

CHAPTER 1.

INTRODUCTION TO PSYCHIATRY

Aim and definitions

The aim of the DOP is to present the basics of mental disorders. The target population is medical students, but general public readers may also find it useful. The mental disorders form a huge, mysterious and problematic body of knowledge. They also indicate a huge body of ignorance, and represent a major challenge to contemporary science, government and humanity. When the less severe forms are included, more than 25% of the people in western populations will experience a mental disorder at some time in their lives (The World Health Report, 2001).

The terms mental disorder, mental illness, mental disease, psychiatric disorder, psychiatric illness, and psychological illness, all mean much the same. These terms refer to a group of recognized medical conditions in which the central feature is psychological distress or disability.

There are no satisfactory definitions of these umbrella terms. This is not a great concern, however, as while the definition of mental disorder may be elusive, there is universal agreement about the specific disorders which are covered by these headings. There is agreement, for example, that schizophrenia, bipolar disorder, major depressive disorder and obsessive-compulsive disorder are among the mental disorders, and armed robbery, chicken pox and being old are not.

Classification systems

Currently, there are two main classification systems which are used around the world. Both were composed by large teams of informed professionals using extensive resources. These separate teams have also worked together, so that their documents are very similar, or the same, in most aspects.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, was published by the American Psychiatric Association in Washington, DC, in 2002. It is widely used, and was designed for clinical and research purposes. For convenience it is usually referred to as the DSM-IV.

The other major classification system is the International Classification of Diseases, Edition 10, Classification of Mental and Behavioural Disorders, which was published by the World Health Organisation in Geneva, in 1992. It is usually referred to as the ICD -10.

This can also be used in the clinical setting and is used in this way in Great Britain. However, in many parts of the world (Australia, for example) it is predominantly used for administrative purposes, for example, as a tool in the counting of the number of cases of particular disorders in particular populations, and in keeping track of the type of services being provided in particular regions.

Symptoms, signs and syndromes

These terms are used in all branches of clinical medicine. If you wake up one morning with a severe pain in your big toe, that is a symptom – a symptom is something the patient notices and usually complains about. If your toe was swollen, red and tender to touch, these are signs – signs are observations a doctor can make during an examination.

Symptoms and signs usually form patterns. Recognising a particular pattern (thereby identifying the precise disorder which the patient is suffering) is called making a diagnosis. The most likely disorder in the case of the painful, swollen, red, tender big toe would be gout. For some disorders special tests, such as blood or X-ray examinations, may confirm the diagnosis. Unfortunately, at this time, there are no special tests which confirm the presence of particular mental disorders. However, special tests may be used to exclude certain conditions, such as brain tumours, which may have similar signs and symptoms to a mental disorder, such as schizophrenia.

The term syndrome also refers to a set of signs and symptoms, and for present purposes, it can be considered to mean much the same as disorder. Technically, the term syndrome is used when there is some doubt and doctors are not able to diagnose a specific disorder.

No single symptom is found in only one disorder. A pain in the toe may be the result of a broken bone, an infection, a form of arthritis other than gout, pressure on a nerve in the back or a brain disease. A pain in the toe may even occur when the toe and the entire leg has been amputated years previously.

Rarely is a single sign found in only one disorder. A leg bent at right angles following a motor bike accident strongly suggests a fractured bone. But other possibilities would include dislocation of the knee, or the individual may have escaped injury to the lower limb, but carry a congenital deformity of the leg.

Thus, to diagnose a disorder, even with relatively straightforward medical conditions, it is necessary to collect all the available symptoms and signs and to match them with patterns which have been sanctioned by panels of experts (such as the DSM-IV and ICD-10).

There is a wide range of psychiatric signs and symptoms. Examples of psychiatric signs include disturbances of mood (sadness/depression, elation/mania, fear/anxiety), delusions (beliefs in the absence of evidence, such as, that one is being watched by aliens) and hallucinations (perceptions in the absence of stimuli, such as hearing voices when none is present). Examples of psychiatric signs include disturbances in behaviour (slowed,

rapid or bizarre movement, or inappropriate crying or laughing) and disturbances in thought processes (distractibility or inability to think in a logical manner).

Different mental disorders have different patterns of symptoms and signs. However, as no symptom or sign occurs exclusively in any single disorder, the diagnosis in a particular case depends on the nature and pattern of the signs and symptoms present at the time of assessment. For example, schizophrenia, mania, drug induced psychosis, and major depressive disorder, may all present with delusions. The nature of the symptom may give some clue (but this can not be given too much weight): the person with schizophrenia is more likely to believe he is being followed by spies, the person with mania is more likely to believe he is the richest person in the world, the person with drug induced psychosis is more likely to believe he is being watched by the police, and the person with major depressive disorder is more likely to believe he is guilty of neglecting his responsibilities. The combination of the signs and symptoms gives the most accurate answer. While the deluded person with schizophrenia is more likely to be also hearing voices, the deluded person with mania is more likely to be also unable to stop talking and the deluded person with major depression is more likely to be also wringing his hands and attempting to hang himself.

Accordingly, this download will describe some common signs and symptoms in detail, as well as cover the main mental disorders.

Faking it

We will consider the topic of faking mental disorder in greater detail in later chapters, but it is worth briefly mentioning this topic at this early stage. For some reason, those of us who are well can be suspicious of those of us who are not well. Perhaps we are concerned that those who are unwell are getting an unfair advantage by being excused from the usual responsibilities of life, such as going to work, or are getting undeserved attention from their families and important people (like ourselves). Perhaps some of us lack confidence and are concerned that we could be being “made fools of” by some of those who are unwell. Concern that people may be faking being unwell is greater with mental disorders than with other medical disorders. This is probably because in mental disorders there is less for the observer to observe. At some point most people with a mental disorder say they would prefer to have broken leg or to have lost an arm, so that others could then “see” they have a genuine problem.

The most pressing desire of people who are incapacitated by mental disorders is to return to a “normal” life, and that means returning to active parenting, dressing in style, going to work and paying taxes. Any small advantages of the sick role are generally greatly outweighed by the disadvantages.

The patient who is suffering major depression is not being self-indulgent or mischievously seeking attention. In this disorder the mood is low and distressing, and recovery is beyond the control of the patient. He or she is incapable of responding to the

advice to “pull yourself together” or “snap out of it”. This disorder may be so severe that the patient commits suicide. This can happen to an individual who, when well, would not contemplate such action because of family responsibilities, or on religious or moral grounds. (However, suicide can occur for reasons other than major depression.)

The patient suffering delusions is not pretending to believe things which others find laughable. He or she may be so convinced of the truth of their belief that suicide is seen as the only option, or innocent others, even loved family members, may be verbally or physically attacked. The patient with obsessive-compulsive disorder who has washed his or her hands ninety nine times will usually readily agree that logically, his or her hands must be clean, but may be unable to resist the compulsion to wash them one or many more times. More common examples include patients who are suffering anxiety (butterflies in the stomach, tremor of the hands, headache, worrying and irritability), who know they have nothing to fear, but cannot shake off the symptoms which are appropriate to dangerous situations.

We are what we think, feel and do. We pick up real signals from the external world (not hallucinations) and respond appropriately. These abilities form our essence or being, they are central to our ability to function logically, independently and in accordance with our own plans and decisions. They enable us to function as autonomous (self-governing) individuals. Mental disorders, however, interfere with the individual's ability to interpret the world accurately, to feel appropriate emotions, to think, to plan and to act appropriately to our external and internal circumstances. To lose a leg is a terrible loss, but to suffer a mental disorder is to lose the sense of control, the sense of autonomy, of being a human being. It is no wonder that mental disorders are greatly feared.

Mental versus physical disorders

People develop disorders, not minds or bodies. The division of disorders into mental and physical categories is a mistake, which became prominent in the 18th century when the philosopher Rene Descartes popularized his idea of “dualism”. This was the belief that the individual can be separated into two parts, a body and a mind. Dualism seems to fit the experience of most humans most of the time, and it has therefore been difficult to get the public (as well as many doctors) to move beyond this unhelpful idea. The mind is a function of the brain. Dualism seems to fit the experience of most humans because the brain does not “see” or is unaware of itself. Thus, the mind is encountered as something separate from the body rather than a function of the body.

The interrelationship of mind and body can be demonstrated in many ways. If the brain is damaged, the mind may be damaged. A brain tumour (part of the body) may present with symptoms of hallucinations or delusions (so-called problems of the “mind”). Many mental disorders have a strong genetic basis. Genes exert their influence by altering physical structure: in the case of mental disorders, genes influence the structure of the brain. Also, the mind changes the brain. All would agree that learning a lesson represents a mental or mind function. If a laboratory animal learns something, such as to push a

lever for food, and the brain of that animal is then examined, it is found the connections between particular brain cells are changed. Microscopically, they became darker and thicker. It is chilling to realize that when we were taught the two times table at school we were having our brains changed, and the only reason we can remember our tables now is that those brain changes have remained.

There are no distinct mental or physical disorders. For example, the early stage of infections, from influenza to plague, is loss of emotional spark and a feeling of malaise. Conversely, with most of the so-called mental diseases there are physical signs and symptoms, such as loss of appetite, loss of weight, insomnia and diarrhoea or constipation.

The DSM-IV is apologetic in using the term 'mental', calling it an "anachronism of mind/body dualism". The authors state it appears in their document only, "because we have not found an appropriate substitute". It is used in the DOP so as to stay in step with leading authorities. It is hoped an holistic concept will be embraced in the near future.

Mental health and mental health problems

The concept of mental health is confusing. It is a theoretical construction and has been popularized by governments and their agencies.

Theoretically, when individuals have impaired mental health they can be experiencing either 1) a mental disorder, or 2) a mental health problem. These categories are frequently, unwisely, but understandably, rolled together and made the responsibility of government funded mental health services.

The focus of the DOP is mental disorders. But, let us take a moment to explore the second category: mental health problems. The term 'health' is used in this setting to put a positive spin on the facts. It is claimed "health" emphasizes wellness rather than sickness. Health is stated to mean "much more than the mere absence of disease". And, mental health is defined as "the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective well being, optimal development and use of mental abilities and the achievement of individual and collective goals." A central notion is that mental health has to do with "subjective well being".

Accordingly, mental health problems have been described as "a disruption in the interactions between the individual, the group and the environment producing a diminished state of mental health". Thus, a mental health problem has occurred when something has disturbed the individual's subjective well being. A loss at the races, a disagreement with the spouse, being mugged – by definition, all of these can be seen as mental health problems.

For the sake of administrative neatness, in many settings, mental health problems have been cobbled together with mental disorders, and made the responsibility of government

funded mental health services. While psychiatrists and other mental health professionals have a good understanding of personal distress, they generally have little to offer in the case of mental health problems, which are better considered as social or theological rather than medical problems.

Causes of mental disorders

The causes of the mental disorders are not fully understood. Nor are the causes of many other medical disorders fully understood. Pneumonia is understood, it is usually a bacterial infection of the lungs. But apart from the infections, we have much to learn about most diseases and disorders. Even with a genetic disease in which the exact location of the gene on the chromosome and the abnormality of the gene have been discovered, we still have much to learn. Huntington's disease, a serious genetic brain disease, is a good example. Although we know the location of the gene and the abnormality of the gene, we still do not know why the gene becomes corrupted, or the mechanism by which the corrupted gene results in damage to brain cells.

Mental disorders, in general, are multifactorial, meaning many factors contribute to the appearance of symptoms and signs. These include biological, psychological and social factors, which are rolled into the cumbersome term "biopsychosocial", which can be applied to both cause and treatment.

Most mental disorders have a genetic (biological) basis, meaning there is an inherited genetic vulnerability or tendency. Schizophrenia is a good example. If one monozygotic twin (monozygotic twins have exactly the same genes) develops schizophrenia, there is a 50% chance that the other twin will also develop that disorder. When we consider that the prevalence of schizophrenia in the population is about 1%, it is clear that genetic factors are important in this disorder. However, looked at the other way, when one twin develops schizophrenia, 50% of the other twins do not develop the disorder. This means that in addition to the genetic factors, other factors (presumably environmental) also play a part.

Stress (psychological) can contribute to mental disorders. Stress during childhood has long been thought to contribute to anxiety and insecurity in adulthood. There is now strong evidence that severe childhood stress, particularly the psychological stress associated with physical and sexual abuse, contributes to the severe adult disorder called borderline personality disorder. The more immediate, and therefore more obvious, damaging effect of stress occurs in post-traumatic stress disorder. In this disorder, healthy adults subjected to horrific trauma, such as warfare or rape, may develop disabling anxiety, difficulty with thinking and personality change. One current theory is that the hormones which help the individual deal with stress may, when released in excessive amounts, damage the brain.

Social factors, which may be conceptualized as a particular set of current stressful events, are also important. It is recognised that the loss of status associated with loss of employment may trigger major depressive disorder. In anorexia nervosa (excessive

purposeful weight loss) the impact of social factors is recognized. The fashion industry, the media and peer groups all promote the desirability of thinness, encouraging undue attention to body image and eating.

Treatment of mental disorders

Few branches of medicine provide cures. Most bacterial infections, such as bacterial pneumonia, can be cured with antibiotics. Broken limbs can be set and some joints can be replaced. But most chronic disease, such as arthritis, diabetes and heart disease, is managed rather than cured.

The treatment of most mental disorders is aimed at providing relief. There are four main types: psychotherapy, medication and other physical treatments and rehabilitation.

Psychotherapy is a form of treatment which depends on verbal interchanges between patient and therapist. It is "talking therapy". There are many forms. Psychoanalysis was described by Sigmund Freud and seeks to deal with mild to moderate mood and personality disorders by investigating and modifying feelings and beliefs which have their origin in the early years of life and about which the patient is not fully aware. More recently cognitive behaviour therapy (CBT) has been described. Again, this treatment is best suited to mild and moderate mood and personality disorders. In CBT the therapist is more actively involved in therapy sessions (than is the psychoanalyst) and the focus is often the self-defeating beliefs which patients have come to accept. For certain disorders, psychotherapy may be the sole treatment. However, all psychiatric treatment, indeed all medical treatment, involves educational and supportive elements, which can be viewed as a form of psychotherapy.

Medication is widely used in the treatment of mental disorders. Nerve cells are like long wires and messages pass along them as electric impulses. The connections between nerves are called synapses. At these connections the message is passed along by the release of a chemical (neurotransmitter) from the first nerve cell, which travels across a tiny gap, and plugs into a specially designed receiver (receptor) on the second nerve cell. There are at least two hundred different neurotransmitters. Most psychiatric medication acts by influencing the production, destruction, release or arrival of neurotransmitters. Others have a more direct action on the nerve cells themselves. Medications of the future are likely to be of this latter type.

Other physical treatments include electroconvulsive therapy (ECT), light therapy and transcranial magnetic stimulation (TMS). ECT is the strongest antidepressant available. The patient is given an anaesthetic and while unconscious, a small electric current is applied to the head. TMS appears to be an effective treatment of mood disorder (Pridmore et al 2000; Avery et al, 2006). The patient is not given anaesthetic and tiny electrical currents are produced in localized areas of the brain using electromagnetic apparatus.

Rehabilitation means a return to normal activities and independent living. When provided to workers who injure their backs, it involves various treatments and a graduated return-to-work. Similarly, the rehabilitation of people who develop mental disorders may feature a return-to-work program. Rehabilitation of some chronic mental disorders (such as schizophrenia), however, may be protracted, extending over years. Such disorders may impair a wide range of functions and there may be a need for help with daily living activities, such as personal hygiene and budgeting, re-training in social skills, support with housing, and assistance to increase the quality of life. Teaching and encouragement are important tools.

Psychiatrists and mental health teams

A psychiatrist is a qualified medical doctor who has obtained additional qualifications in the diagnosis and treatment of mental disorders. Psychiatric training provides a broad understanding of the psychological, social and biological contributions to these disorders, and their treatments (psychotherapy, medication, electroconvulsive therapy and transcranial magnetic stimulation).

The psychiatrist is able to contribute in many situations of distress. However, when the distress is not a feature of a mental disorder, the psychiatrist may be no better placed to help than other helpers. In fact, the psychiatrist may be less well placed to help than social workers or religious officers, who have their own skills, experience and support systems.

Other members of the mental health team include clinical psychologists, psychiatric nurses, occupational therapists and social workers. Some teams have a member who has special knowledge and skill in placing people in employment.

Clinical psychologists do not have medical training and do not order medical investigations or prescribe medical treatments. They are skilled in psychological testing and usually have training in talking therapies such as counselling, psychotherapy and behaviour therapy.

Psychiatric nurses are the most numerous group and form the back bone of psychiatric services. Their training is broad and they may develop specialized interests. Occupational therapists help in the rehabilitation of people who have been damaged by severe mental disorder.

Mental health teams provide comprehensive care, but they are expensive and are usually provided only by governments or other well funded organisations.

The medical model

The term “medical model” has been used to denigrate psychiatry, the suggestion being that doctors are paternalistic, ideological and use medications excessively. This is inaccurate. To counter the damaging effects of this label, Shah & Mountain (2007) suggest a definition: the medical model is “the process whereby, informed by the best available evidence, doctors advise on, coordinate or deliver interventions for health improvement”. They summarise the medical model as, “does it work?”

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