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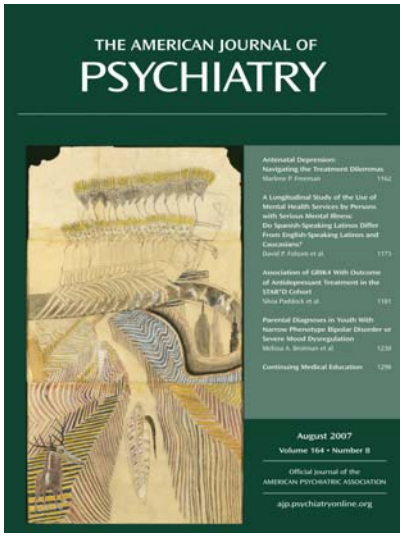

Sometimes the research articles that appear in *The American Journal of Psychiatry* are more informative for clinical practice than one might first suspect. This month's featured Journal Club article by Dr. Melissa Brotman, titled "Parental Diagnoses in Youth With Narrow Phenotype Bipolar Disorder or Severe Mood Dysregulation," is a prime example. Both parents and psychiatrists are troubled by the upsurge in diagnoses for bipolar disorder in children and adolescents. Rage and irritability are well known concomitants of the torment of transitioning from childhood to adolescence to adulthood. Freud conceived of latency as the "calm before the storm" in psychosexual development. Do children who have severe emotional outbursts have an illness? If it is an illness, is it a variant of bipolar disorder, which is the disorder that is most characterized by mood swings?

Psychiatrists are often taught to look for the manifestation of symptoms for subclinical disorders that seem to merge with normal behavior. If a psychiatrist discovers that an adult patient's irritability is periodic and accompanied by some signs of mania, then the treating psychiatrist has taken problematic behavior and recharacterized it as a treatable illness. Oftentimes that strategy is effective. The best reason to go to a psychiatrist is, in fact, for a diagnosis, so that severe behavioral disturbances can be treated.

But often in our profession we do not know if we have gone too far. Sometimes it seems as if psychiatrists think the whole world has bipolar disorder. We are accused by parents and the media of medicalizing normal variants in human behavior. The incidence of overmedicated youths who are not held responsible for their own misbehavior is on the rise.

Brotman et al.'s article investigates this very issue. The authors examined two groups of children: 1) those with narrowly defined bipolar disorder for whom manic episodes with elevated or expansive mood or grandiosity were a key feature, and 2) those with severe mood dysregulation for whom irritability, anger, or sadness with hyperarousal, including racing thoughts and pressured speech, were prominent features.

It is easy to see how the second group could be lumped in with the first, but is that actually correct? Brotman and her colleagues decided to examine the parental history for both groups. They found that parents of children in the first group were more likely to have bipolar disorder than parents of children in the second group. The authors concluded that the two groups shared different familial and probably genetic origins; therefore the symptoms of the two groups of children should not be thought of as different manifestations of bipolar disorder.

In her accompanying editorial, Dr. Gabrielle Carlson points out that if psychiatrists stop characterizing children with severe mood disorder as bipolar, then we can discover what these children really do have—a combination of attention deficit hyperactivity disorder and oppositional defiant disorder, which has long been associated with the development of conduct disorder later in adolescence and antisocial personality in adulthood. The clinician who is treating such a child then has a rather difficult task in trying to create a behavioral structure so as to prevent or delay the onset of more significant behavioral disorders. The misdiagnosis and mistreatment of bipolar disorder would be an unfortunate distraction. The editorial is an interesting exchange between Dr. Carlson and the authors in their cooperative attempts to clarify this point for the readers.

If your Journal Club reads this article and accompanying editorial and reaches its own opinion, you are welcome to contribute an editorial of your own to the Residents' Journal. These editorials can be submitted to our manuscript submission site at http://mc.manuscriptcentral.com/appi.

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Empathy: Do Psychiatrists and Patients Agree?

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Objective: *A psychiatrist's self-perception of empathy may not match the patient's perception of the psychiatrist's empathic skills. The purpose of this study was to assess the relationship between psychiatrists' self-assessment of empathy and their patients' assessment of their empathy.*

Method: *Ten outpatient psychiatrists—six residents and four attending psychiatrists—completed the Jefferson Scale of Physician Empathy (range=20–140). Five patients of each psychiatrist completed a corresponding questionnaire rating their psychiatrist's empathic skills.*

Results: *No significant correlation was found between psychiatrists' self-perception of empathy and their patients' perception of their empathy. Mean test scores for psychiatrists' self-assessed empathy were significantly higher than mean test scores for patient perceived psychiatrist empathy. This difference was most marked between male psychiatrists and female patients.*

Conclusions: *There was no significant correlation between psychiatrists' self-assessment of empathy and their patients' assessments of their empathy. Psychiatrists rated themselves significantly higher than their patients did.*

A physician's interaction with patients has been thought to play a vital role in the healing process from the time of Hippocrates (1). Patients' satisfaction with their care is related to independent measures of the physician's general sensitivity to emotion and ability to express feelings (2).

According to Stedman's Medical Dictionary, "empathy" is defined as "Direct identification with, understanding of, and vicarious experience of another person's situation, feelings, and motives," and is thought to be a vital component in the formation of the doctor-patient relationship. A physician's ability to be empathic affects all aspects of his relationship with patients, from taking a history to a patient's compliance with treatment (2–5).

Research in neuroscience has offered a biological basis for empathy (6). The perception of behaviors, emotions, and cognitions in others activates corresponding neural activity in the brain of the observer through what are known as "mirror" neurons (6). This neural basis of empathy finds further support in research on dysfunctions in the "mirror" systems of humans with autism and functional MRI (fMRI) research on normal subjects designed to assess intentionality, emotions, and complex cognition (7).

Empathy is difficult to measure. Hojat et al. developed the Jefferson Scale of Physician Empathy to measure physician empathy (8). The scale requires that physicians quantify their empathic skills through self-assessment. This raises the question of whether a physician's self-perception of his or her empathy can be an accurate measure of empathic communication in the clinical setting. The literature demonstrates that for empathy to be effective, it must be both perceived and felt by the patient (9, 10). These studies found that client-perceived empathy but not therapist-perceived empathy was associated with positive therapy outcomes. It is the patient's feelings of being understood, i.e., patient-perceived psychiatrist empathy, which is related to better treatment outcomes.

Studies show that empathy as perceived by teachers, supervisors, or colleagues is often not related to that experienced by patients (9, 11). Does a measurement of empathy based on physician self-assessment lead to an accurate measurement of the empathy the patient perceives? We examined the relationship between physicians' self-assessment of empathy with their patients' perception of their empathy to answer this question.

METHOD

The Jefferson Scale of Physician Empathy was modified to request a patient's view of their physician's empathic skills. For example, one of the items on the original scale states, "It is difficult for me to view things from my patient's perspective." The corresponding item on the modified JSPE states, "It is difficult for my doctor to view things from my perspective." Physicians were asked to fill out the unmodified JSPE and their patients were asked to fill out the modified JSPE (mJSPE); these results were then correlated.

The psychiatrists in the outpatient department of Maimonides Medical Center (MMC) were approached; the study was explained, informed consent was obtained, and they were requested to complete the JSPE. Patient recruitment was done by either the treating psychiatrists or the author. After a complete description of the study to the subjects, written informed consent was obtained. Patients were then requested to fill out the mJSPE.

The study sample included 10 physicians (six psychiatry residents and four psychiatry attending physicians) and 50 patients. The physicians were psychiatry residents and attending psychiatrists working in the outpatient psychiatry clinic at the MMC in Brooklyn, N.Y. The patients were receiving psychopharmacological treatment in the outpatient clinic and included five patients from each of the participating psychiatrists. The study was approved by the Institutional Review Board at the MMC.

The JSPE includes 20 items answered on a scale from 1 to 7 (from strongly disagree to strongly agree), with possible scores in the range of 20–140. The scale is composed of three factors that include perspective taking, compassionate care, and standing in a patient's shoes. The scale has construct validity, convergent validity, and discriminant validity, as illustrated by significant correlations with relevant measures such as compassion (r=0.56), Interpersonal Reactivity Index (r=0.40), perspective taking (r=0.27), and a lack of a relationship between this measure and measures such as self-protection (r=0.11). The internal consistency is supported by a reliability coefficient of 0.81. The test-retest reliability coefficient is 0.65.

We compared the psychiatrist self-assessed empathy scores with the average of the patients' perceived empathy scores using a t test. All reported p values were two-tailed and set at 0.05. Correlation between self-perceived scores and the mean of patient-perceived empathy scores was studied using a Pearson correlation.

RESULTS

There was no significant correlation between the psychiatrists' self-perception of empathy and their patients' perception of their empathic ability (r=0.40, p=0.30).

Psychiatrist empathy scores (mean=119.7, SD=8.65) were significantly higher than patient perceived physician empathy scores (mean=104.4, SD=11.3). Each of the 10 psychiatrists rated themselves much higher than the mean of their patients' ratings (mean difference between physician and patient perceived empathy scores=15.3, p<0.0001).

The mean scores of female psychiatrists were slightly higher when compared with male psychiatrists (120.8 versus 118; mean difference=2.8, p=0.2). A gender match was done comparing female psychiatrists' ratings **(**mean=120.8) with female patients' ratings (mean=108.2) and male psychiatrists' ratings (mean=118) with male patients' ratings (mean=96.2) (Table 1). Where there was a gender match, the differences between the physician self-rating and the patients' ratings were not significant (female: p=0.09; male: p=0.10). Where there was not a gender match, that is, a female psychiatrist (mean=120.2) with male patients (mean=104), there was no significant difference (p=0.08). However, in the case of a male psychiatrist (mean=118) with female patients (mean=95.6**)** the difference between patient and physician rating was significant (p<0.0001).

DISCUSSION

Each of the psychiatrists in the study rated their

empathic skills significantly higher than their patients did.It is likely that most people view themselves more favorably than others view them. A review study including multispecialty physicians found that physicians have a limited ability to self-assess (12). In the clinical setting however, this may lead to a decreased ability by physicians to understand patients and their needs, which may negatively affect the quality of treatment. It raises the possibility that psychiatrists will be less sensitive to what the patient is experiencing and attribute difficulties in the patient-doctor relationship to the patient himself.

Table 1. Mean JSPE Scores Compared by Gender

	Male Patient		Female Patient	
Physician	**Mean**	**p**	**Mean**	**p**
Male Psychiatrist (Mean score=118)	96	0.10	95	<0.0001
Female Psychiatrist (Mean score=121)	104	0.08	108	0.09

We did not find a statistically significant correlation between how physicians viewed themselves and how their patients view them. This underscores a possible disconnect between the psychiatrist and the patient. It is the patient's experience of the psychiatrist that is predictive of the outcome of therapy. The usefulness of self-rated empathy scales depends on the reason for its use. They could be used to monitor changes in the patient's perception and how these changes relate to treatment outcome, both in psychotherapy and pharmacotherapy. It could encourage psychiatrists to continue to assess their empathic skills throughout their professional careers.

Where there was not a gender match between the psychiatrist and the patient, the empathy ratings were significantly different only for male psychiatrists and female patients. This encourages supervisors to scrutinize this type of pairing more carefully.

The biggest limitation of this study was the small size of the study sample. This pilot study is a step toward empirical examination of the important concept of the doctor-patient relationship and needs to be replicated with a larger sample size. Also, the scale used to measure physician empathy is a validated instrument. The modified version we used was not validated. The other limitation of this study was the self-selection bias. Some patients refused to participate and we can hypothesize that patients that agreed to participate tend to think more favorably of their doctors. Thus, the possible disconnect between doctors' perception of their empathy and their patients' perception could be larger than we found. Even though the literature has verified the significance of empathy in doctor-patient relationships, there is a lack of empirical research in understanding the various contributing factors to empathy. We need to look into factors that lead to this difference in perception of empathic skills. Are we less empathic than we think we are? Are we unable to convey our empathy to our patients, or are there external factors that influence our empathic skills? Our examination of possible changes in empathy in a psychiatrist-patient dyad over time might enhance our understanding of the therapeutic relationship.

PATIENT PERSPECTIVES

It was a very interesting experience to hear different patients react differently when informed about the study. Patient reactions were widely varied. A lot of patients said they were pleased to hear that we were making an effort that might lead to better doctor-patient communication. One of these patients said, "I love my doctor and would fill out any questionnaire that would help you know how great she is". There were some patients, whom when informed about the study, responded "What relationship? I only come here for medications." On the other end of the spectrum were patients who said they did not want to participate in the study because they did not want any documentation of what they think of their doctors, anonymous or not. One patient in particular remarked that he was very happy to participate, as he did not like his doctor.

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Dr. Aggarwal reports no competing interests.

References

1. Hippocrates: Volume II: Prognostic. Translated by Jones WHS, Cambridge, Mass., Harvard University Press, 1923
2. DiMatteo MR, Hays R: The significance of patients' perceptions of physician conduct: a study of patient satisfaction in a family practice center. J Community Health 1980; 6:18–34
3. Colliver JA, Willis MS, Robbs RS, Cohen DS, Swartz MH: Assessment of empathy in a standardized patient examination. Teach Learn Med 1988; 10:8–11
4. Kim SS, Kaplowitz S, Johnston MV: The effects of physician empathy on patient satisfaction and compliance. Eval Health Prof 2004; 27:237–251
5. Stewart MA: Effective physician-patient communication and health outcomes: a review. CMAJ 1995; 152:1423–1433
6. Carr L, Iacobani M, Dubeau MC, Mazziotta JC, Lenzi GL: Neural mechanisms of empathy in humans: a relay from neural systems for imitation to limbic areas. Proc Natl Acad Sci U S A 2003; 100:5497–5502
7. Nishitani N, Avikainen S, Hari R: Abnormal imitation-related cortical activation sequences in Asperger's syndrome. Ann Neurol 2004; 55:558–562
8. Hojat M, Mangione S, Nasca TJ, Cohen MJM, Gonnella JS, Erdmann JB, Veloski J, Magee M: The Jefferson Scale of Physician Empathy: development and preliminary psychometric data. Educ Psychol Meas 2001; 61:349–365
9. Free NK, Green BL, Grace MC, Chernus LA, Whitman RM: Empathy and outcome in brief focal dynamic therapy. Am J Psychiatry 1985; 142:917–921
10. Kurtz RR: Different approaches to the measurement of therapist empathy and their relationship to therapy outcomes. J Consult Clin Psychol 1972; 39:106–115
11. Woolliscroft JO, Howell JD, Patel BP, Swanson DB: Resident-patient interactions: the humanistic qualities of internal medicine residents assessed by patients, attending physicians, program supervisors, and nurses. Acad Med 1994; 69:216–224
12. Davis DA, Mazmanian PE, Fordis M, van Harrison R, Thorpe KE, Perrier L: Accuracy of physician self-assessment compared with observed measures of competence. JAMA 2006; 296:1094–1102

Adjudicative Competence and the Ethical Dilemma of Forcing Medication to Restore Competency

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Approximately 7000 defendants are involuntarily committed each year to public hospitals for restoration of competency. Most states rely on landmark cases to make decisions regarding forcing medication for this purpose. In this article the authors review landmark decisions such as Washington v Harper, Riggins v Nevada, Sell v U.S., and Jackson v Indiana that have shaped policies on forcibly medicating defendants to restore competency. The authors also discuss the dilemmas faced by both the legal system and psychiatrists when confronted with this issue.

Assessment of adjudicative competency is the most common evaluation performed by psychiatrists for the courts (1, 2). The Supreme Court defines adjudicative competency as the ability of a defen-

dant to have rational and factual understanding of the proceedings against him and to assist and consult an attorney with reasonable and rational understanding (3). Approximately 25,000 to 50,000 criminal defendants are referred for competency assessment annually (4) and about 7000 are involuntarily committed (5).

Roughly 90% of these defendants are committed to state hospitals or forensic mental hospitals to restore competency (6). Methods to restore competency include treatment of the mental illness and education about the trial proceedings (6). Even when found to be incompetent, defendants are presumed competent to make treatment decisions. When defendants refuse medication, no clear guidelines exist to force the administration of the medication solely to restore competency. The U.S. Supreme Court opined on several landmark cases regarding this issue. The case of *Washington v Harper* involved forcing the administration of medication in prison when the inmate was considered dangerous to himself or others and the treatment was in his best interest (7). In the case of *Riggins v Nevada*, the U.S. Supreme Court acknowledged the liberty of an inmate to refuse medication in a pretrial context (8).

In the third case, *Sell v U.S.*, the U.S. Supreme Court clarified that the administration of medication can be forced to restore competency only when there is a compelling reason for trial, as in cases of heinous crimes (9). The medication must be in the "best interest" of the patient and should be likely and necessary to restore competency, while unlikely to interfere with the defendant's ability to assist counsel (9). Additionally, there should not be any other less intrusive alternative. If an inmate is dangerous, the above criteria need not be fulfilled (7, 9, 10). A judicial review is required to force the administration of medication to restore competency in a non-dangerous inmate (11–13).

Commitment to a psychiatric facility for the sole purpose of restoration of competency may be permitted only when restoration is likely and cannot exceed the period required to determine if there is a possibility for restoration (14). If inmates are found not restorable they may be civilly committed to a psychiatric hospital. If they do not qualify for commitment, they may be released if the charges are not compelling enough to force medication (1, 14).

A common concern is that forcing medication may threaten the constitutional rights of inmates (11). Medications may make the defendant too sedated or appear "too normal" for an insanity plea (15, 16). This may cause eventual incarceration or even execution once restoration of competency occurs. An inmate refusing medication who does not qualify for forced medication may continue to suffer from mental illness. Civil commitment criteria are fairly strict and the inmate may not qualify for treatment. If civilly committed, the inmate may stay longer than the designated sentence. Sadly, many mentally ill persons who do not fulfill the criteria for forced medication continue to file in and out of prisons for minor crimes and while their illnesses go untreated, leaving much work to be done on the part of the healthcare and legal systems.

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References

1. Resnick PJ, Noffsinger S: Competency to stand trial and the insanity defense, in Textbook of Forensic Psychiatry: The Clinicians Guide to Assessment. Edited by Simon RL, Gold LH. Arlington, Va., American Psychiatric Publishing Inc., 2003, pp 329–347
2. Gutheil TG, Appelbaum PS: Forensic evaluations, in Clinical Handbook of Psychiatry and Law. Philadelphia, Lipincott Williams & Wilkins, 2000, pp 261–316
3. Dusky v U.S., 362 US 402 (1960)
4. Hoge SK, Bonnie RJ, Poythress N, Monahan J, Eisenberg M, Feucht-Haviar T: The MacArthur Adjudicative Competence Study: development and validation of a research instrument. Law Hum Behav 1997; 21:141–179
5. Steadman H, Hartstone E: Defendants found incompetent to stand trial, in Mentally Disordered Offenders. Edited by Monahan J, Steadman H. New York, Plenum, 1983, pp 39–64
6. Noffsinger SG: Restoration to competency practice guidelines. Int J Offender Ther Comp Criminol 2001; 45:356–362
7. Washington v Harper, 494 US 210 (1990)
8. Riggins v Nevada, 504 US 127 (1992)
9. Sell v U.S., 539 US 166 (2003)
10. U.S. v Charters, 863 F 2d 302 (4th Cir 1988)
11. U.S. v Brandon, 158 F 3d 947 (6th Cir 1998)
12. Appelbaum PS: The right to refuse treatment with antipsychotic medications: retrospect and prospect. Am J Psychiatry 1988; 145:413–419
13. Rivers v Katz, 504 NYS 2d 74 (1986)
14. Jackson v Indiana, 406 US 715 (1972)
15. Ladds B, Convit A, Zito J, Vitrai J: Involuntary medication of patients who are incompetent to stand trial: a descriptive study of the New York experience with judicial review. Bull Am Acad Psychiatry Law 1993; 21:529–545
16. Geller JL, Appelbaum PS: Competency to stand trial: neuroleptic medication and demeanor in court. Hosp Community Psychiatry 1985; 36:6–7