Brit. J. Psychiat. (1977), 130, 374–6

Psychiatric Decision Making

By RICHARD MAYOU

Summary. Questionnaire replies from 43 experienced psychiatrists showed wide variation in the ways they would manage a common type of neurotic problem. There were considerable differences in the nature and duration of treatment and in the use of other members of the psychiatric team. The conclusions have implications for training and for the use of health care resources.

Introduction

Doctors often have very little understanding of the way in which psychiatrists assess patients and formulate their treatment. Psychiatrists themselves are aware that they have learnt by practical experience rather than through any systematic training. Whilst there have been many investigations of the process of psychiatric diagnosis and the principles of interviewing, there has been very little concern with how treatment plans are actually formulated.

Throughout the interview the doctor must have in mind the decisions to be made about further management:

1. Further information required from patient or other sources.
2. Type of care—Out-patient, in-patient, day-patient referral to other agency, or nil.
3. Specific treatments—Immediate or long-term.
4. Further contact—When? how often? by whom?

The determinants affecting what Lazare (1976) has described as hypothesis generation and testing are numerous, depending not only upon the patient's problems but upon the doctor's attitudes and the time and facilities at his disposal:

1. Attributes of the patient—Nature of problems and social situation; expectations; motivation.
2. Attributes of the doctor—Treatment attitudes; experience; personality.
3. Setting of consultation—Expectations of referring agency; time available; availability of other resources; teaching functions.

It would be valuable to extend to psychiatry the increasing interest in medical decision-making, since conclusions would not only be helpful in clinical practice and in training but also fundamental to the planning of services. Current discussion about manpower, the team approach and the whole organization of resources is carried on with little knowledge of what psychiatrists actually do and in the face of some evidence that there is a very wide variation in practice.

Method

Members of the Chilterns and Thames Valley Division of the Royal College of Psychiatrists were circulated with a 250 word case history of a common neurotic problem: a 28-year-old married lady with three young children presenting with a four month history of panic attacks, agoraphobia and mild depressive symptoms and with some indications of minor marital and sexual difficulties. The pyschiatrists were asked to specify as precisely as possible what further information they would require and what general treatment aims they would consider in their out-patient clinic. The answers to 43 fully completed questionnaires are analysed.

Results

Important differences were evident in the way individual psychiatrists viewed assessment,

https://doi.org/10.1192/bjp.130.4.374 Published online by Cambridge University Press

decisions about treatment and use of resources. The replies indicated four principal clinical approaches:

1. Interpretative psychotherapy.
2. Conjoint or family therapy.
3. Behaviour therapy.
4. Antidepressant medication.

Whilst all the respondents would have liked more information, the specific replies seemed to reflect basic attitudes to treatment. Those who proposed intensive psychotherapy would have wanted to know about early childhood experience and laid particular stress on factors such as insight and transference. Those favouring brief counselling were more interested in specific recent stresses, while others were concerned with clarifying the history of depression, indications for medication and response to any previous physical treatment.

A major difference was evident in the emphasis on seeing the husband, 11 would not have wished to see him, 23 would have wanted to interview him themselves, 4 would have asked a social worker to do so and 2 wished to see the whole family, including the children.

Treatment

Many of the replies favoured a single type of treatment, but a minority suggested that they would consider some or all of these methods concurrently or successively. Particularly clear differences were:

1. Extent to which treatment was seen as requiring the active participation of husbands (conjoint psychotherapy or more rarely in behavioural treatment).
2. The emphasis on the appropriateness of individual psychotherapy.
3. The role of antidepressants.
4. The role of organized programmes of behaviour therapy (usually desensitization) either initially or following drug or other treatment.

Treatment time

Half the psychiatrists envisaged approximately six half-hour follow-up appointments at two to three week intervals. Eight doctors envisaged more regular long-term therapy, whilst six favoured not more than three appointments of not longer than a quarter of an hour.

Use of other members of the team

The assistance of other therapists was commonly proposed:

Clinical psychologists	14
Social workers	14
Community nurse	2
Behaviour therapy nurse	1
Day hospital staff	4

There was considerable variation in expectations from these other workers; in several instances it was gathering information or undertaking a specific task under supervision, but in the rest a sharing or passing on of full responsibility.

A minority stressed the value of working with the general practitioner and of taking his interests and skills into account in making treatment decisions. Some, especially those who would embark on psychotherapy, saw the supervision of antidepressants as the general practitioner's responsibility, whilst others saw this as a specific psychiatric task, often the principal reason for follow-up appointments.

Discussion

It would be wrong to draw too many conclusions from a written questionnaire based on a single brief case history, since it is likely that confronted with full information from an actual patient psychiatrists would show more agreement. However, very clear differences were evident in the ways in which experienced psychiatrist would deal with a common neurotic problem:

1. Types of further information required.
2. Type of treatment.
3. Number, frequency and length of treatment sessions.
4. Use of other therapists.

These differences were not attributable to the wide variation in resources of individual units, since three quarters of the psychiatrists thought that there would be no difference in the management if they had optimal facilities and time available. Those who would have liked to manage the patient differently usually

https://doi.org/10.1192/bjp.130.4.374 Published online by Cambridge University Press

wished to spend more time on psychological therapy. Four psychiatrists said they were limited by lack of an adequate clinical psychological service in their areas.

No psychiatrist would wish to suggest there is a single correct treatment for the type of problem described in the case history. Good evaluative studies are available on the use of antidepressants and a variety of behavioural treatments in agoraphobia, but their direct application to the complexities of ordinary clinical practice is limited and each individual psychiatrist has to rely on his own clinical experience and training. However, both the complexity of the decision making process and the existence of several conceptual models may, as Lazare (1976) has described, lead to an unnecessary limitation of the treatment options. Such models do not deny the importance of clinical relationship or of interviewing skills but rather make explicit what experienced psychiatrists actually do. Further knowledge would lead to more effective treatments, better training and more rational use of increasingly complicated treatment resources. There is a clear need for studies both of individual decision making and of the functioning of psychiatric teams.

ACKNOWLEDGEMENTS

I would like to thank the Committee and members of the Chilterns and Thames Valley Division of the Royal College of Psychiatrists for their help.

REFERENCE

LAZARE, A. (1976) The psychiatric examination in the walk-in clinic. *Archives of General Psychiatry*, **33**, 96–102.

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(*Received 25 June; revised 30 July 1976*)

https://doi.org/10.1192/bjp.130.4.374 Published online by Cambridge University Press