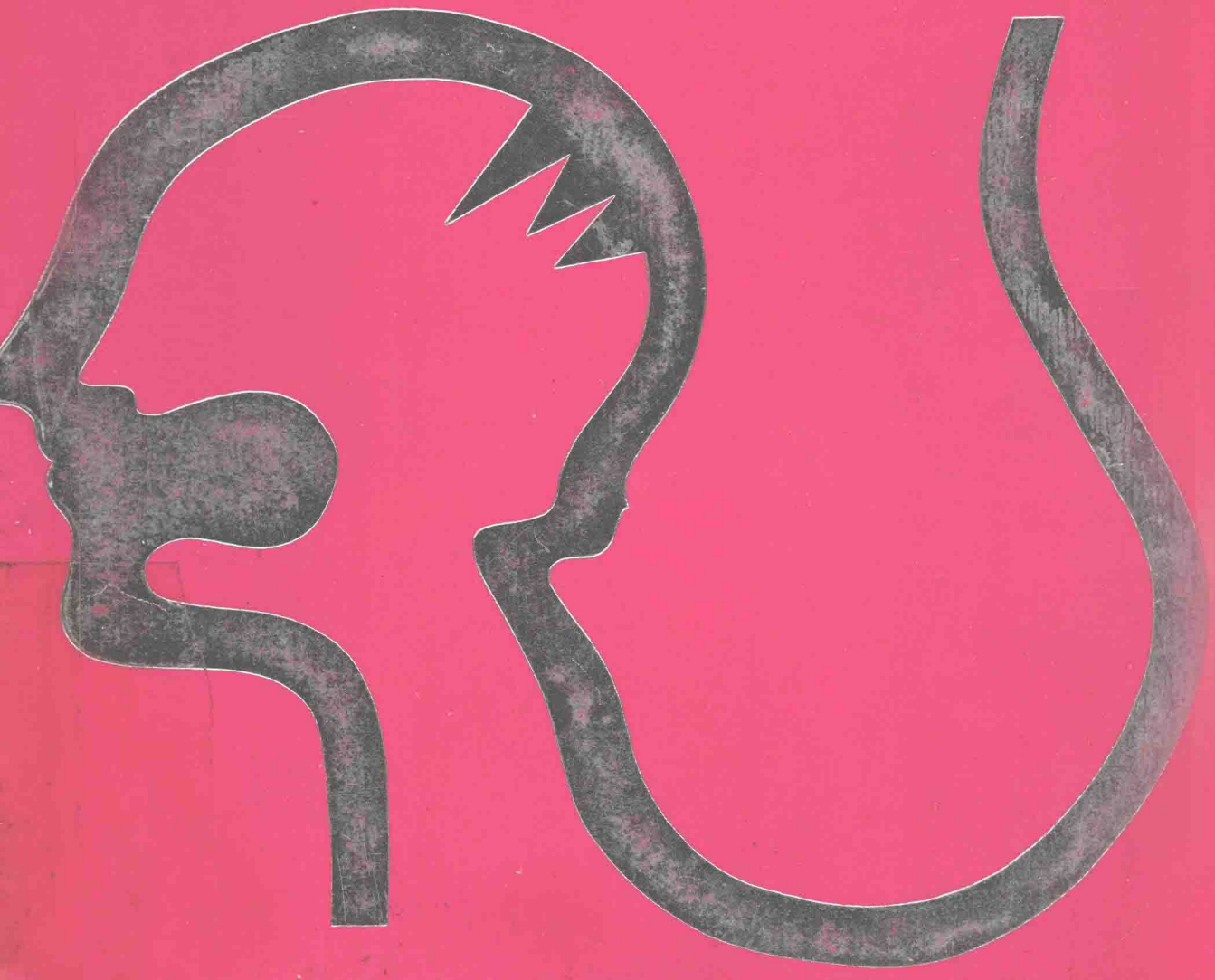
Psychiatry

Essentials of Clinical Practice
With Examination Questions, Answers, and Comments
Second Edition

Ian Gregory, M.D.
Donald J. Smeltzer, M.A.



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Preface

In 1974 we introduced a *personalized study program* for Ohio State University medical students during their two-month clinical clerkship in psychiatry. This highly successful system supplements patient care experiences by a combination of structured reading and testing with individualized tutorial assistance. Its principal components are as follows:

1. Eight reading assignments, each consisting of two or three chapters from this book
2. A private meeting with a tutor after studying each assignment
3. A practice quiz of multiple-choice questions on the topics studied
4. Immediate feedback from the tutor about the quiz questions, and discussion of the student's difficulties with the assignment but with no grade reported by the tutor
5. Progress at a self-determined pace based on successful completion of the assignments at an average rate of one per week
6. Optional attendance at supplementary lectures and use of audiovisual aids
7. Satisfactory performance on a written examination at the end of the clerkship

Our graduating medical students have shown exceptional mastery of psychiatry on Part II of the National Board Examination. The mean score of each class has been higher in psychiatry than any other subject and substantially above the national average. Without overemphasizing the importance of test scores, it may be noted that this is the only external criterion of educational achievement that is readily available.

This volume is an adaptation of our teaching program to a self-study format. It contains a careful selection of up-to-date material that is relevant to students of psychiatry at all levels: the medical student taking a first course or clinical clerkship, the busy physician reviewing for an examination or needing a reference in daily clinical practice, or the experienced specialist wishing to update knowledge in areas outside his or her regular practice. We have tried to be selective rather than encyclopedic, but each chapter includes an eclectic bibliography to which the reader may turn for more detailed information as desired.

Chapters 1 through 10 contain general information in a sequence based partly on how urgently it is required. Chapters 11 through 20 contain specific information on the categories of psychiatric disorders, organized in the same sequence as the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) recently published by the American Psychiatric Association. Chapter 21 discusses disorders of sleep and arousal, and is based on the official nosology of the Association of Sleep Disorders Centers.

At the end of each chapter are practice questions similar to those asked on standardized examinations. For optimal learning we suggest that the chapter be read first, followed by an attempt to answer the corresponding

questions. Only then should the answer key and remedial feedback at the end of the book be consulted. Where possible, the latter contains page references to the text; however, the quizzes and feedback cannot possibly cover all the material included in the text itself, and we recommend that you avoid the temptation to refer prematurely to the questions and answers. As in our personalized study program, the quizzes are designed as an additional study resource, and we have occasionally supplemented the discussion in the text by including further material in the question sets.

It takes much time and effort to condense and distill the accumulated wisdom from a knowledge explosion that is still continuing. In this venture we have been most fortunate to receive assistance from many fine colleagues, several of whom contributed portions of this volume. Malcolm Gardner and Walter Knopp worked closely with us in developing and implementing our personalized study program, and also contributed much of Chapter 18 on psychosexual disorders. L. Eugene Arnold, who directs our educational programs in child and adolescent psychiatry, wrote Chapter 12. William Bates completely revised Chapter 11 on mental retardation. Helmut Schmidt, who directs our sleep disorders center, provided Chapter 21, which is new to this edition.

We also acknowledge with pleasure the efforts of others who helped to make our task easier. We are most grateful to Gretchen Hammond, Vicky Watkins, Pamela Furney, Theresa Niznansky, Lisa Atcheson, and Christine Mines for their valuable secretarial and other assistance. Finally, we wish to thank our many students, who helped us recognize what needed to be done, and who have rewarded our efforts by their own achievements.

I. G.
D. J. S.

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Notice

The authors have made every effort to ensure that the drug selection and dosages described in this text are accurate and in accord with the standards accepted at the time of publication. However, in view of current research, changing government regulations, and the constant updating of information regarding drug therapy and adverse reactions, the reader is urged to consult the package insert for changes in indications and dosage recommendations, and for added warnings and precautions. This is particularly important when the selected drug is a new or infrequently prescribed agent.

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Development and Dynamics

A man will sometimes rage at his wife when in reality his mistress has offended him, and a lady complains of the cruelty of her husband when she has no other enemy than bad cards.

Samuel Johnson

PSYCHIATRY AND PSYCHOANALYSIS

Psychiatry

The term *psychiatry,* derived from Greek roots meaning "mind healing," refers to the medical science that deals with the study, diagnosis, treatment, and prevention of *mental disorders*. These disorders may affect persons of all ages, and may involve either intellectual or emotional processes, verbal or nonverbal behavior. They may result from disturbances in biological function, or from the adverse influence of psychological or sociocultural factors.

Licensed physicians specializing in psychiatry are known as *psychiatrists*. In the United States their education usually includes 3 or 4 years in an approved residency following graduation from medical school. Following postgraduate training, certification of competence may be obtained by passing written and oral examinations of the American Board of Psychiatry and Neurology. Additional training is necessary for certain subspecialities such as child psychiatry and psychoanalysis.

All medical schools in the United States currently include psychiatry as a standard part of their curricula, usually in the form of a required clinical rotation. This is also one of the major subjects in the examinations of the National Board of Medical Examiners and of the Federated Licensing Examinations Board (FLEX).

Psychotherapy

Psychotherapy is a generic term for treatments that are based mainly on communication (verbal or nonverbal) between therapist and patient or client. Psychotherapies may be used to alleviate emotional disturbance, to assist the person in reversing or changing maladaptive patterns of behavior, to encourage personality growth, or to promote greater effectiveness in coping with the problems of living. All forms of psychotherapy involve a structured relationship in which the therapist applies selected procedures (based on a theoretical rationale) in an individual, group, or family setting.

Psychoanalysis

This is the branch of science developed by Sigmund Freud and his followers for the study of human psychological functioning and behavior. Three applications of psychoanalysis are usually distinguished: (1) a method of investigation or research into mental processes; (2) the development of a systematized body of knowledge and theory concerning human behavior and development; and (3) a method of psychotherapy. Psychoanalysis involves *free association* and the analysis of dreams, fantasies, thought processes, and behaviors in relation to emotion (*affect*). A limited return to earlier methods of reacting (*regression*) is encouraged, so that derivatives of forbidden wishes and repressed memories may find expression in current ideas and feelings. Hitherto unconscious conflicts, associated with earlier traumatic experiences, are made con-

scious through *interpretation,* which involves the analysis and elimination of defenses and resistances. Psychoanalysis and other psychotherapies derived from it have been considered most effective in the treatment of some neuroses, and have also found application in attempts to modify character disorders.

Psychodynamics

Literally interpreted, this is the study of mental forces in action. Current usage of the term focuses on intrapsychic processes (rather than interpersonal relationships) and on the role of unconscious motivation in human behavior. The psychoanalytic model of psychodynamics is based on Freud's *structural theory,* according to which there are three major divisions (structures) of the psychic apparatus: the *id* (representing instinctual drives); the *ego* (representing executive and inhibiting functions); and the *superego* (representing the influences of conscience and the need to strive toward an idealistic goal). Each of the mental structures is assumed to involve interaction between innate and environmental factors. Psychodynamics is concerned with both the genesis and the development of current mental processes and behavior.

Psychopathology

This is a broad term referring to the study of significant causes and processes responsible for the development of mental disorders, as well as to the various manifestations of these disorders. Psychodynamics should therefore be regarded as a subset of the larger field of psychopathology, which is concerned with description, dynamics, development, and causation (etiology).

Psychology

This term refers to an academic discipline, a profession, and a science dealing with the study of mental processes and behavior in humans and animals. The minimum standard for election to full membership in the American Psychological Association is a doctoral degree (usually a Ph.D. or Psy.D.). A number of subspecialties are recognized, including *clinical psychology,* which is concerned traditionally with the diagnosis and evaluation of mental disorders, and in more recent years with psychotherapy. One aspect of the training of clinical psychologists is *psychometry,* defined as the science of testing and measuring mental and psychological ability, efficiency, potential, and functioning. Test administration is sometimes performed by a *psychometrist* with a bachelor's or master's degree, although interpretation of test results remains the responsibility of professionals with more advanced training.

HISTORY OF DYNAMIC PSYCHIATRY

During the latter part of the nineteenth century, an English neurologist named *John Hughlings Jackson* (1835–1911) formulated some important principles concerning the *dissolution of function* within the nervous system, resulting in regression to earlier developmental levels. He viewed the nervous system as organized in hierarchical fashion, with the most complex functions (associated with the cerebral cortex) being the most recently evolved, and also the ones most vulnerable to dissolution under conditions of lesion, trauma, or stress. Jackson noted a regression of neural function to lower and more primitive levels under adverse conditions, and recognized that higher centers may be concerned with inhibiting the function of lower centers; the latter would then act unopposed if the functions of higher centers were disrupted. In analyzing the effects of brain damage, he therefore distinguished between *negative* symptoms due to loss of function (loss of "government") and *positive* symptoms due to release from inhibition, which he characterized as "the anarchy of the now uncontrolled people." For every mental state there was a corresponding physical state in the brain, and the observable symptoms and signs of neurologic and psychiatric disorder consisted of a combination of positive and negative symptoms. Jackson's principle of the dissolution of complex functions and his concepts of dynamic interaction within the nervous system not only are relevant to the manifestations of organic brain syndromes, but also were employed by Freud in his formulations on unconscious intrapsychic dynamic processes.

At about the same time, many neurologists were becoming aware that the bodily symptoms of some patients could not be attributed to anatomic lesions in the nervous system. Such patients (with *conversion hysteria* and other neuroses) appeared relatively intact in intellectual,

emotional, and behavioral function—and were frequently seen as clinic outpatients or general hospital patients rather than as inmates of mental asylums. A major stimulus to psychological treatment and understanding of such patients came from the therapeutic application of *hypnosis.*

Franz Anton Mesmer (c. 1733–1815) was a German physician who claimed to be able to cure all illnesses by the touch of a rod, thereby equalizing a magnetic field that was assumed to fill the universe. Disease was attributed to the uneven distribution of animal magnetism. However, Mesmer's views were criticized by the French Academy of Sciences, and he was forced to retire from his fashionable practice in Paris. A British surgeon, *James Braid* (1795–1860), rejected Mesmer's theories but became interested in his technique, which he termed *hypnosis* ("nervous sleep"). The French physician *Ambrose Liébeault* (1823–1904) became interested in hypnotism after listening to a report of Braid's work before the French Academy of Sciences, and applied the technique in the treatment of hysterical patients at Nancy.

In 1883 *Hippolyte Bernheim* (1840–1919), the physician in charge of the Nancy Asylum, referred a patient suffering from sciatica to Liébeault and was amazed to find the patient subsequently cured. Bernheim in turn became an exponent of hypnotism, which he regarded as merely an exaggerated form of *suggestion* and only quantitatively different from the phenomena of normal mental function. He also investigated posthypnotic suggestion, or "latent memory," by "implanting" suggestions during the hypnotic trance that the patient later carried out without any recollection of the suggestion or its source. Bernheim was among the first to use the term *psychoneurosis,* but did not believe that suggestibility and posthypnotic amnesia were restricted to neurotic patients.

By contrast, the more famous French physician *Jean-Martin Charcot* (1825–1893) regarded hypnotic phenomena as unique to hysteria patients. Charcot took charge of La Salpêtriere in 1866, and attracted many students to witness his dramatic demonstrations. One of these, *Pierre Janet* (1859–1947), studied many other neurotic manifestations including phobias, anxiety, obsessions, various abnormal impulses, and tics. He is best remembered for his report (1899) that some neurotic patients recalled traumatic memories under hypnosis and lost their symptoms after such ideas were consciously expressed. While he corroborated Freud's early findings on the clinical significance of unconscious processes and the therapeutic effects of emotional catharsis, Janet's methods of treatment were directed more toward conscious and emotional reeducation.

The man destined to become the best-known student of Charcot and Bernheim was *Sigmund Freud* (1856–1939), who was born in Freiberg, a small town in Moravia, which was then part of Austria. His father was a Jewish merchant who moved his family to Vienna when Freud was a child, and Freud continued to live there until 1938, when the political situation forced him to take refuge in London. He died there the following year. Freud was a brilliant student who experienced some conflict between his theoretical interests or scientific curiosity and the practical necessity of earning a living as a physician. For 6 years he worked in Ernst Brucke's physiology laboratory and studied the histology of the nervous system. He graduated from medical school in 1881, and one year later he transferred to the general hospital where he continued studying the anatomy of the brain and organic diseases of the nervous system. In 1885 he went to Paris to study for a year under Charcot. The following year he opened a neurologic practice in Vienna.

The practice of neurology involved many neurotic patients, and Freud was dissatisfied with the current techniques of hydrotherapy, electrotherapy, massage, rest, and diet. From Charcot he had learned that hysteria could occur in men as well as in women, and that hypnosis could produce hysterical symptoms as well as remove them. From Bernheim he had learned that private patients could not be hypnotized as readily as charity patients in the clinic, and that suggestion alone (in the waking state) might be as effective as suggestion while the patient was under hypnosis.

After his visit to Bernheim in 1889, Freud collaborated with *Josef Breuer,* who had used hypnosis in the prolonged treatment of a hysterical girl from 1880 to 1882. Under hypnosis this patient (Anna O.) had recalled previously forgotten and highly emotional experiences, from which specific symptoms could be dated. After talking over these emotional experiences under hypnosis, she had been relieved of symptoms that had stemmed from the experiences. Freud confirmed these observations, and he and Breuer published their results in *Studies on Hysteria* (1893–1895). They postulated that ideas and

memories having unpleasant emotional significance are banished from accessibility by an involuntary and automatic mental force that they called *repression;* that repressed material may be recalled under hypnosis; and that some detail of a repressed traumatic experience may be shown to correspond with some aspect of a hysterical symptom. They termed the transformation of emotional impulse into an abnormal bodily function *conversion,* their method of treatment *emotional catharsis,* and the emotional release that took place *abreaction.*

FREUDIAN PSYCHOANALYSIS

Freud encountered various problems in the application of hypnosis and suggestion to patients. Not all patients could be hypnotized, and symptoms removed during hypnosis were apt to be replaced by other symptoms before long. Moreover, hypnosis had no effect on the repressive forces responsible for excluding traumatic memories from consciousness. However, he found that repressed material could sometimes be recalled with difficulty in the waking state by the use of a process called *free association,* involving uninhibited verbal reporting of all conscious thought regardless of apparent irrelevancy. He realized that these free associations were not really free and concluded that they were determined by unconscious material that had to be analyzed and interpreted. He therefore called his new technique *psychoanalysis* (1896).

Freud noted that when patients free-associated, dreams of the night before or even from many years previously might occur to them. Free associations to fragments of dreams often led more quickly to the disclosure of unconscious memories and fantasies than free associations to other subjects, and he concluded that dreams represented symbolic or disguised forms of *wish fulfillment.* He termed the image recalled on awakening the *manifest content* and the true underlying motive the *latent content.* He postulated that the symbols represented in dreams are derived not only from the experiences of the individual, but also from a widespread tendency of people in a given culture to represent certain unconscious thoughts (particularly sexual ones) by characteristic symbols. Thus the human body might be represented by a house; the male genital by a snake, stick, weapon, or tree; and the female genital by a box, cave, other container, or doorway.

For a while Freud believed that a neurosis originated in some isolated emotional shock that the patient had undergone. He used the methods of free association and *dream analysis* to help patients recall repressed emotional experiences, and this process was frequently accompanied by relief from the neurotic symptoms. However, some patients returned after a short time with somewhat different symptoms. Freud's explanation for this was that he had not analyzed sufficiently far back in the patients' lives, and he began probing further back into childhood and even infancy.

Eventually he found it necessary to modify his theoretical formulation. A number of his female patients reported having been seduced or sexually attacked by fathers, brothers, or other relatives, but some of these reports were found to have no factual basis. Freud decided that these false memories represented fantasies of later childhood that arose from conflicts and unfulfilled wishes of early childhood. He further postulated that neurosis was the result of early childhood conflicts between drives and fears. Mediating between drives seeking discharge (especially the sexual drive) and the fear and guilt associated with these drives, the developing ego had resolved the conflict by repressing the drives from awareness; since the drives were thereby rendered not inactive but merely unconscious, the result was the formation of neurotic symptoms. Freud thus came to believe that a cure of neurosis might be accomplished by a revival of the emotional attitude of early childhood (regression) without the necessity of achieving full recall of actual events.

During the reexperiencing of these repressed emotions, the patient unconsciously displaces onto the analyst the feelings, attitudes, and wishes originally associated with other significant persons. The patient's positive or negative feelings toward the analyst thus constitute a symbolic reliving of the previous emotional experience. This phenomenon is called *transference* and is present to some extent in all psychotherapeutic treatment. The reciprocal phenomenon, in which the therapist develops illogical attitudes or feelings toward the patient as a result of his or her own personal conflicts or inappropriate stereotyping, is called *countertransference.*

Partly because of discomfort and partly because of the transference relationship with the therapist (whom the patient may, at various times, view as a punitive authority

figure or a benevolent parent), the patient frequently experiences inability or unwillingness to discuss certain topics. These episodes, which are often but not always unconsciously motivated, are called *resistances*. The analysis of transference and resistance is the prime function of the psychoanalyst, who, at appropriate times, comments to the patient about what is happening, or perhaps about what is *not* happening. This process is called *interpretation* and is aimed at helping the patient achieve greater insight into his or her needs and conflicts so that realistic solutions can be consciously considered.

The three successive goals toward which Freud directed his efforts in psychoanalysis may now be summarized as follows: (1) understanding the patient's unconscious emotions or conflicts and *interpreting* them to the patient at the right time; (2) assisting the patient to confirm such interpretations through his or her own recall, by enabling the patient to understand and overcome the resistances that had previously prevented their recall; and (3) enabling the patient to relive repressed emotional experiences. The main theories arising from Freud's progressive refinements of the psychoanalytic technique may be divided into three broad groups: (1) *economic concepts;* (2) *dynamic concepts,* including the *libido theory;* and (3) *topographic concepts* and the *structural theory* of personality.

Economic Concepts

These theories concerned the fundamental modes of operation and distribution of psychic energies. The term *libido* is a quantitative concept originally referring to the drive energy of the sexual instinct but later interpreted in the broader sense of all strivings toward pleasurable experience. Other major forces governing motivation are the *aggressive drive* and the *self-preserving* instincts of the individual. (The latter are sometimes referred to as *ego instincts.*) Freud believed that dammed-up psychic energy causes pain and tension, while the release of energy produces pleasure. The basic tendency to seek pleasure and avoid pain was termed the *pleasure principle,* which is modified during the course of development by the *reality principle*. The latter strives to postpone impulse gratification in accordance with the demands of the environment. An even more basic tendency than the pleasure principle is the *repetition compulsion,* which Freud described as a tendency to repeat emotional experiences and situations regardless of their apparent pleasurable or painful consequences.

Dynamic Concepts

These dealt with the interaction of forces leading to conflict or overt behavior. Originally Freud divided all instincts into the sex drive (serving the pleasure principle) and the self-preservative drives (serving the reality principle). Subsequently he combined both of these into the concept of *eros,* which he now considered opposed by *thanatos,* consisting of the aggressive drives toward death, destruction, and dissolution. Freud's concept of the death instinct is still controversial and has been incisively questioned both within and outside the psychoanalytic field. Most analysts, however, retain and use the concepts of the libidinal and aggressive instinctual drives.

Libido Theory

This includes a theoretical description of a characteristic maturational sequence of libidinal or psychosexual phases in development from birth to mature adulthood. The drive organization is subject to *progression, fixation,* or *regression,* determined in part by the extent to which the individual encounters normal, excessive, or frustrated gratification.

The *oral phase* is the earliest stage of development and is associated with behavior appropriate to the first year of life, particularly extreme *dependency*. Fixation at or regression to this phase of development is considered characteristic of schizophrenia, severe affective disorders, and alcohol and other drug dependence.

Society chooses the second year of life as an appropriate time for toilet training, and the child derives conscious pleasure from excretory functions and the ability to control them. This *anal phase* of development implies the ability to give or to withhold and requires the child to learn to compromise between primitive wishes and the rewards obtained by conforming with the demands and expectations of significant adults. "Anal" traits persisting in adults include excessive orderliness, miserliness, and obstinacy. If present to a significant degree, they may be associated with the development of an obsessive compulsive disorder.