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Psychopathological dimensions and the clinician's subjective experience

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ABSTRACT

Classical psychopathology highly valued the interaction between clinician and patient, and recent findings have provided preliminary evidence of an association between categorical psychiatric diagnosis and the clinician's subjective experience during the first clinical assessment. To extend these findings, the present study examined the relationship between psychopathological dimensions and clinicians' subjective experiences. The study involved 45 clinicians and 783 patients in several psychiatric inpatient and outpatient units. When they saw a new patient, the clinicians completed the Assessment of Clinician's Subjective Experience questionnaire (ACSE) and the 24-item Brief Psychiatric Rating Scale (BPRS). Scores on five core psychopathological dimensions supported by meta-analytic evidence (Affect, Positive Symptoms, Negative Symptoms, Activation, Disorganization) were derived from the BPRS. Multivariate analysis revealed that each psychopathological dimension was characterized by a distinct pattern of independent associations with certain aspects of Clinician's Subjective Experience, as measured by the ACSE. This study provided preliminary evidence of significant and theoretically consistent relationships between major psychopathological dimensions and the psychiatrist's subjective experience during the first clinical evaluation. Improving the understanding of intersubjective processes may have important implications for theory, practice, research, and training.

1. Introduction

In the last three decades, the reliability of the DSM and ICD systems has been greatly increased through the introduction of an internationally shared framework of concepts, rule-based classification, and explicit diagnostic criteria. This, in turn, has improved diagnostic agreement among clinicians and provided researchers with rigorous diagnostic standards. However, focusing exclusively on the symptoms and signs listed in these classification systems risks producing an impoverished view of psychopathology (Kendler, 2016). While good diagnostic criteria can maximize reliability while requiring only low levels of inference, there are other important clinical phenomena which are subtle, and difficult to evaluate. Some of these phenomena lie in the intersubjective dimension. Indeed, classical psychopathology highly valued the interaction between the clinician and the patient, and underscored the key role of the clinician's subjective experience in the diagnostic process (Binswanger, 1924; Jaspers, 1913; Kraus, 1999; Minkowski, 1933; Mishara et al., 1998; Srivastava and Grube, 2009). Furthermore, despite the recent dramatic advances in neuroscience and genetics, clinical diagnosis in psychiatry remains inherently dependent on the clinician's ability to elicit, and the patient's willingness to communicate, subjective experience. Since, in most instances, the evidence required for diagnosis is still essentially phenomenological, communication and semiotic analysis, in which the clinician's trained introspection plays an important role, continue to be central components of the diagnostic process (Fuchs, 2010; Jablensky, 1999; Stanghellini, 2007).

Although our field has difficulties accepting the power and subtleties of subjective experiential data, it is not good science to ignore data altogether. It would therefore seem to be appropriate to study mental health professionals' subjective experiences, as they are indeed data (Strauss, 2011). So far, however, only a handful of studies have attempted to investigate the intersubjective dimension and its clinical correlates through standardized methods, and only very few have been performed in clinical psychiatric settings. While earlier studies of the diagnostic value of the putative schizophrenia-specific ineffable intuition named 'Praecox Gefühl' (Rümke, 1941) yielded inconclusive results (Grube, 2006; Ungvari et al., 2010), a recent study suggested that different diagnoses are associated with distinct profiles of clinicians' subjective experiences (Pallagrosi et al., 2016). In this study, we used a recently developed and validated standardized assessment instrument (Pallagrosi et al., 2014) to study 35 clinicians and 422 patients diagnosed with schizophrenia, bipolar disorder (manic or mixed episode), cluster B personality disorder, and depressive or anxiety disorder. This

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assessment tool reliably measures five dimensions (Tension, Difficulty in Attunement, Engagement, Disconfirmation, and Impotence) underlying a clinician's subjective experience during the first interaction with a patient. The study revealed a significant relationship between the clinician's pattern of subjective experience during the first visit and the patient's psychiatric diagnosis, which was theoretically consistent with a number of traditional concepts of phenomenological psychopathology. The most remarkable findings were higher Difficulty in Attunement with patients suffering from schizophrenia and lower Engagement and higher Disconfirmation with patients diagnosed with a cluster B personality disorder (Pallagrosi et al., 2016).

This study provided intriguing, albeit preliminary, evidence that the clinician's subjective experience may play a useful role in the diagnostic process. However, its findings are only relevant to the classical categorical approach to psychiatric diagnosis, which is currently the object of much debate, and has been challenged in several ways (Cohen, 2016; Kendell and Jablensky, 2003; Phillips et al., 2012). No ideal method of classifying mental disorders has emerged, and the problem of drawing boundaries between the diagnostic entities in psychiatry has so far defeated all attempts at finding an optimal solution by various rearrangements of symptoms and signs (Jablensky, 1999).

Based on the observation that psychiatric disorders appear to occur along a range of psychopathological dimensions that cut across diagnostic boundaries (Goldberg, 2000), alternative approaches, such as transnosological psychopathology (Mundt, 1995) and functional/dimensional psychopathology (Van Praag et al., 1990) have been proposed. The dimensional approach to diagnosis, which classifies clinical presentations based on quantification of attributes rather than assignment to categories, has received empirical support. For instance, studies comparing the predictive ability of empirically derived dimensions and existing diagnostic categories of psychotic disorders using clinical or outcome measures as external validators provided strong support for the utility of dimensions (Potuzak et al., 2012).

Given the current relevance of the dimensional approach for psychiatric diagnosis and practice, it would be interesting to investigate the relationship between psychopathological dimensions and the clinician's subjective experience during the clinical encounter. The present study aimed at delineating the dimensional patterns of psychopathology associated with specific aspects of the clinician's subjective experience. Our previous study (Pallagrosi et al., 2016) was performed on carefully selected cases with well-defined and specific diagnoses, allowing the formulation of relatively strong hypotheses regarding association with particular aspects of clinicians' subjective experiences. In contrast, the present study was exploratory in nature and was based on a large, very heterogeneous sample of 783 patients presenting with a wide variety of mental disorders.

2. Methods

2.1. Setting and participants

The study was performed in a number of psychiatric inpatient and outpatient units of the National Health Service in Rome, Italy. The clinicians working in these units were requested to complete a number of assessment instruments when they met a previously unknown patient for clinical and diagnostic evaluation. To be included in this study, patients had to meet the following criteria: 1) age of 18 years or more; 2) Italian nationality (to rule out potential problems in mutual understanding due to language difficulties in foreign patients); 3) absence of mental retardation or significant cognitive impairment; 4) absence of substance use disorder; 5) absence of major non-psychiatric medical illness.

Overall, 30 psychiatrists and 15 senior psychiatry residents with different theoretical backgrounds and attitudes were involved in the study. The mean number of patients rated per clinician was 17.4 (range 4–40). The clinicians' characteristics are reported in Table 1. They recruited a total of 783 patients, of whom 44.6% were seen in outpatient clinics, and 55.4% in hospital settings (acute inpatient wards or emergency rooms); the mean duration of the visit was 42.1 ± 15.8 min. Patients' demographic and clinical characteristics are summarized in Table 2.

Table 1
Clinicians' characteristics.

	Psychiatrists (N = 30)		Senior psychiatry residents (N = 15)	
Dependent variable	**N (%)**	**Mean (SD)**	**N (%)**	**Mean (SD)**
Sex				
Male	12 (40.0)		6 (40.0)	
Female	18 (60.0)		9 (60.0)	
Age		40.7 (10.0)		30.9 (2.8)
Years of post-graduation experience		13.7 (9.3)		2.8 (0.9)
Years of post-residency experience		10.0 (9.0)		
Theoretical background				
Psychodynamic theories	10 (33.3)		11 (73.3)	
Clinical/biological psychiatry	7 (23.3)		2 (13.3)	
Cognitive-behavioral theories	10 (33.3)			
Phenomenology	2 (6.7)			
Family systems theory	1 (3.3)			
Transactional theory			2 (13.3)	

Table 2
Patients' characteristics.

Dependent variable	**N (%)**	**Mean (SD)**
Sex		
Male	348 (44.5)	
Female	434 (55.5)	
Age		42.9 (15.2)
Education		
Primary school	50 (6.4)	
Junior high school	188 (24.0)	
Senior high school	353 (45.1)	
University degree	171 (21.8)	
Primary Axis I diagnosis		
Schizophrenia	155 (19.8)	
Acute psychosis	16 (2.0)	
Schizoaffective Disorder	36 (4.6)	
Delusional Disorder	21 (2.7)	
Unipolar Depression	120 (15.3)	
Bipolar Disorder, manic or mixed episode	66 (8.4)	
Bipolar Disorder, depressive episode	11 (1.4)	
Bipolar Disorder, unspecified	32 (4.1)	
Dysthymic Disorder	18 (2.3)	
Other Mood Disorders	46 (5.9)	
Anxiety Disorder	77 (9.8)	
Obsessive-Compulsive Disorder	15 (1.9)	
Eating Disorder	43 (5.5)	
Somatic Symptom Disorder	9 (1.1)	
Adjustment Disorder	22 (2.8)	
Other disorders	17 (2.2)	
No Axis I diagnosis	79 (10.1)	
Primary Axis II diagnosis		
Cluster A Personality Disorder	21 (2.7)	
Cluster B Personality Disorder	165 (21.1)	
Cluster C Personality Disorder	28 (3.6)	
Personality Disorder, not otherwise specified	32 (4.1)	
No Axis II diagnosis	537 (68.6)	
BPRS total score		50.0 (15.9)

Numbers may not add to 783 and 100%, respectively, due to a few missing data.