Beyond the Chief Complaint

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Key to the psychiatric evaluation is opening the narrative of the life events and emotional states associated with the emergence of the presenting symptoms. This is fundamental to establishing a therapeutic alliance and laying a foundation for the psychotherapeutic part of the treatment plan. Three composite case examples illustrate common patterns of such discovery in a psychotic illness, panic disorder, and depression. *(Journal of Psychiatric Practice* **2011;17:285–287**)

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The "title page" in a psychiatric record is the chief complaint. This sets the direction of a whole internal protocol in the evaluating psychiatrist's mind as the interview progresses. For example, if the chief complaint is depression, the checklist will include history about losses, narcissistic injuries, vegetative signs, suicidality, mood disorders in the patient's past and in the family, symptoms of other medical disorders affecting thyroid, brain, or pancreas, and so on—and mental status observations such as affect, level of anxiety, self-deprecation, psychomotor retardation, delusions, and suicidal or homicidal risk. Assessing broad personality traits and considering other possible diagnoses will also be part of the protocol.

Today, it's quite likely that the protocol will be on a computer screen in front of the doctor, who will be tempted to save time by ticking off boxes as the information comes in and hence will look more at the screen than at the patient. Aside from the possibility that the latter approach may be the kiss of death to the therapeutic alliance, it risks leading to a one-dimensional, simplistic, symptom-oriented, and hence incomplete treatment of the patient.

After noting the chief complaint, a more revealing question is, "What made you decide to come in at this time?" Then one sits back, maintains eye contact with the patient, and listens. Psychiatric illness commonly doesn't happen in an instant. It has probably been going on for some time. Something has happened that made the patient—or someone close by—decide that it was time to seek professional help. The story of how this came about is quite likely to enrich our knowledge of the patient as a person and of the complex web of relationships and emotions that contributed to the causative event. Here the narrative begins. As the patient tells his or her story, a relationship of trust and collaboration is likely to germinate, and we begin to see the picture in three-dimensional color. We initiate the process of untangling how this illness works and what it means to the patient.

The event that led to the patient's seeking help (or someone else seeking it for him or her) usually didn't come out of the blue. Something was building up to it, with incremental changes occurring until a balance tipped and the catastrophic event occurred—a major trauma, a blowup, a retreat into isolation, a harmful act, a panic attack, an urgent verbal appeal for help, or somatic distress—and the patient came to the office or the emergency department directly or through referral. Tracing the thread of how it built up may uncover more primary precipitants of the illness. The following case studies illustrate how these triggering events may present in therapy.

A College Student Who Makes a Suicide Attempt

A freshman college student has had increasing difficulty studying and understanding the material because of intrusive persecutory thoughts and strange visual phenomena. He has been dating a female student, but because of his strange behavior she has been avoiding him. He confronts her and she breaks off the

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relationship and leaves the room. He goes to nearby woods and clumsily tries to stab himself. A campus policeman intervenes and takes him to a hospital.

The presumed suicide attempt is the cause of his being brought to professional attention, but the earlier difficulty with focusing his attention in order to learn and the withdrawal by his girlfriend due to her anxiety about his changed mental state are precipitating factors that led to the catastrophic event. They in turn are the result of his growing disorders of thought process and content resulting from the primary illness, emerging schizophrenia.

Even that is not a total explanation, because emotional factors such as being away from his home, complex relationships with his parents and sister, and fears and guilt about a sexual relationship with a woman may have contributed to his problem. Tracing these issues back to their sources places his schizophrenia in the context of development from adolescence into adulthood, family ties, maturation of sexuality, self-image, self-esteem, and ability to form close and committed relationships. Planning the care of this patient with schizophrenia involves not only diagnosis and selection of medications but understanding the patient as a whole adolescent person coping with independence, adult sexuality, and a terrifying, newly manifested disease.

A Young Mother Who Has a Panic Attack

A young woman suffers a panic attack while on an evening out with her husband. Having no previous history of panic or problems with anxiety, she is startled and alarmed by this event, and a low-intensity state of anxiety ensues. She is reluctant to take anxiolytic medication, so her internist refers her for psychiatric evaluation. In the office, she is composed and calm but concerned about the recent abrupt onset of fear, trembling, and hyperventilation. She describes herself as a well educated, competent person who stopped her business career when her first-born son, now 3 years old, was born. She has been a full-time mom since then, nursed her son for a year, and has been careful to do all the right things as a mother, although she sometimes misses her working life. Although there are tensions, her relationship with her husband seems strong.

Her psychiatrist asks her to describe in detail what happened on the night of the panic attack. It was the first time she and her husband had hired a sitter and gone out on their own. Partway through the dinner she had a sudden urge to call home to check on her child, followed immediately by the panic attack.

Much more information of all kinds will be needed to complete the evaluation, but the association between the impulse to call home and the panic attack is an important lead into the back story of this woman's illness. In a psychodynamic framework, anxiety is not just another symptom but rather is evidence of a psychic conflict of which the patient is unaware: a marker of the unresolved clash of basic impulses and drives with one's conscience, internal standards for oneself, or realistic concern about consequences. Sometimes the clash is between the opposing drives of love and hate.

In twice weekly psychotherapy, this young mother deals with her guilt about sometimes wishing she could be out in the working world again instead of spending her days with a bright, charming, but enterprising and sometimes very naughty 3-year-old. At times she feels detached from him and, when her attention has been distracted, he has done a few dangerous things. Over the months of treatment it comes out that her mothering style is similar to that of her own mother, who was sometimes quite oblivious in times of crisis and need. Early sibling rivalry with her younger brother also enters the picture, as her son's maddening ways remind her of her brother's behavior as a pre-school child.

Several months into therapy she starts to have recurrent dreams of being a pre-school girl in a babysitter's house. Subsequent recurrences bring incremental details of being pinned down on the floor, then of a young man trying to molest her sexually, and then of some kind of explosive outburst. She becomes aware of a distinct memory of the particular house she had dreamed about, being molested in this way, and her father's coming into the house and being enraged. A further dream brings the transference into the picture: she is in an operating room surrounded by green figures who are examining her genitals, and to whom she gives a name that resembles the name of her male therapist, whose therapy at this moment feels invasive despite the welcome relief and support that it provides. She recalls that the molestation and father's outburst had led to a trip to an emergency room and her having a pelvic examination. Afterwards, in a manner characteristic of her very proper family, nothing was ever said about the incident. Working through all this takes many months. The outcome of the treat-

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ment is full relief of symptoms, healthy dealing with attachment and separation issues with her son, and improved function overall.

Depression After the Death of a Loved One

A third example involves the common situation in which a person develops depression after the death of a loved one. Sadness, preoccupation with the loss, difficulty believing that it really happened, remorse about minor oversights or hurts, and persistent thoughts about a lifetime of memories of the loved one are characteristic of normal grief, as the mourner works through his or her whole memory bank and associates those memories with the new information that the loved one has died. This lasts for many months and preempts the energy of the mourner, but ultimately it fades away. The mourner accepts the reality of the loss and has energy for other activities and new relationships.

On the other hand, feelings of hopelessness or abandonment, persistent guilt, self-recrimination, smoldering resentment, or desolation, along with persistent anorexia or sleep disturbances, slowing of thought, action, or speech, or suicidal thinking are signs that clinical depression has emerged. The depression can be psychotic, as it was with a woman who blamed herself for being a severe alcoholic and vile philanderer who gave syphilis to the world—characteristics that described her dead abusive husband but couldn't remotely apply to this saintly, churchgoing lady. Clues to such ambivalence (a mixture of love and resentment) in the initial evaluation may give some hint of resentment towards the deceased loved one or towards other members of the family.

Another common pattern is inappropriate dependency in the relationship that is now over. Extreme dependency carries its own freight of ambivalence, because the dependent survivor has not gone through the maturing process of separation, building confidence, and being on his or her own. The developmental needs of the survivor were a casualty of the relationship with the person who has died, and the survivor feels abandoned, inadequate, and resentful.

Sometimes a deceased parent has done something that has caused great hurt to the child or children, such as a late-life marriage and transfer of the estate to a hostile and despised new spouse. Hurt feelings and anger at this irreversible injury—and complicated mixed feelings among the surviving siblings—make it very hard to go through the normal process of grief.

Another example involves the death of an aged mother who has always been perceived as physically or mentally abusive towards a daughter, who nonetheless, in a reaction formation against her resentment, has been extremely attentive and protective of the mother in her old age. The feelings of being abandoned and unloved, mixed with hateful memories and self-deprecation that are an internalized reenactment of the relationship with the mother, make for a persistent feeling state that keeps the patient mired in depression.

Accurately diagnosing and appropriately treating such patients begins with the first contact, getting the patient to start the narrative of the relationship with the lost parent, or spouse, or friend, or even a job or deeply invested activity. The story begins with what happened at the tipping point—the precipitating event—but as time goes on, it leads deep into relationships, ambivalent feelings, guilt, shame, internal conflict, defensive coping strategies, and many other issues of which the patient was completely or partially unaware until he or she had the opportunity to talk them out or reenact them in a trusting and attentive treatment relationship.

Final Thoughts

Beyond the chief complaint and the related symptoms, the patient's narrative about how it all happened may considerably facilitate the diagnostic task as the details emerge. It also has psychotherapeutic value, because even the process of articulating the story may clarify something in the patient's understanding while facilitating self-reflection. Expressing related emotions in a controlled environment may also bring the patient some relief. Most of all, the psychiatrist's attentive listening establishes the patient's confidence and trust that someone is really interested and knows how to be helpful—the beginning of the therapeutic alliance.

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