Introduction to Psychiatry

Learning objectives

.Obtain the ability to identify psychological symptoms -1

The recognition of serious psychiatric disorders (in order to refer patients to -2 the psychiatrists) and simple disorders that can be treated by GP

How to manage psychiatric conditions in the Emergency department -3

What are the drug groups commonly used in psychiatry and what are their -4 .side effects and interactions

The relation of psychiatric disorders with other branches of medicine -5

Definition of important terms

Psychiatrist, psychologist and therapist

A psychiatrist is a medical doctor, or physician, with a degree in medicine. Psychiatrists must complete an undergraduate and medical degree, plus a four-year residency in psychiatry. They may then choose to complete a fellowship in a sub-specialty. As medical doctors psychiatrists can prescribe medication, and while they may provide some counseling, a psychiatrist might refer a patient to a psychologist or therapist for additional counseling or .therapy

A psychologist specializes in the study of behaviors and mental processes. This includes emotional and cognitive processes, how people interact with their environments, and how they interact with other people. Psychologists who are trained in clinical psychology can diagnose mental illness and can treat patients but only by psychotherapy so they can't prescribe drugs

Therapists provide mental health diagnosis and develop a treatment plan. Therapists work in offices, hospitals, treatment centers, and group homes. There are many different types of therapy such as play therapy, cognitive behavioral therapy, animal-assisted therapy, dialectal behavioral therapy, and many others. Therapists cannot recommend or order medications, but they can refer patients for evaluation .for medication or other treatments

Diagnoses, diseases, and disorders

The term ‘diagnosis’ has two somewhat different meanings. It has the general meaning of ‘telling one thing apart from another’, but in medicine it has also acquired a more specific meaning of ‘knowing the underlying cause’ of the symptoms and signs about which the patient is complaining. Underlying causes are expressed in quite different terms from the symptoms. For example, the symptoms of acute appendicitis are distinct from the idea that will form in the mind of the doctor that the appendix is inflamed and producing peritoneal .irritation

Unfortunately, for most psychiatric patients it is rarely possible to arrive at this type of diagnosis, the only exception to this being, by definition, ‘organic’ psychiatric disorders. The lack of clear disease categories, in a medical sense, .’has led to the use of the more general term ‘disorder

The definition of a psychiatric disorder in ICD-10 is: …a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental .disorder as defined here

Organic and functional

There is a distinction that is conventionally drawn between organic and functional disorders. Organic disorders are those that arise from a demonstrable cerebral or systemic pathological process; the core disorders are dementia, delirium, and the various neuropsychiatric syndromes. ‘Functional disorder’ is consequently an umbrella or default term for all other psychiatric .disorders

Neurosis and psychosis

In modern usage, the term **psychosis** refers broadly to severe psychiatric disorders, including schizophrenia, and some organic and affective disorders, .but some cases are relatively mild

Lack of insight is often suggested as a criterion, but insight itself is difficult to define. A somewhat more straightforward criterion is the inability to distinguish between subjective experience and external reality, as shown by the presence of delusions and hallucinations. Indeed, the presence of a delusion is sometimes .regarded as sufficient to diagnose a psychosis

Neurosis

In the same way as for psychosis, the terms ‘neurosis’ and ‘neurotic’ remain useful as simple descriptors, especially if the specific disorder cannot yet be determined, to indicate disorders that are often comparatively mild, and usually associated with some form of anxiety

Current psychiatric classifications

The International Classification of Diseases (ICD), Chapter V

The International Classification of Diseases (ICD) is produced by the World Health Organization (WHO) as an aid to the collection of international statistics about disease. The current version is the 10th edition (ICD-10). Of the 21 chapters, Chapter .V is devoted to psychiatry

Diagnostic and Statistical Manual (DSM5)

the American Psychiatric Association (APA) published the first edition of the Diagnostic and Statistical Manual (DSM-I) as an alternative to the widely criticized .ICD-6

When planning for DSM-V (later renamed DSM-5) began, it was hoped that the classification could be based on aetiology (including the use of biomarkers) rather than description. But this was proved to be very ambitious and the currently used DSM5 retain most of the diagnostic criteria of its predecessors .with some changes in classification

Hierarchies of diagnosis

If two or more disorders are present, it has been conventional (although not always made explicit) to assume that one takes precedence and is regarded as the main disorder for the purposes of treatment and recording. For example, organic disorders 'trump' schizophrenia, and schizophrenia takes precedence over affective disorders and anxiety. This type of assumption is justified because there is some clinical evidence for an inbuilt hierarchy of significance between the disorders. For instance, anxiety symptoms occur commonly with depressive disorders, and are sometimes the presenting feature. If the anxiety is treated, there is little response in the depressive symptoms, but if the depressive disorder is treated, there is often improvement in .anxiety as well as in the depressive symptoms

Comorbidity

Recently, less emphasis has been placed on hierarchies of diagnosis, with greater weight being placed on comorbidity (also called dual diagnosis). This has occurred for three reasons. First, research has shown that comorbidity is very common. For example, about 50% of patients with major depressive disorder also meet the criteria for an anxiety disorder. Secondly, it reminds the clinician to focus on all the various disorders that may be present, and not to assume that the disorder highest in the hierarchy is necessarily the only, or even the most important, target for treatment. Thirdly, the diagnostic 'rules' used in current classificatory systems allow, if not encourage, multiple diagnoses to be made

Stigma

People stigmatize others when they judge them not on their personal qualities but on the basis of a mark or label which assigns them to a feared or unfavoured group. The tendency to stigmatize seems to be deeply rooted in human nature as a way of responding to people who appear or behave differently

Stigma in psychiatry

People fear mental illness and they stigmatize those who are affected by it. The reasons for this are complex. They include the notion that people with mental illness cannot control their own behaviour, and that they may act in odd, unpredictable, and possibly violent ways. Thus they are seen as directly threatening, and perhaps also as indirectly threatening because their lack of self-control threatens our belief in our ability to control our actions. Whatever the underlying psychological mechanisms, fear of mental illness makes people react to mentally ill individuals in the same cautious .and unfavourable way—that is, to stigmatize them