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Lecture Notes on Psychiatry

Third edition

LECTURE NOTES ON
PSYCHIATRY

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AN INTRODUCTION TO PSYCHIATRY

Medical students often say that they find psychiatry interesting but disappointing. Interesting because psychiatry is a clinical subject and all students seem to like this, disappointing because as they frequently put it 'it all seems vague and woolly', also they are put off by the apparent lack of a sound body of psychiatric knowledge and the disagreements about diagnosis and treatment.

This book is not intended as a comprehensive text, the length and omissions should make that clear. It is written to try and answer the sort of questions that students seem to need answering fairly quickly when they start a psychiatric clerkship. They find themselves in difficulties because they have to learn a new language and acquire a new set of concepts of illness if they are to retain any interest in psychiatry at all. Too often they are discouraged from trying and emerge as doctors with blind spots for psychological illness.

The training of Medical students remains a subject for discussion, research and revision but as yet it does not adequately prepare the majority of students for much more than a somewhat unwary first encounter with the practice of psychiatry. Students tend to have heard that psychiatry is a discipline 'by schisms rent asunder' and this may make them unnecessarily sceptical, particularly if their half notions are reinforced by the misinformation still so freely available from an intriguing range of sources.

Also there *are* unresolved dilemmas about what things should be taught. Certain medical schools may favour a clinical approach based on traditional diagnosis, treatment and

prognosis. Others favour early introduction of the student to psychological principles—showing him how human behaviour may be governed by unconscious processes and relating this to interpersonal relationships and *their* consequences in people's life styles and behaviour. Whilst others have suggested that students need to be introduced quite early to the practice of psychotherapy—since this will provide them with a living illustration of human psychopathology. But while these divisions of opinions may exist (since as yet no one has *proved* what are the needs of students), at least we see the beginnings of a medical student training in which the importance is stressed of the patient as an individual and as a social being—not a mere collection of mechanical systems.

Medical student training may be the subject of discussion, research and revision, but the fact is that it does not equip students for the easy assimilation of psychiatric attitudes and ideas.

For a start the student finds that he needs to re-examine his own concept of disease. Up to now he has had no difficulty in seeing that patients with tumours, fractures, diabetes etc., are in diseased states. His psychiatric patient, on the other hand, often appears well and disclaims symptoms; no handicap is obvious until he finds that the patient's inner life is dominated by a series of fantastic beliefs which have caused him to alter his way of living so that he is now in hospital—maybe against his will. What does he make of that? Is he ill? Are there many patients like that and if so what is wrong with them?

Psychiatry deals with this sort of patient and many others; what they all have in common is disturbances affecting their behaviour, emotions, thinking and perception. Perhaps most important of all is the recognition that 'psychiatric illness' occurs when these disturbances are real changes which persist and exceed commonly accepted limits of normality and are changes about which the patient may complain, be bothered and puzzled about—so that we are justified in regarding them as symptoms. This is the psychiatric frame of reference. We

can set it down more formally by saying that we recognize psychiatric illness by examining the patient's

(1) behaviour,
(2) mood,
(3) perception,
(4) thought content,
(5) intelligence level,
(6) memory,
(7) concentration,
(8) orientation in space and time,

} cognitive functions

and by discerning abnormalities make a clinical diagnosis.

The manifestations of psychiatric disorder can be recognized without great difficulty. The medical student's difficulty in examining psychiatric patients can be traced to:

(1) lack of method,
(2) lack of practice.

It is our intention in this work to provide a simple clinical guide to psychiatric language and syndromes.

The student should always remember:

(1) to listen carefully,
(2) to record conscientiously,
(3) to avoid interpreting and speculating about what he supposes the patient means,
(4) to get a history from as many informants as possible,
(5) only to use words that he understands.

CLASSIFICATION OF MENTAL ILLNESS

The ideal classification would be based on aetiology. In psychiatry this is rarely possible except in certain organic disorders (e.g. G.P.I., delirium tremens), so that classification tends to be descriptive, that is to say based on the dominant observable features of the syndrome (e.g. anxiety, depression). This is unsatisfactory but inevitable at present. The danger of the descriptive method lies in the possibility that the name given to a syndrome may assign to it a separate existence. For example we may talk about schizophrenia without assuming

that there is a 'thing' schizophrenia. If the word is allowed to assume a concrete reality this stifles further enquiry.

Classification then may be unsatisfactory but necessary since we have to achieve some sort of order. Many systems are used, some are more satisfactory than others. In this work we will use this classification: it is clinical, oversimple no doubt, but adequate.

Schizophrenia	Simple Hebephrenic Catatonic Paranoid
Affective disorders	Anxiety Depression Mania and hypomania
Organic states	Delirium Dementia
Hysteria	Hysterical personality Conversion hysteria
Personality disorder	Abnormal personalities Psychopathy
Obsessional disorder	
Subnormality Severe subnormality	

CONTENTS

CHAPTER 1. THE HISTORY— SOME TERMS DEFINED— THE EXAMINATION

The psychiatric history, like any other, is an attempt to set down an accurate account of an illness. It is taken in the usual way but the technique should be modified to permit the patient to tell his story without becoming unnecessarily distressed. Distress and misery are commonplace since so often the history refers to painful topics. The patient should be allowed to start off wherever he likes in the history rather than adhering to a rigid scheme of questioning—there should be time to sort out all the data afterwards.

THE FIRST INTERVIEW

One should attempt to take as full a history as possible on this occasion but it may not be a practical nor a humane possibility. This first interview is likely to be an event of great significance for the patient—he may have been dreading it or preparing himself for it for days and when it is over it is something he is likely to remember. With this in mind the doctor should do all he can to make the experience bearable for the patient and resist the temptation to question like a cross-examining attorney.

(a) How to elicit a history

Students often complain that they don't know what questions to ask the patient and are surprised when a more skilled examiner unearths facts they had missed. The answer to this difficulty is relatively simple. A history, after all, is only an

edited series of answers to an elaborate and unstructured questionnaire and with practice the expert learns what questions to ask, and constructs his own questionnaire. Listening to others taking a history illustrates this very well—actually this is as good a way of learning to take a history as any, and not widely enough used.

(b) Symptoms and signs

Modes of presentation and symptomatology are of a different order in psychiatry, though not inevitably so. One patient complains of bodily symptoms, another brings a story of persecution by others, whilst another complains of altered mood and poor concentration. Many patients have no complaint at all and deny all symptoms, the history being given by relatives who tell a different story.

(c) The relationship

The relationship between doctor and patient starts as the patient comes through the door. The patient's initial greeting may be friendly, hostile, suspicious or just neutral. Whatever it is the doctor stands to lose or gain a great deal by his own behaviour. There is no substitute for *friendly politeness* and no place for patronizing pseudo-omniscience. The patient should be accepted as he is and not subjected to value judgements. The talkative patient should be permitted to tell his story as he likes at first, and then be guided through the areas that the doctor wants to cover so that a comprehensive history can be taken. The reticent patient needs encouragement, and although this can be difficult, one must not put words in the patient's mouth.

THE PLACE OF HISTORY TAKING IN DIAGNOSIS

There is a fashionable tendency for some psychiatrists to decry diagnosis, to question the 'medical model' of psychiatric ill-

ness. And there is good sense in many such criticisms. Just because a person consults a psychiatrist this does not automatically confer on him the status of being ill. This needs to be mentioned for some psychiatrists talk as if they believed that this were the case! Practical psychiatry should remain a clinical subject in which traditional medical training in diagnosis etc. are of clear usefulness without being overvalued. The clinical approach remains to date a humane and pragmatic one. We should recognize too that the clinician has always to be aware of how it is individual and psychological and social forces may influence the content of an illness but not the form of clinical syndromes—and form is what diagnosis is about. Perhaps we would do well always to remember the large gaps in our knowledge and resist the temptation to conceal them with all embracing theories which illuminate all and clarify nothing save their continued existence as untested and untestable hypotheses—ugly white elephants which retain our mistakes long after we have forgotten them.

Diagnosis is made by examination of the mental state. The history contributes to our understanding of the mental state—it is a pointer to the diagnosis. History taking takes time. One cannot learn much about a patient in five minutes or even fifty, for that matter. There is no place in good psychiatry or good medical practice for the 'spot diagnosis'—in psychiatry it generally turns out to be no diagnosis at all. Most diagnostic errors can be traced to poor history taking.

A scheme for history taking

A formal scheme has to be used for writing down the history. This does not mean that one has to take it down in the following order.

COMPLAINT

This should consist merely of a short statement of the patient's complaint, or if he has none, a short statement of the reason for his referral for psychiatric opinion.

FAMILY HISTORY

In this one should enumerate the *parents* and *siblings*, noting carefully such details as *ages, employment, illnesses, causes of death*. It should also include where possible some account of the incidence of any *familial psychiatric illnesses*. Direct questions should always be asked about incidence in the family of epilepsy, delinquency, alcoholism and drug use, suicide and attempted suicide. The family history too should give some information about the *social status* and *inter personal relationships* within the family.

PERSONAL HISTORY

This should commence with a note of the date and place of birth. Any information available about the patient's infant development should be recorded with particular reference to *health* during childhood, *neurotic symptoms* and *infant milestones*. *School record* should next be noted down, concentrating not only on the names of the schools and the leaving age etc., but attempting if possible to state the individual's attainments at school and estimate his social popularity etc. *Occupations* should next be considered in chronological order with wages earned and status. These details may throw some light on the person's pre-morbid personality and also on the evolution of the illness since frequently work performance is impaired by psychiatric illness—it may even be the presenting complaint e.g. 'can't seem to cope with my job—keep having to change my job—can't settle to anything'. It is also useful to make some note of the individual's relationships with employers and colleagues.

MENSTRUAL AND PSYCHO-SEXUAL HISTORY

This includes the usual menstrual history with the addition of psycho-sexual topics such as how the patient acquired sexual information, his/her *varieties* and *frequency of sexual practice* and *fantasy*. The marital history should be noted with details of *engagement, marriage* and *pregnancies* and their outcome.

There should always be careful enquiry about psychiatric disturbance during and after pregnancy.

PAST ILLNESSES

Recorded chronologically. With details of any admissions and treatments received.

PAST PSYCHIATRIC ILLNESSES

Recorded chronologically.

PRE-MORBID PERSONALITY

An attempt should be made to describe as accurately as possible the individual's personality before the illness. This is the part of the history that usually causes the great difficulty since our methods of describing the personality are so imperfect. In practice, the most helpful descriptions of the pre-morbid personality are not those which consist merely of one or two adjectives but rather those which give a portrait of the individual, consisting of a few paragraphs.

DESCRIPTION OF PRESENT ILLNESS

This should be a detailed chronological account of the illness from the onset to the present time. There should always be an accurate description of the order, mode and speed of the change in the person's symptomatology.

THE PSYCHIATRIC EXAMINATION

The examination of the patient does not stop short at the examination of his mental state but includes a general physical examination, and where needed, physical investigation. Many individuals referred to a psychiatrist turn out to have either associated physical disease or else disease causing their altered mental state. Examples of the latter would be such conditions as cerebral tumours, general paresis, disseminated sclerosis and

myxoedema. The physical examination, too, has a positive value in the reassurance of a hypochondriacal patient.

PSYCHIATRIC LANGUAGE—A FEW TERMS DEFINED

Before going any further into details of how we examine and describe the mental state, here is a list of commonly used psychiatric terms.

Anxiety
A feeling of fear or apprehension commonly accompanied by autonomic disturbance. Anxiety may be felt by healthy subjects in the face of stress such as examinations etc., but is described as morbid anxiety when it pervades the mental life of an individual.

Depression
Pathological mood disturbance resembling sadness or grief. Depression is described as reactive when it can be related to an apparent causal agent, and endogenous when it appears out of the blue. The mood change is accompanied by characteristic disturbance of sleep, energy and thinking.

Dementia
Progressive, irreversible intellectual impairment. Dementia is caused by organic brain disease.

Delirium
An organic mental state in which altered consciousness is combined with psychomotor overactivity, hallucinosis and disorientation.

Depersonalization
A subjective feeling of altered reality of the self, e.g. 'I'm not

myself any more. I feel as if I were dead; I feel unreal. Different to what I was. If only I could wake up.'

Derealization
A subjective feeling of altered reality of the environment, e.g. 'Everything around me seems strange like in a dream. Things don't look or feel the same,' usually associated with depersonalization.

Delusion
A false belief which is inappropriate to an individual's sociocultural background and which is held in the face of logical argument. True delusions commonly have a paranoid colouring (q.v.) and are held with extraordinary conviction. Delusion is thus a primary and fundamental experience in which incorrect judgements are made. The experience of delusion proper precedes its expression in words and hence, when stated, is incomprehensible and beyond argument, e.g. 'I was walking along the street and saw a dog and immediately I knew by the way it stood that I was a special person predestined to save mankind.'

Delusional ideas
Delusional ideas differ from true or primary delusions in that instead of arising out of the blue they occur against a background of disturbed mood and are entirely explicable in that context. Thus the severe delusional ideas of guilt and condemnation and persecution shown by a psychotic depressive are seen to be an outgrowth of the depressive state. In the same way the delusional notions of grandeur and exaltation of the manic spring from his elevated mood—a mood which brings with it breezy overconfidence and insouciance which can easily develop into ideas of omnipotence.

Flight of ideas
Accelerated thinking, characteristically seen in hypomanic and

manic illness. The association between ideas are casual, and are determined by such things as puns and rhymes. However links are detectable and the flight can be followed.

Hallucinations
A perception occurring in the absence of an outside stimulus (e.g. hearing a voice outside one). Hallucinations are particularly common in schizophrenia. Patients hear voices which tell them to do things, comment on their actions, utter obscenities or murmur wordlessly. The phenomenon of 'hearing one's thoughts spoken aloud' is encountered in schizophrenia. Hallucinations are described as hypnagogic if they are experienced whilst falling asleep and hypnopompic if experienced whilst waking up.

Hypochondriasis
Preoccupation with fancied illness. Hypochondriacal features are common in depression and may be found as bizarre phenomena in schizophrenia. Hypochondriasis may be the central feature of a hysterical illness. It seems likely that hypochondriasis does not exist on its own but is usually a manifestation of some underlying psychiatric condition or personality disorder.

Illusion
A perceptual error or misinterpretation. These commonly occur in organic mental states, particularly delirium. A patient in such a state misinterpreted a building outside his window as being a liner about to sail.

Ideas of reference
The patient who has ideas of reference experiences events and perceives objects in his environment as having a special significance for himself. For example a patient noticed that all the TV programmes she saw indicated to her in some unusual way that she had been singled out for observation by a secret police force.