Narrativity and clinical reasoning: A case study of the psychiatric assessment of an Iraqi refugee

Dr Pauline Savy
Faculty of Humanities & Social Sciences
La Trobe University
Victoria
p.savy@latrobe.edu.au

Dr Anne-Maree Sawyer
Faculty of Humanities & Social Sciences
La Trobe University
Victoria
a.sawyer@latrobe.edu.au

Abstract:
This paper highlights the problem of ‘place’ for an Iraqi refugee who, for years, had been tortured and imprisoned in his home country. The paper presents a case study of a clinical encounter with this refugee, whose relatives sought to have him ‘put away’ for ‘threatening’ behaviour through the psychiatric intervention of an Australian Crisis Assessment and Treatment Team (CAT Team). Our analytical starting point is that the narrativity of the encounter is situated and realized within the institutional circumstances of a risk-oriented, psychiatric assessment. We construct and analyse the case study to illustrate the interpretive machinery of ‘clinical reasoning’ and in particular the tension and play between ‘paradigmatic thinking’ and narrative thinking’ (Mattingly 1991). Our analysis follows the work of social scientists (notably Behar 1996; Frank 2001; Kleinman 1995; Hydén 1997; Skultans 2004; Wilkinson 2005) who seek to expand methodologies for writing about human suffering.

Introduction
Countless people have fled civil disorder, war and torture in recent decades. The physiological and psychological consequences of displacement and exile are well documented in socio-anthropological and psychiatric literature (for example, Pupavac
2004; Momartin et al. 2003). Common themes include estimates of psychological illness of refugees, the medicalisation of distress, and the moral panic engendered by politicians and the media (Steel et al. 2002; Jupp 2002; Leach 2006; Wazana 2004). Limited theoretical attention has been paid to the experience of displacement and, by implication, to suffering and the social pathologies that produce it (Skultans 2004: 292; Wilkinson 2005). We see that this lack of attention, combined with the pathologising of experiences of displacement (Pupavac 2004) amounts to denial of refugees’ stories, their suffering, and their resilience.

This paper was conceived during reflections on a ‘case’ attended by one of the authors who works as a social worker in a Victorian-based CAT Team. We re-present and analyse the clinical encounter to illustrate the tension and play between ‘paradigmatic thinking’ and ‘narrative thinking’ (Mattingly 1991). That is, we explore the uncertainty of clinical or ‘paradigmatic thinking’ as it exposes the problem of sense-making within the task of clinical reasoning, and within the interpretive parameters of a particular narrative environment.

We begin by outlining our theoretical footing which incorporates the relevance of risk discourse (Rose 1998) within the provision of psychiatric crisis services, and selected strands of narrative theory. We move on to analyse the case and to conclude by urging sociologists to contribute to critical analysis of the social situations and the suffering of those who are fearful, tortured and displaced at the hands of de-humanising political regimes (Wilkinson 2005).

Theoretical background: risk discourse and narrative theory

Structurally and operationally, health and welfare services reflect the ascendancy of risk discourse. Over the past two decades, the containment of risky individuals has become the central criteria for prioritising and rationalising services (Rose 1998). In Victoria, CAT Teams provide a frontline, psychiatric service in which the asseessment of risk has become increasingly central to the treatment of clients. CATT clinicians assess adults deemed to be at risk of harming themselves or others. Following assessment via history-taking and application of a standard mental state examination and risk assessment they tailor a ‘management plan’ that may include admission to a psychiatric inpatient unit,
referral to a mainstream health or welfare agency, or a series of home visits by CATT clinicians.

A substantial literature elaborates the re-contouring of professional practice as a shift from care and therapy to administration and surveillance (Rose 1998: 183; Kemshall 2002: 97; Harper 2004: 409; Green 2005; Sawyer 2005). These authors argue that risk-oriented assessment and treatment plans transform the obligations and subjectivities of mental health practitioners. In short, traditional forms of professional action and judgment such as short-term counseling and support are sidelined (Brown 1987; Rose 1996: 15; Clare 1999; Sawyer 2005). Some argue that risk ‘logic’ creates new forms of exclusions; many clients receive minimal professional input and those classified as ‘low risk’ are rejected, minimally supported, or left to their own devices or to the goodwill of family and carers (Green 2005: 3, 5).

To recognize, reflect on and represent illness narratives, researchers must take into account the situatedness of their emergence. For example, in the case of institutional settings, clinicians work from particular definitional, discursive imperatives to make clinical sense of illness. Prepared through their professional discourses, clinicians work with and on the stories told by clients and their families. They are trained to listen empathetically for signs of pathology and they are qualified to institute controlling modes of treatment. Thus, they practice across two quite distinct, seemingly oppositional ways of thinking.

Following Bruner (1986, 1990), Mattingly (1991) elaborates these two modes of clinical thought as **paradigmatic thinking** and **narrative thinking**. Paradigmatic thinking emerges from propositional arguments and generalizations and leads clinicians to understand a particular case as an instance of a general type (Mattingly 1991: 998-9). For clinicians, causal clinical reasoning frames assessment as they try to fit individual symptoms into the ‘certainty’ of diagnostic explanation (Mattingly 1991: 999). In contrast, clinicians employ narrative thinking when they pursue ‘likely connections among particular events’ (Mattingly 1991: 999) to understand a client’s experience in terms of social and personal implications. These two modes may be conceptualized as distinct but we illustrate here that, in practice, both may appreciably be in play together as clinicians, in collaboration...
with clients, ‘actively struggle to emplot clinical encounters by enfolding them into larger developing narrative structures’ (Mattingly 1994: 811).

In the analysis of our case study, we regard the work of the clinicians present as their search for a narrative (Ricoeur 1984). Following Mattingly (2000) we attempt to grasp the beginnings of a narrative as it emerges from the particulars of the social situation. We uncover the interpretive machinery that operates in what Ricoeur (1984) calls the pre-configurationial phase, or those moments of the encounter that await meaning-making work to bring order and a point of closure to the episode.

The clinical encounter

The following summary is presented in the words of the author who attended the assessment of Adil with another clinician.

Adil, a 70-year old Iraqi man, has been brought into the unit by his nephews for a psychiatric assessment. Adil arrived in Australia as a refugee six months earlier. According to the referral note, after attending his brother’s burial yesterday, Adil had violently ‘attacked’ a relative. The note referred to Adil’s ‘aggressiveness’ and ‘abusiveness’ towards relatives since arriving in Australia. Adil’s nephews say that he is mad, they will no longer keep him, that he must be ‘locked away’.

We need to determine whether Adil has a mental illness and, if so, whether to institute hospitalization or community treatment. Adil speaks no English, so we have an Arabic interpreter present. We ask for Adil’s account of the previous day. His nephews prevent this by interjecting frequently. When Adil suggests that his return to Iraq is inevitable, they agree: ‘Send him back to Iraq. Or put him on the streets’. We ask them to leave the room while we continue the assessment.

We learn a little of Adil’s history. His wife died in childbirth, along with their only child, in the 1970s. Shortly after, Adil was drafted to fight in the Iran-Iraq war. He was imprisoned in Iran for over ten years. One year after returning to Iraq, he was imprisoned again for another ten years. Inside, he was subject to the basest forms of humiliation, torture and deprivation. His body bears shrapnel and torture scars. He witnessed the killing of fellow prisoners. Adil weeps as he says that he has no relatives to whom he can return in Iraq, and no-one here to look after him. Aside from this, Adil remains calm and polite during the interview.

We find no symptoms of major depression, mood disorder or psychosis. Although Adil voices persecutory thoughts about the family, these are not of delusional intensity. He denies any suicidal or homicidal ideation. We have no recourse to a medical or psychiatric history. We focus on the context of Adil’s personal history and speculate that the reported aggressive and ‘hyper-vigilant’ behaviours are probably the result of the everyday brutalities of prison life.
After the assessment, we report to Adil’s relatives that we found no symptoms of acute mental illness, and that we are unable to hospitalize him. We offer our interpretation of Adil’s excessive and violent reactions to situations but Adil’s relatives are unmoved and tell us again to ‘turn him onto the streets.’ We must find a place for Adil who, since the death of his brother who sponsored his migration, has no citizenship rights. If we request assistance from the Immigration Department, might he be repatriated to Iraq? Our options are narrowed to locating a bed for Adil in a supported accommodation facility for homeless men.

A sociological account of the case

This summary of the encounter provides a variety of substantive materials for analysis. As an interview conducted by health professionals, the local narrative environment, the talk and motives that constitute the interaction, and the institutional discourses, particularly those concerning bio-medicine and risk that shape the action, are substantial, well-conceptualised elements (Davies 1981; Drew and Heritage 1992; Mishler 1986; Rose 1998). We draw from such conceptualizations to establish the encounter, and its narrativity, as situated and realized within a set of socio-cultural circumstances. These circumstances, Adil’s predicament, the family’s demands and the clinical task at hand are at once the background reality of the occasion, and the pre-narrative materials for storying it. Regarding the encounter this way, our analysis gives substance to the subjective, interpretive work involved in framing and bringing the episode’s unruliness and uncertainties into the ‘wholeness’ of a narrative, to enable it to become a ‘followable story’ (Patterson 2002: 77).

The family’s demands and the absence of case notes hampered the clinicians’ efforts to follow regular procedures and develop their psychiatric assessment of Adil. The assessment did not reveal major depression, psychosis or mood disorder; the clinicians were unable to diagnose his situation in psychiatric terms. They concluded that Adil posed no risk to himself or to others and so did not meet the criteria for admission to hospital. For all parties, the situation remained unresolved.

Such ambiguity around diagnosis and outcome is usually masked by clinical judgments and techniques of certainty that erase the meaning-making processes, and the clinicians’ efforts to tie together disparate pieces of information, to ‘articulate the illness and illness events as a meaningful whole’ (Hydén 1997: 61). The certainty achieved, however, does
not imply that what was uncertain becomes certain. Rather, certainty in clinical assessment refers to the discursive tools and processes that accomplish diagnosis, establish the person as a ‘case’, initiate a course of action, mark the clinician as a member of a particular profession, and legitimate and reproduce the frame from which the reasoning proceeds (Lingard et al. 2003).

For narrative theorists, the accomplishment of a biomedically-oriented diagnosis eclipses the lived experiences of a patient’s distress and suffering (Frank 2001; Kleinman 1995; Hydén 1997). However, in Adil’s case, the absence of diagnosis does not mean that his world of experience fills the interpretive void. Within the paradigmatic frame of assessment, the clinicians cannot use Adil’s account because it fails to confirm the presence of psychiatric symptoms. Thus Adil is represented in the clinical notes through his absence of psychiatric symptoms, as neither sick nor suffering. The notes sanitise his situation, obliterating human meaning and distress, dispensing the chaos of the encounter and producing it as neat and ‘closed’. In the same way, this record of absence masks the clinicians’ uncertainty.

The contemporary context of crisis psychiatry demands that clinicians work at producing an emplotment of risk, as opposed to a therapeutic emplotment (Mattingly 1991; 1994) of the client’s presenting problem and history. As they gain a history of the person’s self-harm and assess current propensity for self-harm, clinicians’ deliberations are recorded as discrete symptoms. Adil is clearly disadvantaged by his ‘low risk’ status, excluded from CAT Team service provision (see Green 2005). There is no avenue for the CAT Team clinicians to respond to Adil’s needs, except to move him on to a homeless men’s shelter.

Using narrative thinking (Mattingly 1991), the clinicians pull elements of Adil’s story into a particular frame or province of meaning (Davies 1981) to make sense of his present situation. Their assessment imaginatively takes in Adil’s past history of imprisonment and torture, rather than focusing narrowly on recent events and behaviours through the formal assessment tools. They see that the conditions of Adil’s life, past and present, are inseparable; the trauma he has endured may be past history in a temporal sense but it continues to matter, to profoundly influence his ongoing experience (Patterson 2002). The cruelties and horror that, for many years, constituted Adil’s daily world, place him in
a liminal place beyond the ordinary comprehension of the clinicians. But what they do recognize in his story is a sense of injustice; Adil’s life should not be like this. Now, in their country, and with their help, his suffering should recede.

Conclusion

Our analysis illustrates and explores the concepts of ‘paradigmatic thinking’ and ‘narrative thinking’ (Mattingly 1991) as these interpretive modes constitute the clinical means for imposing order and meaning. We argue that the relationship between these two ways of reasoning can be understood as a subjective space marked by tension, play and struggle. It is a pre-narrative or pre-configurational space (Ricoeur 1984) where the natural fibres of uncertainty and ambiguity await discursive synthesis or emplotment.

There is no place in the assessment documents for writing about human suffering: such an account is effectively frozen out by biomedical and risk categories (Kleinman 1995: 100). The narrative, as the clinicians emplot it, is an attempt to counter this lack of interpretive space through narrative thinking. It conveys the unspeakability of Adil’s suffering – the protracted marginality of his life. As Arthur Frank might put it, the narrative conveys that Adil experiences himself ‘on the other side of life as it should be’ (Frank 2001: 355). Yet, the trauma narrative does not resolve the matter for Adil whose sorrows, displacements and social abandonment continue.

The case study illustrates the possibility of individuals ‘falling through the net’, losing their hold on a meaningful social place, when standardised assessment fails them. We conclude by urging the adoption and extension of methodologies that will contribute to a ‘sociology of suffering’ (Wilkinson 2005) and importantly, to raise awareness of the plights of politically abused and displaced persons and their global connection to us.

References


Footnotes

1 Malnutrition, low life expectancies and rampant diseases are predictable outcomes of civil upheaval and displacement, as is marked psychological distress (Pupavac, 2004: 162).

2 CAT Teams are staffed by psychiatrists, psychiatric registrars, psychiatric nurses, social workers, psychiatric nurses and occupational therapists who work shifts to deliver an extended hours service, seven days a week.

3 The mental state examination refers to the well-established set of observations and questions that are used by psychiatrists and mental health clinicians to determine whether a person is suffering from a mental illness. ‘Behaviour’, ‘thought form’ and ‘mood’ are examples of such categories of observation.

4 Home treatment can extend from less than three days to two months, though most clients are discharged from the service within three-four weeks.
5 Adil is a pseudonym.