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特別講演

Bearing Values on Clinical Decisions

Ho Young Lee (Dasarang Center Hospital)

Psychiatry is more value-laden than any other field of medicine because it is concerned of human experience and behavior. It is natural that psychiatry should recognize the role of values, alongside facts, in all areas of clinical practice-diagnosis, treatment and rehabilitation. There is a considerable concern on the development and the current form of evidence-based psychiatry whether this being sufficient in decision making in complex environment of mental health services of today. Psychiatric diagnosis derived from observed symptoms silence the interpersonal dialogues. The clinical encounter is narrowly focused on the forms instead of contents, meanings and background of human mental distress. We need a complementary value model, value-based approach, which runs parallel to evidence-based psychiatry. Value-based approach, like evidence-based, is a resource for effective decision-making in psychiatric practice. It starts from equal respect for all values, individual patients, their families and communities, and the recognition of the fact that various value terms already exist in DSM or ICD diagnostic systems. To respect values, psychiatry must step down to be equal with service users. Current development of mental health services are based on the principles of patient centered decision-making and multidisciplinary teamwork. This should provide basis for value-based as well as fact-based psychiatric practice.

＜**Key words**: value-based practice, classification, patient-centered＞

Symptom-centered approach and DSM-ICD

We are all trained psychiatrists and naturally medical thinking comes to the fore when we see patients with mental health problems. We try to establish a diagnosis first because it is a primary task of our practice. During the course of diagnosis, since we are so imbued to look for symptoms, we may selectively pick those information considered relevant and useful to identify symptoms. This professional sieve that only pass symptom-related information may have become our disposition, for establishing an accurate diagnosis is the first duty of a medical doctor.

This diagnosis-first trend became more solidified after the publication of DSM and ICD manuals. It has become an obsession that we must identify symptoms fit to the criterions of

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the manuals to make an 'authentic' diagnosis. Accuracy and authenticity that go with the manuals are the essence of 'scientific' psychiatry and to following this line is the royal road to the standard psychiatric practice. Thus, DSM and ICD became the bible of psychiatry, chartered and blessed by two utmost authorities of world medicine and psychiatry-World Health Organization and American Psychiatric Association.

After the decades of experience with DSM and ICD, in a way, mental disorders have become limited treatable mental symptoms. As the diagnosis-centered psychiatric practice prevailed, the mental patient is reduced to the 'walking embodiment of a psychiatric diagnosis'. The symptom-oriented psychiatric practice based on the medical model reduced human to a diagnostic category and the range of human experience to the symptoms of illnesses.

Psychiatric practice simplified

Once diagnosis is made then the next step is to treat the symptoms on which the diagnosis is based. Of course, the first is treatment with drugs. The initial pharmacotherapy is a routine practice today. And the decision to select the drug of choice is easy because drug algorithms designed by experts are readily available. It covers all the contingencies along the courses of drug therapies for most of the diagnosed mental disorders. After initiating a drug therapy, all you have to do is to wait and see the result, how the given drug brings changes to the treated symptoms. In essence, the process of psychiatric diagnosis and treatment is now formularized; the rise of a new 'psychiatric technology.' And the psychiatric practice became simplified.

There are other important cultural factors contributed to the simplification of psychiatric practice. Changed concept of time of people is one thing. Nowadays, people are impatient of waiting, expecting to see the outcomes quickly at doing or receiving ends of services. There is not enough time for people to visit doctors offices often, and to spend lengthy time waiting, explaining and listening to the details of their illnesses at sessions. They like quick services as they like to eat fast food. For psychiatrists, this has changed the pattern of practice; increased the number of patient's visits counting more than lengthy services which attributed to better quality. Ex-student of mine, a staff of a university medical center confided with me that he sees about 50 out-patients a day, including new patients. Psychiatric practice is simplified in Korea.

Psychiatry is a discipline of depth. Traditionally, psychiatry always stressed the significance of personal experience and the empathic listening to patients' stories. The promotion of personal growth and development is the core spirit of all the psychiatric interventions. Many of us, as medical students, were attracted to this humanistic element of psychiatry which led us to choose this field as career. Have those humanistic element abide with this tradition not been curtailed because of the over-emphasis of symptom-oriented approach and the dominance of scientific side of discipline?

Of course, this is not to discount the contribution and the importance of scientific knowledge and the development of other technologies contributed to mental health services. Neither to call a return to the past model practice stressing only the value of humanistic side. The point is that the future progress of psychiatry is not to be made by science alone. For a better

psychiatric practice of tomorrow, more balanced priorities of references to be set including both value-side and humanistic-side issues in all areas of psychiatric practice.

Diagnosis and the implications

Human mind is complex, and so are the mental symptoms because they are the products of this mind. In the last few decades, in order to improve studies of human mind, psychiatry has established a professional model the means through which complex human experiences and maladies are structured. Psychiatry invested considerable efforts in attempts to establish a diagnostic system that are 'valid' and 'reliable'. The DSM and ICD are products of this purpose, and with many revisions and additions, the manuals are voluminous today with valuable changes and additions. We now heavily depend on this tool to establish authentic psychiatric diagnoses which has become a fundamental part of psychiatric practice. DSM and ICD are the compasses of our professional voyage.

Psychiatric diagnosis, however, has brought on concerns for the implications and influences particularly of power and control. Let's examine what control and power a psychiatric diagnosis may yield.

First of all, insurance companies will not pay for your service unless there is a diagnosis. This is why psychiatrists try to establish a quick, clear and authentic diagnosis. In some occasions, you may not be certain of diagnosis just after an initial interview. For warranted the third party payment, however, you may tend to make an ultimate diagnosis in consensus with DSM or ICD at the very beginning and initiate treatment accordingly. Diagnosis conscious approach may influence the pace and the order of your practice.

Diagnosis also bears power of control and coercion. We are confronted with situations when the patient appears dangerous to either himself or others due to his disturbed psychotic state. And the patient refuses any help while he or she remains in a state of extreme agitation. The diagnosis of an acute psychotic disorder is inevitable which legally permits the use of coercive methods to hospitalize the patient against his will. Psychiatric diagnosis, furthermore, may shape the reality of a person through discourses. For example, if the patient's paranoid delusion is acute and his competence on reality testing may be open for doubt. Only a psychiatric diagnosis can clear the air arbitrating that the reality testing is impaired. Important human right can be overruled with a psychiatric diagnosis, and a coerced treatment may be justified with the diagnosis.

The point is that a psychiatric diagnosis is not solely a medical decision identifying a mental disorder, it embraces complicated human issues of vital importance; legal, social and ethical.

Diagnosis does not represent the essential truth of the patient

The next issue is the downgrade of humanistic values in symptom-centered psychiatric practice.

Since establishing a diagnosis is important, psychiatrists are so prepared to look for symptoms. While we were preoccupied with searching for symptoms, however, we might leave out important information of personal experiences. Though it may seem trivial and irrelevant to diagnosis, the part dismissed may have helpful information to understand 'the person' who is affected with mental disorder. And to understand patient's personality is important for

planning treatment and the prediction of the course and the prognosis of the treatment.

We claim that we are experts on "personality". We underwent extensive post-graduate training to study various psychiatric theories on human behavior. We also studied "phenomenology of psychopathology", the phenomenon of various manifestations of abnormal mental states. It is an important tool through which the mental symptoms are conceptualized and makes apparent of the nature of psychiatric symptoms. It also tells us how to explore symptoms. The exploratory process begins with careful listening to the explanations of patient's experiences; the perceptions of 'inner side'-feelings, thoughts and beliefs. Thus, information of the 'inner side' is verbalized through language and coming to the 'outer side'. The externalized patient's subjective experiences then undergo diagnostic screening, sorting out to find what seems to be pathological and identifiable with psychopathology already conceptualized. For example, if a patient says he is tired, moody, lost general interest, has difficulty in falling asleep, the condition becomes 'depression'-a psychopathology. If another says that he believes that he has a special mission to save the world, he is suspected to have a delusion, a standard criterion for identifying a serious mental disorder. If you further prove that the person's reality testing is impaired with his belief of saving-the-world mission rigidly fixed, then he has a delusion. What you are doing here is to explore the patient's mind, bring a part of the contents out to identify it with the one already defined as a psychopathology. Some experiences the patient expressed are reformulated and translated into psychiatric terminology. Painful thoughts about ending one's life, for example, with all the religious, cultural, personal and family implications are mere "suicidal ideation". In essence, psychopathology is not the content of what the patient says but the terms experts formulated and conceptualized through intensive studies on the manifestations of mental disorders.

Notwithstanding, the contribution of phenomenology to psychiatry is resplendently fertile. To ensure the tradition of making 'accurate scientific' diagnosis, phenomenological approach laid out the basis of psychiatric practice upholding the principles to be very precise, clear cut and ultimately scientific. With this tool, a psychiatrist is trained to understand a patient and we believe that we are so capable of understanding patients' world through this approach.

Now the question is whether the understanding we appropriated through this approach fully represents patients' inner world. Is it not for 'our view of them' in doctor's perspective? The answer to this question is negative. Psychiatric diagnosis does not represent the essential truth of the patient's condition. It may even obscure the truthful part of the patient's condition because the diagnostic exploration usually does not go into the 'content' of symptoms, but it side-tracks to the 'form'.

Content set aside

Philosophers argue that the naming a disease represents to set the 'form' of illness, while the illness experienced in particular patient corresponds to the notion of 'content'. The diagnosis of schizophrenia for example is universally same for every patient regardless of contexts. But the content of symptoms vary according to individuals. For the psychiatrist, 'form' is the central concern. But the patient is

more concerned about the content of symptoms. The meaning of an auditory hallucination can be very disturbing to the patient. While psychiatrists are preoccupied in identifying symptoms, the true experience of fearful thoughts and feelings interwoven with psychological, cultural and practical realities may be left out. The experience expressed in his language that bears meanings and contents may be lost.

Philosophers also argue that "the world of psychiatry, involving emotions, thoughts, beliefs and behaviors is a world of meaning and thus of context. The centrality of these twin issues of meaning and context that separates the world of 'mental' from the rest of medicine"[1]. Postpsychiatrists also suggest that 'mental medicine', psychiatry, must reverse the traditional approach. Instead of identifying symptoms first, psychiatrists must understand the context first ; social, cultural, temporal and bodily factors[2].

The humanistic element once was an attraction of psychiatry. Psychoanalytic theory certainly enriched the humanistic side of psychiatry. Humanistic spirit was the core of the development of dynamic psychiatry, which taught us to listen to the content of the patient's experience. Dynamic psychiatry encouraged us to look into context while exploring the meanings of the patient's experience. It is unfortunate that this humanistic spirit of psychiatry has been fading, along with the decline of psychoanalytic thinking in contemporary psychiatry.

Since DSM and ICD, mental disorders became limited treatable psychiatric symptoms ; treatable mainly with drugs to suppress those symptoms. Today, drug therapy is the most popular treatment model in psychiatry. Furthermore, the drug therapy algorithm is available covering all the contingency angles through the course of drug therapy, including the suggestion of alternative drugs in case initially chosen drug is either not effective or yields untoward side effects. Drug therapy has become the routine of psychiatric practice.

The contribution of pharmaceutical companies to the simplified drug-oriented psychiatric practice is another knotty issue.

Context and meaning

Mental symptom is a manifestation of patient's inner struggles ; a way of coping, fighting, avoiding, negotiating, compromising with troubling conflicts. It may be a primitive coping behavior for survival to prevent an impending catastrophe that the patient is fearful of. Boss wrote that "A symptom evolves from a complicated disturbed human mind, and the afflicted person is impaired of his ability to relate himself through perception to what reveals itself to him in the world"[3]. This tells us the fact that there are reasons behind symptoms and these reasons should not be overlooked.

Things happen while we live for reasons. If we do not know what that reason is, then we create one. This is a part of what makes us human. Also, there is a need to explain things that happens. Some explained reasons make sense, but others do not. Some are possible and others are not probable. But it is important to respect the desire that drives us to look for 'meaning' in our lives.

In out practice, we should look for meanings of patients' experiences together with patients because we are not only dealing with the patients' symptoms but also with their lives. We should look for a moral of their stories and discuss it with them ; meanings and contexts.

Desirably, we should do this before identifying symptoms because this helps us to understand something more significant to the patient's reality.

How do we do this? At first, we listen to what the patient says carefully, paying attention to the patient's perspectives, particularly to his or her 'values'. This leads us to exploring the content of symptoms. While we discuss contents with patients, we will find ourselves already dealing with contexts and meanings pertained in the patient's experiences.

Value-based psychiatry

There is a growing importance of ethical issues in medicine. With this background, 'value-based medicine' has arisen. Just as evidence-based medicine offers a process of working more effectively with complex and conflicting evidences in medicine, value-based medicine also offers a process for working more effectively with complex and conflicting values in medicine.

More than any other field of medicine, psychiatry is value-laden. Starting from the diagnostic assessment, psychiatrists not only rely on facts but to be involved in number of value judgments based on these facts. When DSM was first published, the diagnostic decision-making was considered purely a scientific process hence it is value-free. As more diagnostic criteria emerged and their clinical significances tested, it became clear that the assessment process not only depends on facts but it also includes value judgments. In DSM, for example, in the judgment of dysfunction as a part of diagnosis, not only the degree of functional impairment is assessed but also the value judgment counting on individual and cultural values are involved. For instance, leaving his work and family to participate a religious retreat to pray for the world peace may be thought of 'good thing' in one country. But in a work-oriented country like Japan or Korea, it may be considered 'functioning badly' for the company or the family. Value-judgment is very much involved while assessing the patient's behaviors in personality disorders. Beside the behavioral diagnostic criteria of the manual, the inclusion line says 'when the behavior is considered pathological'. To judge what is pathological, personal factors of informants and the assessing psychiatrist can be determinative. To draw a line when a behavior appertains to psychopathology is a challenge. We should not solely depend on facts but our decision also bears value judgment.

There has been a significant international development to explore the role of values in psychiatric assessment and diagnosis. The World Psychiatric Association, NIMHE (National Institute of Mental Health in England) and other international organizations held seminars to deal with this issue. Consensus was repeatedly arrived from discussions that the value-based psychiatric practice is an essential partner to the evidence-based psychiatry.

Awareness of values

Value that goes by different names-principles, purpose, convictions, ideals and beliefs-is an important fundamental belief that we all cherish. People usually hold personal values that are valid and relevant to their self-concepts. Psychiatrists are trained to exercise empathy with patients to understand their core emotions and inclined thinking. Equipped with this empirical method, we are in a better position to understand others values. Psychiatry also is a medical discipline where various per-

sonal, cultural and social human issues are involved. Psychiatry, therefore, should be the first branch of medicine to understand the value-laden nature of mental disorders and the value involvement of medical decisions in practice. Psychiatrists need to be sensitive to value-laden issues and to deal with them effectively through learning.

To learn the value-based practice, we should begin to focus our attention to the evidence first. Usually the value-based approach is closely linked to the evidence-based. To consolidate value-based approach in our practice, the first step is to "listen to the evidence", to find out about values in the traditional areas of evidence-based practice. After listening to the patient and identify symptoms, and before you make a diagnosis with these symptoms, you should consider variety of different treatment options and their effectiveness. Through your empathy, you see all these options and weight their pro and cons, but this time, in 'patient's perspectives'. This is how you find values hidden behind symptoms.

By a simple guessing, we are not able to find values that impinge on our work. Ability to reason on values and developing sensitivity to identifying values come from training. A comprehensive training manual for value-based practice is available. "Value-Added Practice : A New Partner to Evidence-Based Practice and A First for Psychiatry?" by K. W. M. Fulford is an excellent text[4] The training exercises are very helpful to develop awareness of values and of the diversity of values.

The Department of Health, UK, published 'New Ways of Working for Psychiatrists" which strongly suggests a new value-based approach to psychiatry. It calls for 'big culture change' stressing that psychiatry must adapt to a "person-centered" ethos in mental health services. Diagnosis and treatment plan should be a process of exploratory endeavor pursued by professionals and patients together. It should be an attempt to develop a framework of understanding and explanation looking for different sorts of knowledge. Doctor's knowledge is not a privilege over others. In this process, patient's understanding of his world must move to the center stage. It is quite a challenge.

Training psychiatrist of tomorrow

Value-based psychiatric practice should start from the beginning of the medical education. The first thing is to learn to work with the patient and to show compassion to the patient. It is important to start from medical students to learn how to be involved with patients and to become patient-centered.

To be sensitive and aware of values involved in clinical decisions, it is advised that the psychiatric training to be partly dehospitalized, meaning that the training site should include practice sites other than hospitals. As the training itself moves away from placement oriented hospital-based services to primary practice, community and community organizations, the trainees learn to relate to other stakeholders and to improve understanding and communication with them in multidisciplinary context.

Training and teaching predominantly of biomedical theories fix the attitude of the trainee strictly in medical model. Later on as a practitioner his services may deprive the choice and control of service users. The new image of a psychiatrist for the coming era is an expert practicing evidence-based medicine at the same time able to make value-based clinical deci-

sions who also sees mental distress in its social and cultural contexts.

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