Comment on “I’m Virtually a Psychiatrist: Problems with Telepsychiatry in Training”

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To the Editor:

We read with interest Dr. Scott’s reflection on difficulties with telepsychiatry as a learner [1]. The author highlights that “telepsychiatry changes communication, most readily evident in technical limitations” [1]. We agree that telepsychiatry has changed communication; however, we would highlight the *technical opportunity* for psychiatrists to now have an unprecedented view of patients’ within their own homes [2]. This newly obtained information influences how we understand a person and their experience of mental illness, informing our diagnostic impression and recommendations. In this way, telemedicine created a new component of the psychiatric mental status examination (MSE)—“the milieu.”

Since Adolph Meyer’s development of the standardized MSE in 1918, it has been refined from a free-form narrative to a more operationally defined approach [3], with components such as appearance, perceptual disturbances, and insight. Significantly, the MSE rests upon the premise of consistency in other areas of the interview, such as the interviewer and the office backdrop. Yet, telemedicine disturbed that regularity. Patients choose their setting, whether that is in a vehicle or in their bed. Resembling other components of the MSE, these choices are often guided by psychological factors and social circumstances outside of control. As a result, we can glean unique information from standardized exploration of a person’s milieu.

The term *milieu* was selected because it highlights both the physical and social natures of a person’s observable context. Unlike the words, setting or background, milieu also resists the portrayal of the individual as a character on a computer screen. Although unlikely to be exhaustive, four

qualities of milieu could be examined: (1) physical space (e.g., location, orderliness), (2) social environment (e.g., privacy, interruptions), (3) interpersonal interactions (e.g., with family members or roommates), and (4) variation in setting (e.g., individual moving to different locations during the course of interview). As an example, the milieu of a 42-year-old male financial advisor may be described as, “Mr. X is situated in an orderly bedroom with frequent interruptions from his partner. During the assessment, he asks his partner once to stop entering the room. Thereafter, knocks continue. Mr. X spontaneously moves to a nearby clean bathroom and locks the door.” From attending to Mr. X’s milieu, the interviewer has learned important information about how he maintains the physical space, his relationship with his partner, and how he handles conflict. With other elements of the assessment, these details may influence the diagnostic impression or subsequent recommendations.

This development of the MSE expands its scope. The current MSE focuses on the individual as an independent person, while adding milieu situates the patient in their surroundings and relationships, akin to the adaptation of individualistic autonomy to relational autonomy [4]. By incorporating social factors into the MSE, clinicians extend the bio-psycho-social model to psychiatry’s physical exam. A second effect is that it encourages psychiatrists to deeply consider the social circumstances influencing a clinical presentation. How do social determinants of health like culture, poverty, or familial relationships affect this person’s depression or anxiety disorder? A third implication of carefully observing the milieu may be enhanced care for those experiencing intimate partner violence (IPV). As highlighted by MacMillan, Kimber, and Stewart, “IPV is often not obvious” [5]. Explicit attention to the milieu (including privacy) may offer opportunities for recognition and safe assessment of IPV.

Some may fear attending to milieu leads to inevitable negative judgements of living environments. However, most psychiatrists already record other elements of the MSE, such

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as speech, thought process, or affect, without prejudice. It is likely that most psychiatrists would make observations of milieu in a similarly objective manner. Others would appropriately note that clinicians have a narrow view in an assessment, often of a single portion of one room. It would be inaccurate to characterize the whole milieu from just this view. Yet, this is how many elements of the MSE already exist. A patient's affect or attitude could be drastically different outside of one specific interaction. This limitation is important to consider but could be readily addressed through repeated assessments. The MSE is not interpreted in isolation but with information from the history and prior assessments.

The introduction of milieu into the MSE creates several unanswered questions, including:

What observations could be made about milieu?

How should clinicians optimize observations of the milieu during their assessments?

How should clinicians interpret these observations for diagnosis and management plans?

The COVID-19 pandemic has created several barriers to the delivery of effective psychiatric care. Still, in these periods of disruption, there are chances for improving long-standing approaches to care. Including milieu more consistently in the MSE may be one such advance that warrants scrutiny.

Declarations

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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