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ABSTRACT

Previous research on medical discourse suggests that physicians minimize patients' social problems through conversational and linguistic interactions. There has been little assessment, however, of the neglect of violence by psychiatric staff. In an attempt to address this important area, the case presentations of 77 recently violent psychiatric patients were examined. A contextual analysis of the violence mentioned during the case presentations revealed four categories of identification violence as part of the primary problem, as a psychiatric disorder, as an unrelated incident, or not mentioned at all In nearly two-thirds of the case presentations, the violence was not identified as part of the primary problem The findings and case examples substantiate the assertion that social problems are neglected, minimized, or medicalized in medical discourse They also suggest that clinical protocol should be established to ensure more extensive consideration of the "dangerousness" implied by reported violence

The sociological study of medical discourse—that is, the discussion among physicians, clinicians, and patients—has become a rich and fruitful field in recent years (Kuipers, 1989; Mechanic, 1989). The broad perspective of this research has exposed the interactive processes by which medical conditions are defined and addressed. This research suggests how macrolevel

social structures are translated into microlevel personal experiences. For example, socially deviant behavior, like drinking excessive amounts of alcohol, may be redefined as a physical disease or psychological disorder through a physician's discussion with a patient (Conrad & Schneider, 1980).

The research on medical discourse has also stimulated critical assessment of the interaction among medical staff and patients (Kuipers, 1989; Mechanic, 1989). Physicians, according to several studies, systematically neglect or reframe social problems presented by patients as personal medical problems (Anspach, 1988; Mishler, 1984; Waitzkin, 1989). By social problems, we refer to dysfunctional, destructive, or disruptive behavior that is a manifestation of the social system or social structure of society. As a result, medical care often leaves patients subject to the worsening effects of untreated social problems and unprepared to deal with them.

The previous research on medical discourse generally described the medical response to social problems in one of two ways: Social problems tend to be either "medicalized" or "minimized." Medicalization refers to the tendency to identify a social problem as part of a medical problem (Conrad, 1975; Conrad & Schneider, 1980). For example, violent or criminal behavior might be interpreted as a manifestation of a psychosis. Minimization refers to the tendency to give a major social problem secondary or peripheral status to a medical problem (Anspach, 1988; Mishler, 1984). For example, medical staff might list a patient's attacks on his wife as merely one of several social circumstances such as poverty, unemployment, and homelessness.

How psychiatric staff discuss and evaluate the social problem of interpersonal violence has, however, not been substantially investigated. This topic is of particular interest because current violence is a primary factor in determining a patient's "dangerousness" (i.e., the likelihood of inflicting further harm on others), which is in turn a mandated criterion for involuntary commitment to a psychiatric hospital (Mulvey & Lidz, 1985). Psychiatric staff are in a position to identify potential violence and assist with intervention to interrupt or prevent it (Appelbaum, 1988). The Surgeon General has, in fact, designated interpersonal violence as a major health problem in America, and has prompted the medical profession to expand its role in reducing the level of violence nationwide (Koop, 1985).

This paper reports the results of a study examining an initial and fundamental step in addressing interpersonal violence: the identification of violence in psychiatric case presentations. We analyzed psychiatric case presentations to determine the nature and extent of psychiatric staff's actual mention of the violence which was reported by emergency room patients. An understanding of this violence identification process may not only fur-

ther sociological assertions about the nature of medical discourse, but also point to changes in clinical practice that can help to address and reduce violence.

The psychiatric case presentation by clinicians to psychiatrists seems a logical place to begin an investigation of the psychiatric response to violence. The case presentation is a pivotal point in the psychiatric evaluation process, conducted in a psychiatric emergency room or diagnostic center (Shea, 1988). During the case presentation, the clinician reports information to be used in determining the patient's diagnosis and disposition. The case presentation, in the majority of cases, is also the basis of the written case summary that becomes the official record of the patient. In short, the case presentation is where the patient's situation is formally defined.

In these presentations, clinicians (psychiatric nurses and staff psychologists) summarize information about a patient collected during their initial interviews with the patient. The psychiatrist (or psychiatrist-in-training) uses this information to guide both his or her brief interview with the patient and his or her eventual diagnosis and disposition of the case. The psychiatrist's interview is usually used primarily to substantiate or clarify the clinician's preliminary assessment which was summarized in the case presentation.

Research on Medical Discourse

Sociolinguistic analysis of medical discourse has become an increasingly popular means to assess the interactions among medical staff and patients. This approach has only recently been applied to the discussion of violence by psychiatric staff. Nevertheless, studies of physicians imply that psychiatric discussions tend to neglect reported violence. Mishler (1984), for instance, analyzed the interruptions during medical interviews to demonstrate how physicians control information and constrain patients' discussion of their "lifeworld." Physicians are shown to interject questions that redirect the patient's focus, whenever a patient begins to elaborate on a social problem or condition.

Anspach (1988) specifically assessed the case presentations in gynecological examinations as a "sociolinguistic ritual." Her analysis revealed a series of rhetorical devices used to reinforce physicians' medical decisions and minimize patients' social problems. Medical practitioners, for instance, use account markers, (e.g., "The patient reports..." or "The patient claims that..."), which emphasize the subjectivity of a patient's comments. They

also commonly use euphemistic or vague terminology, such as "marital conflict" to refer to extensive physical assault by a partner.

The emerging research on the discussion of violence in medical discourse has, however, generally focused on larger contextual markers. Several studies on physicians' discussion and reports about injured women in hospital emergency rooms show a more basic oversight: There is little mention or question about the possibility of an assault by a family member (Kurz, 1987; McLeer & Anwar, 1989; Warshaw, 1989). As few as 6% of the injured women in one emergency room were identified as "battered women," in contrast to nearly 30% who were identified as having been assaulted (McLeer & Anwar, 1989).

The communication patterns and structure of the case presentations themselves contribute to the neglect of violence. This line of research suggests that case presentations are part of the professional socialization process. Physicians tend to interrupt or correct clinicians until their presentations conform to a set procedure—namely, summarizing the pathology of the patient (Anspach, 1988; Arluke, 1978). Moreover, case presentations generally follow a prescribed structure that reflects the established diagnostic axes (i.e., clinical syndromes, personality disorders, physical disorders, psychosocial stressors, and global functioning) (Waitzkin, 1989). Social aspects of a patient's case are usually presented, if at all, only after medical problems have been discussed (Frader & Bosk, 1981).

In summary, the sociolinguistic research on medical discourse has revealed a variety of conversational and linguistic mechanisms that serve to minimize social problems. This research has not, however, offered a clear indication of how violence is identified in the first place. There is some indication that the identification of violence in case presentations is likely to reflect the expected diagnostic format or structure of these presentations. Reported violence, like other social problems, is most likely to be relegated to a social circumstance secondary to the patient's medical problem.

Method

Sampling

This study is based on data collected as part of a research project on the clinical management of dangerousness (see Mulvey & Lidz, 1985). Data were collected on 392 psychiatric patients who visited the emergency room of a metropolitan teaching hospital during a 6-month study period in 1985-1986. The psychiatric patients in this study represent a wide range of ethnic and

class backgrounds comparable to those in other urban psychiatric hospitals (Klassen & O'Connor, 1988; Segal, Watson, Goldfinder, & Averbuck, 1988). Researchers were present during the entire psychiatric evaluation process, including patient interviews and staff discussions. Using a form of shorthand, they took verbatim notes of the psychiatric discourse for each patient. These notes were later transcribed and used as the primary data base for this study.

A sample of 92 recently violent patients was identified from the transcripts of the evaluation interviews. Any patient who reported having assaulted another person (as defined by the Conflict Tactics Scale [Straus, 1979]) within the previous three months was considered "recently violent." This time frame was used to identify cases whose assaults were of most clinical concern. The majority of reported incidents which occurred more than three months prior to the interviews were lacking details and a specific time. A period of less than three months would have excluded assaults that had received clinical response and mention in clinical records. (For further discussion of the temporality, frequency, tactics, and targets of the reported violence, see Gondolf, Mulvey, & Lidz , 1989.)

Seventy-seven (84%) of the 92 recently violent cases were examined further in a qualitative analysis of the case presentations. Fifteen cases (16%) were deleted from the original sample (n=92) for one of the following reasons: 1) they did not include a case presentation; 2) only one staff person was available during the evaluation; or 3) the patient was sent directly to seclusion or to the ward without an evaluation interview. Therefore, the final sample of recently violent patients with case presentations numbered 77.

Case Presentations

The case presentations were assessed in terms of how clinicians presented the patients' report of violence to the attending psychiatrists. As mentioned in the introduction, we conducted a contextual analysis of the violence mentioned or alluded to in the case presentation. The categorization of the mentioned violence is grounded in the conventional format of the case presentation, and reflects the generalizations asserted in previous discourse research.

Case presentations follow a set format, according to training textbooks (Shea, 1988) and discourse studies (Waitzkin, 1989). The format is generally organized to deliver information on the five diagnostic axes used in evaluating psychiatric patients. Some statement about the primary problem or chief complaint usually begins the presentation, followed by psychiatric

symptoms and history, and social history and stressors. In an initial review of the cases, we found that clinicians presented incidents of violence as part of one of these three topics—or not at all.

Two researchers then reread the case presentations, categorizing the mention of violent incidents into four categories. These researchers, who were not involved in the initial data collection, categorized the mentioned violence with at an acceptable interrater agreement level (Kappa< 80). The four categories were as follows:

1) The violence was mentioned or referred to as part of the primary problem, generally at the beginning of the case presentation. The primary problem was defined as the main reason that the patient came to the emergency room.

2) The violence was mentioned later in the case presentation as a symptom or stressor related to a psychiatric disorder. The violence was reported with symptoms of psychosis, depression, or alcoholism.

3) The violence appeared toward the end of the case presentation, as part of a list of social circumstances apparently unrelated to the primary problem. The clinician at this point would summarize the patient's social history with brief mention of other social circumstances, such as, school behavior, employment, family status, living arrangements, and criminal activity.

4) The violence reported in the initial clinician-patient interview was not mentioned at all in the case presentation.

Representative case presentations are offered in the findings section below to illustrate the identification of violence in case presentations and the use of conversational and linguistic forms in this process.

Findings

Violence as a Primary Problem

Clinicians mentioned the reported violence as part of the primary problem in over a third of the cases (37%; n = 28 of 77). The patient, or someone accompanying him or her, initially reported this violence in the majority of these cases, as opposed to the violence being disclosed through questioning or tangential remarks. In these cases, the patient was likely to have a long history of violence and to apparently be "out of control." Moreover, the case presentations with violence as a primary problem generally provided more details about the violence than cases characterizing violence as a symptom or unrelated incident.

In one exceptional case, the clinician devoted the majority of her case presentation to elaborating the patient's violence, only to have the psychiatrist counter with questions about medical diagnosis. The clinician was obviously concerned about a 250-pound man's outbursts of violence. Her case presentation indicated that the patient had viciously attacked several family members for no apparent reason. She reported that the patient had punched his 65-year-old father in the face, knocking him to the floor, and threatened him with obscenities, until an older brother managed to restrain him.

The clinician began the staff discussion of the patient with the following case presentation:

Clinician: It's a 29-year-old, black, single male. He's 302'd (involuntary commitment) by his father. The patient complains that his father kicked him and his girlfriend out of his house. He punched his father, stood over him and cursed. A brother stopped any more from happening. There were no reported problems up to a year and a half ago. He does report five or six years ago being arrested on charges brought up by another girlfriend for statutory rape, burglary, and a number of other things. His current girlfriend and he lived in his parent's home for six months and things were okay. Then he physically abused her and they argued a lot. He says his parents threw them out. On his return home, he became increasingly violent. He sounds paranoid. Beginning in April he's been out of control. His dad had him arrested for hitting his brother with a pipe and smashing the minister's car window. The past few weeks he has increased in agitation.... The family is really scared of him; they don't want him back.

The psychiatrist responded to this case presentation with several questions about the patient's psychopathology: Does he take his medication? Is he a problem drinker? Any clear episode of manic activity? Any depressed episode? As the staff discussion proceeded, the clinician once again interjected her concerns about the violence:

Psychiatrist: The little I hear, it sounds like psychotic paranoid stuff.
Clinician: He is grandiose and psychotic.
Psychiatrist: We could call him paranoid schizophrenia.
Clinician: He's obsessed with his girlfriend. He probably attacked her.
Psychiatrist: He needs to be in the hospital for medication.
Clinician: The family doesn't want him back. They are scared.
Psychiatrist: We can commit him to one of the state hospitals. Well, I'll go say hello and welcome him to hospital life.

The clinician was obviously concerned about the patient's potential for unprovoked violence. Even when the attending psychiatrist turned the discussion to the psychiatric disorder or treatment ("We could call him para-

noid schizophrenia," and "He needs to be in the hosital for medication"),
the clinician returned to issues related to the violence ("...He probably
attacked her," and "...They are scared"). She later warned the psychiatrist
to take precautions in the psychiatrist-patient interview, including contact-
ing the security guards. The psychiatrist asked the patient eight or nine
questions about his medication, announced that the patient was to be com-
mitted, and had the patient escorted to the assigned hospital unit. The psy-
chiatrist, however, did not ever specifically acknowledge the violence,
investigate it, or explicitly consider the safety concerns expressed by the
clinician.

Violence as Symptom of a Psychiatric Disorder

Violence was presented as a symptom of a psychiatric disorder in
approximately one-eighth (13%; n = 10 of 77) of the case presentations of
recently violent patients. It was most commonly associated with chronic
schizophrenia, alcoholism, or major depression. The clinician's presentation
of the patient's violence generally occurred relatively early in the presen-
tation, and was presented with other symptoms, such as hallucinations or
suicide attempts. The description of violence in these cases tended to lack
detail and to use vague terms to refer to the violence.

In one example, a woman came to the psychiatric emergency room and
provoked a physical fight with another patient in the waiting area. While
being interviewed by the clinician, the patient swore profusely and accused
the staff of being "evil." The clinician alluded to this behavior at the out-
set of the case presentation, but implied that the patient's "abusiveness"
was linked to the patient's disorder rather than being a primary problem.

Clinician: Ms. L. is an 18-year-old, white, single female. She just got out
of Bellevue Hospital in New York. She is real abusive, very loose in asso-
ciations, and real psychotic. The medicines that she is on now are Lithium,
Navane, and Norpramin. She reports an overdose on Lithium; she won't
say how many she took, just "a lot." She seems real angry and very irri-
table.

Psychiatrist: Do we know anything about her?

Clinician: Yes, she was admitted in July. She went to the ninth floor,
then moved to the tenth. She was diagnosed as an atypical psychotic. She
also suffers from some type of venereal wart. Apparently she went home
after she was in New York , but experienced some type of problem with her
father. She spoke with a lot of hostility during the interview. She did
report that she would get suicidal again unless she got what she wanted.

Psychiatrist: Is she alone?

Clinician: No, she's with a boy called _____. She says that we can't talk to him because it's her right to keep her case private. Like I said, she is very agitated.

In the above example, the clinician's presentation indicated that the patient was abusive, but presented this as only one of several symptoms of psychosis. No details of the "abuse" were mentioned. Moreover, the clinician mentioned three times that the patient was hostile or agitated during the interview, but she did not mention that the patient had provoked a physical fight in the waiting area and had to be restrained by security staff. The clinician did, nevertheless, specifically recommend that the patient be involuntarily admitted to the psychiatric facility, and the psychiatrist agreed. This action was apparently taken because of the patient's psychosis rather than because of her violence.

Violence as an Unrelated Incident

In thirty percent (30%; n = 23 of 77) of the recently violent cases evaluated in the emergency room, clinicians presented the violence as unrelated to the primary problem. The violence was mentioned as part of a list of social or personal circumstances: "The patient has experienced long-term unemployment, lives on the street much of the time, and has a history of fighting." The reference to violence was again generally vague, rather than providing details of what was discussed in the clinician-patient interview.

The following example illustrates the identification of violence as an unrelated incident. An agitated patient visited the psychiatric emergency room because of a fight in his neighborhood. He reported ripping off the ear of his adversary, who was in the hospital at the time to have stitches for the injury. The patient explicitly stated during the clinician-patient interview that he was, as a result, very angry and thinking about retaliating in some way. The clinician specifically mentioned both the past incident and present hostility but with an account marker and without elaboration.

Clinician: This guy is Mr. R_____ who's a 23-year-old black, single male. He lives with his mom and dad. He wasn't on meds when he was here before. He's into heavy drugs and alcohol. He was in the emergency room about two months ago and his referral was to a private doctor. Previous diagnosis—substance abuse. He has been living on and off the streets; no job history to speak of. A history of physical problems. He

complained that he was angry and feeling out of control. He claims he hurt someone that he fought with.

Psychiatrist: So, anyway ...

Clinician: Anyway, this is what we've got.

Psychiatrist: Is this guy still in with his mom?

Clinician: Yeah, he said he had five days of sobriety but he's been smoking marijuana. He said he had two drinks tonight but I think he's had more. He has a history of five months of treatment at a county alcohol and drug treatment facility, and says that drugs and alcohol are not his problem. He says he's depressed. His symptoms include his being "evil," and he says that he "hates everybody" and that he "doesn't smile much." He says he has been unable to cry for seven years. He also said that, when he was in here before, he was not medicated for depression.

Psychiatrist: Does he have any other symptoms of depression?

Clinician: I didn't ask him about sleep and appetite. I didn't feel that there was a need at that point. He's telling me he's feeling violent and is thinking of beating up the other person.

Psychiatrist: Is he seeing a counselor?

Clinician: No. He was referred to outpatient treatment on August 13th. Somehow then he got referred to Dr._____. The patient says the doctor thinks he's a pervert and he's not a pervert, so he's not going to see him again.

Psychiatrist: I'm going to go ahead and see this guy.

In the above example, the presenting problem was the patient's violence. He was, in fact, brought to the emergency room because of a physical fight with a neighbor. The clinician's case presentation focused on the patient's polysubstance abuse and treatment, despite the patient's insistence that drugs and alcohol were not the problem. There was no inquiry about the circumstances or frequency of the violence, as might be expected in an assessment of dangerousness or lethality. The psychiatrist inquired about "other symptoms" in an apparent effort to obtain more information for a diagnosis.

The patient was admitted voluntarily to the psychiatric facility with the diagnosis of mixed substance abuse, and with no advisement regarding the patient's violence. The attending psychiatrist stated, in fact, that this patient did not really need to be admitted. The violence, by implication, was reduced to a secondary issue or circumstance.

Violence Not Mentioned

One last means of dealing with reported violence was not to mention it at all. The clinician did not mention the patient's violence during the case presentation in one-fifth (21%; n = 16 of 77) of the recently violent cases. The extent, type, or immediacy of the reported violence did not appear to influence the oversight. For example, there were at least three instances in which patients were assaultive in the waiting room and yet the incidents were still not mentioned.

In the following example, a patient was referred to the psychiatric emergency room by a psychiatrist. The patient told the clinician at the outset of the clinician-patient interview that he had been involved in several street fights and that was why the psychiatrist referred him to the emergency room. However, there was no reference to the violence in the case presentation.

Clinician: This is a very straight-forward case. Mr. F. is a 30-year-old, divorced male. He went to _____ University on a baseball scholarship and got his psychosis there. Apparently Prolixin does well for him. He showed up in the emergency room and has been started on Lithium.

Psychiatrist: Does he get bad to the point of seizures?

Clinician: No. He is very alert mentally. He can do all the problems we gave him. However, he does have some type of problem with his speech. Apparently he wants to play pro-ball. He does agree to come into the hospital. He is on SSI (Security Supplemental Income).

Psychiatrist: Oh, so all I really need to do is say "Hi."

Clinician: Yes, they know him up on the floor too.

Psychiatrist: You might want to send along to the floor some information about possible seizures. They may want to know what to do if he goes "goofy."

Clinician: OK.

Psychiatrist: OK, I'll see him.

In this case presentation, the clinician focused on the patient's pathology. He made no mention of the patient's violence, even though the violence was the main reason why the patient had been referred to the hospital. The subsequent staff discussion suggests that the staff believed that the patient's violence was a symptom of his seizures. Nevertheless, there was no specific elaboration of this point or of the potential danger his behavior posed for others. Yet, the patient's fighting was at least sufficient to have drawn the attention of the outpatient psychiatrist. The patient was admitted voluntarily to the hospital for further evaluation and medication.

Discussion

We reviewed the case presentations of 77 psychiatric patients who reported having committed an assault within the previous three months. In nearly two-thirds of these "recently violent" cases, the violent incidents were not presented as part of the primary problem. The violence was more often presented as a symptom of a psychiatric disorder (13% of the recently violent cases), as an unrelated incident (30% of the cases), or not mentioned at all (21%). Moreover, the urgency of the violence was obscured by account markers and vague terminology, agreeing with previous linguistic studies (Anspach, 1988). Overall, the clinicians focused on individual symptoms related to mental disorders rather than on social problems, such as violence.

In the case study of violence as a primary problem, the clinician's concern about the violence was made explicit throughout the case presentation. This case presentation may, in fact, be atypical in that the clinician deviated from the conventional evaluation structure to emphasize the patient's dangerousness. As in previous research on medical discourse, the psychiatrist used interruptions and questions to direct the case discussion back to symptomatology (Arluke, 1978).

These findings support the theoretical assertion that the medical orientation tends to obscure social problems either through medicalization or through minimization (Conrad & Schneider, 1980; Mishler, 1984). Our analysis suggests, in particular, that the medical structuring of case presentations relegates reported violence to a secondary priority or tangential descriptor, as Waitzkin (1989) has argued. In the process, a major criterion for involuntary commitment into a psychiatric facility may be slighted. Neglecting the reported violence may inadvertently condone the violence and allow it to continue, and even to escalate.

Our research suggests that a structural modification of case presentations could address this problem. Given the public safety and treatment issues involved, a clinical protocol for reported violence should be established. Clinicians might be required to present patient violence with the same thoroughness with which they usually present reported suicides. The circumstances, tactic, severity, target, temporality, and frequency of past violence might be routinely reviewed and assessed. Furthermore, referrals might be systematically made for both perpetrators and potential victims to appropriate human services programs, such as batterers' counseling or women's shelters. Potential victims might, additionally, be advised of appropriate protective services in the criminal justice system, such as "protection orders."

There are four methodological issues that should be weighed in future research on this important topic: 1) The clinicians' implied meanings and attending psychiatrists' unspoken interpretations of reported violence might be investigated. Perhaps psychiatric staff are implying serious concern regarding violence in the diagnoses they give. 2) The reported violence might be compared to verified accounts, since some of the reported violence may be delusional or exaggerated. The current studies on violence assess the mentioned violence at facevalue, whereas psychiatric staff may appear to neglect it because they doubt the patients' reports. 3) The relation of linguistic mechanisms used in minimizing violence to the categories of mentioned violence, derived in our study, might also be more systematically examined. Is the mention of "violence as an unrelated incident," for instance, structured in a consistent way? 4) Future research might also consider the disposition, treatment, and safety consequences of the medicalization, minimization, or neglect of violence in psychiatric case presentations. In other words, what is the actual impact of the practices noted in the current study?

At the very least, our contextual analysis indicates that the identification of violence in psychiatric case presentations warrants further sociological exploration. Our findings substantiate previous research on medical discourse that imply a neglect of patient social problems. Specifically, these findings raise concern about the clinical response to violent psychiatric patients. More needs to be done to insure that violence is sufficiently identified and assessed. This is especially the case given the increased threat to potential victims and jeopardy to public safety in general.

ACKNOWLEDGMENTS

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