Lost in the DSM-IV Checklist

Empathy, Meaning, and the Doctor–Patient Relationship

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In the mid-1980s, I was presenting a workshop at the meeting of the AADPRT that focused on the integration of psychotherapeutic and psychopharmacologic treatment. As an illustration of this education issue, I presented a young woman patient who had problems with both severe manic-depressive illness and borderline personality disorder. After I presented a videotaped treatment hour, a training director in the audience said, “I don’t know why you showed this videotape. This woman has manic-depressive illness and needs medication, and that’s that.”

Too many clinicians, and even apparently at that time some residency directors, believed that good psychopharmacology practice required only knowledge of dosages, side effects, pharmacokinetics, and indications for the medication. To me, though, the essence of good psychopharmacologic management is how I respond when a patient comes into my office and says, “Dr. Tasman, I’m not going to take that medication you prescribed.” Dealing with issues of resistance and treatment compliance, even in a busy medication clinic, an emergency room, or an inpatient unit, requires psychotherapeutic skill and knowledge—an ability to understand the origins and meaning of the patient’s hesitancy and to use the therapeutic relationship with the patient as the force to maintain a treatment alliance and work through the sources of the resistance. This is especially important when we often hear reports that in the United States 50% of all prescriptions are either not filled or not taken correctly.

Fast forward to the present day. At a recent American Board of Psychiatry and Neurology examination, a young psychiatrist did a very interesting interview with a patient. It focused primarily on review of DSM-IV symptoms for the possible disorders that he was concerned about. It was just about as thorough a review as one could wish for, if one wanted to see if the patient met the DSM-IV criteria for various disorders. There was, of course, little time spent focusing on precipitants for the patient’s illness or any antecedent developmental or familial influences.

During the discussion, the psychiatrist made an excellent presentation of symptom clusters and differential diagnosis. But when it came to treatment, the discussion took a turn for the worse. The patient had significant mood problems, but the primary issue seemed to be a borderline personality disorder. When we asked what the psychiatrist would do if the patient were his, we got a very nice review of options for management of medications in borderline patients who have mood disorders.

There was no mention of psychotherapeutic or psychosocial issues. When I asked specifically why this was omitted, the candidate replied with complete seriousness that those aspects of the patient’s problems were the job for a social worker, and the psychiatrist would intend to refer the patient to a social worker for management of those aspects of illness. I asked what the goals of such treatment would be, and the candidate gave a reasonably appropriate answer. I said, “What would happen if you were in a very rural area, and there were no social workers to be found within hundreds of miles? What would you do then?” The candidate, with only the barest smile, said, “I’d try really hard to find a social worker.”

This is an all too common experience. Clearly, a fair number of purportedly well trained psychiatrists either don’t understand or don’t see as part of their job dealing with anything more than prescribing...
medications. Since compliance is one of the biggest problems we face in psychiatry, how can we deal with these problems if we don’t feel comfortable in either understanding or intervening to address psychological aspects of resistance to treatment?

The DSM-IV (1) represents tremendous advances in our approach to clinical diagnosis, but also illustrates the dilemmas about which I am concerned. We have had tremendous gains in our ability to structure a meaningful classification of illnesses, but the DSM-IV is still a symptom cluster approach, and we are still a long way from an etiologically based categorization of illness. It is true that the DSM-IV is a five-axis approach, and issues of precipitating stress and general level of function are included. But in only a few places in the DSM-IV is provision made for understanding the role of psychological conflict or developmental distress in the evolution of the symptoms we see. Moreover, in few places is the capacity for symptoms to have symbolic meaning taken into account. This causes a great problem. Because while we are doing a good job of training our residents to conduct thorough diagnostic exams based on DSM-IV symptom checklists, we are not doing a very good job with these other aspects of understanding. Nor are we training residents in an in-depth approach to DSM-IV diagnosis, as envisioned by its developers.

And what is the impact of the DSM-IV and other changes in residency education? We are in danger of training a generation of psychiatrists who lack even the most basic psychotherapeutic skills or a framework for understanding mental functioning from a psychological perspective. I am not talking about training sophisticated psychotherapists or psychoanalysts here; I am talking about training people who have the same expertise in understanding and managing the therapeutic relationship as they do in managing medications. And there is certainly very little curriculum time these days devoted to helping residents maximize their empathic skills.

Some might say that this is not too important, that with our increasing understanding of brain structure and function, future psychiatric practice relies primarily on somatic, not psychotherapeutic, interventions.

To respond to this concern, I will give a clinical illustration.

As in many residency programs, our department’s outpatient program is designed on a preceptorship model. I saw a woman who had been followed by a nurse clinician and a resident in our clinic for several months but was not improving. Such interactions with the supervisor are scheduled for 15-minute blocks of time, so that everything I am about to describe transpired in that time frame. I was told that this woman in her mid-forties was suffering from a delusional disorder, DSM-IV 297.1. The woman had been placed on an antipsychotic medication, which had been gradually increased over the last several months without any positive effect on the patient’s condition or symptoms.

I interviewed the patient with the nurse and resident for about ten minutes. I was immediately struck by this woman’s ability to relate to me in a human way in our interview, surprising in a woman diagnosed with a psychotic disorder. I tried to find out precipitating causes for her symptoms and asked about changes in her family, her work, or some other aspect of her personal life. She said there had been no changes. For a reason that I still cannot completely understand, there was something that I reacted to empathically in this woman, and a question popped into my mind. Although this is not a common question for me, I asked if there had been any changes in her neighborhood.

Her response made this case stick in my memory. She asked if I remembered a newspaper article about a young nine-year-old girl who had been killed in a drive-by shooting several months before. I said that I had. She said that the girl who had been killed was her next-door neighbor. I replied that that must have been incredibly upsetting. She said yes, it was even more upsetting because, when the girl was killed, she was on the patient’s front porch playing with the patient’s children.

Everything began to fall into place, and I knew this wasn’t just a delusional disorder. I said to her that it must have been incredibly upsetting not only to lose this child in such an upsetting way, but to be fearful that could have happened to her own children or to her, and that it might happen in the future at any time. The patient immediately began to cry. I asked if she had ever mentioned this to anyone, and she said that she had not because she didn’t think it had anything to do with how she was feeling. I asked if the medications had helped her at all. She said no, that they had only made her feel groggy and washed out, and were interfering with her ability to take care