Crisp, 1990). We should recognise that 'insight' forms part of this interaction, and is inferred by the clinician by comparing the biomedical model to the explanatory model employed by the patient, her family and culture (Perkins & Moodley, 1993). 'Insight' is therefore not observed within the assessment process. The explanation employed by the patient clearly forms part of the 'story' told by the patient or her family and we would record this within the framework of the 'narrative'.

The examination

This is the part of the consultation from which we obtain strictly factual information, independent of the narrative and interaction (Skerritt, 1991). In gathering this information we should make a point of collecting data in a form that is reliable and reproducible, for example through the appropriate use of simple psychometric instruments. This might include the measurement of symptoms such as depression, anxiety, obsessive–compulsive symptoms or eating attitudes using the well-known questionnaires in each case. Such measurement at an initial consultation provides an invaluable baseline to gauge

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subsequent treatment effects. A standardised neuro-psychiatric assessment should be carried out, for example the Mini Mental State Examination (Folstein *et al*, 1975), extended in appropriate patients with the use of more specialised instruments. We would, however, abandon the term 'cognitive' in this context as this leads to confusion with the use of the word in cognitive psychology and cognitive therapy. 'Neuropsychiatric' seems more precise, and emphasises the continuity with the appropriate neurological and physical examination.

Inferences

The primary purpose of the psychiatric assessment is to make a diagnosis (see for example Maguire, 1993). We would endorse this conventional view, but we believe that diagnosis often receives undue emphasis in British psychiatry, at the expense of a consideration of other dimensions of the patient's life and experience. We need to be able to structure our inferences in such a way that a broad and practical understanding of the patient emerges from the structure, and multiaxial systems are readily available for this purpose (Mezzich, 1988; American Psychiatric Association, 1994). We would make a plea for their more widespread use in routine clinical practice, as they encourage the clinician to consider not only diagnosis but also constitution, development, environment and adaptive functioning.

But beyond the standard five axes, we need a way of describing presumptive intrapsychic processes. DSM–IV proposes a defensive functioning scale for further study: it is recognised that defence mechanisms are adaptive traits present in all individuals, and these often have a major effect on the presentation and course of illness, as well as on the therapeutic relationship. Vaillant (1986) describes a validated and clinically useful hierarchy of defence and mature coping mechanisms, and we would infer habitual defensive functioning in all cases. One might complement this with a statement about the presumptive attachment style, i.e. secure, dismissive or preoccupied (Kobak & Sceery, 1988). Based on the narrative and on the interaction within the consultation, these would be more useful concepts than that of 'premorbid prsonality'.

Conclusion

Merely because a certain clinical approach is in universal use does not exclude it from evolution and modification. Psychiatry has changed over recent decades with a recognition of the importance of transcultural and family issues in common clinical problems, and diagnostic systems, most notably the DSM system, have evolved beyond a simplistic emphasis on diagnosis. There has also been increasingly frank recognition of the subjective element in the clinical relationship, not merely within psychotherapy but in all clinical contexts. When we reappraise our standard clinical method it appears to be structured in a way that may be more suitable for the assessment of bodily complaints than it is for complex biological/psychic/social systems. We therefore propose that the method of the psychiatric consultation may be re-structured in the following way.

The psychiatrist and the patient (with or without her family) co-construct a 'narrative' of the patient's problems in the context of the overall life story. The objective is to develop a story that makes sense to both the psychiatrist and the patient/family. One can distinguish three threads in this narrative: (a) sense of body, or constitutional factors; (b) sense of self, or psychological factors; and (c) social state, or environmental factors. Relevant physical and psychological data are then collected in a systematic 'examination'. During this consultation process the psychiatrist observes the 'interaction' between himself and the patient, noting communication style, rapport, sociocultural influences and degree of convergence of their explanatory models. Afterwards the psychiatrist formulates 'inferences' based upon a multiaxial system. This includes (a) diagnostic category; (b) personality and development factors (including defensive and/or attachment style); (c) physical and constitutional factors; (d) environmental factors (both past and present); and (e) current level of adaptive functioning.

This approach to the consultation, allowing us to obtain accurate and clinically useful information while engaging the patient in an interactive therapeutic alliance, is a reflection of our own clinical practice and probably that of many others. Rather than leaving trainees to learn these lessons from experience, it should be actively taught and cultivated at undergraduate and pre-membership levels.

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