Chapter

1

Scope of Psychiatry

The common man's concepts about psychiatry and its practitioners are rather fanciful. Unlike other medical conditions, the common man more often associates psychiatric disorders with culturally determined hypothetical causations which range from black magic to brain afflictions. All those who have a therapeutic alliance with the patient are indiscriminately called psychiatrists, psychologists, psychotherapists or neurologists by convenience. Many people do not know the difference between a psychiatrist and a psychologist and a neurologist and their therapeutic roles. Many believe that a psychiatrist, or a psychologist for that matter, is a person who by looking at the patient's face can read his mind so as to later expurgate him of his "offensive thoughts" through "hypnotism" or through "talking out". Thus, while collecting details from a patient about his hallucinations I overheard the patient's father talking to his wife "see—doctor is taking out of Appu's mind all his bad thoughts"!

Elsewhere in some countries psychiatrists are fondly addressed as "head shrinkers". Psychiatrist is a person who treats "loonies" and the hospital for mentally ill is called a "loony bin". Even in our country the psychiatric patients have several pet names: "Half a screw less", "half a circle", or "full circle" (these depending on the degree of derangement), "crack", "nuts", "moonlight", etc.—people treating them also have similar endearing synonyms the exact terms varying from region to region.

A psychiatrist, or a psychologist has no mystical powers. As in any medical discipline he depends on the patient's history,

examination and investigations to arrive at a diagnosis. By definition a psychiatrist is a medical graduate who specializes in helping and treating people with emotional difficulties and disturbed interpersonal relationships as a result of their abnormal perceptions, feelings and thoughts. A medical background is essential for the therapist to comprehend the significance of the anatomical and physiological substrata of human behavior and to know how behavior is influenced by endogenous (meaning, generated inside the body) or exogenous (generated outside) chemical substances.

Box 1.1: Reil and Psychiatry

The term psychiatry was first coined in 1808 by Johann Christian Reil (1759–1813), a German physician, anatomist and physiologist, famous for his discovery of the insula of the cerebral cortex ("The islands of Reil"). The term meant "*the soul as doctor*" (*iatros* = doctor) a way of treating the patient by using his *psyche* (meaning the soul) as the therapeutic agent. What he implied was that the *psyche* with its highly developed faculties like reasoning and judgement would help to cure insanity.

NORMAL AND ABNORMAL

It is often difficult to define what is normal behavior. It is more difficult to define its range—that is to say where normality ends and abnormality starts. What is considered as normal at one point of time may not be so at another epoch. It also varies with culture. In a country of cannibals a Buddhist monk preaching *ahimsa* (nonviolence) is as abnormal as a cannibal is in our midst. Certain behavior which is considered normal at one point of one's life may not be normal at another period. Examples are babbling and thumb sucking.

One important criterion of normal behavior is its social confirmity. This implies that in a given population a particular behavior which is shared by the majority of its members is accepted as normal. It is therefore a statistical criterion. Behavior which is deviant from the norms is a point of focus for the media also (Fig. 1.1).

Fig. 1.1: Faces of abnormality

Though simple, statistical criterion will not by itself identify abnormality in many instances. As for example, consider the distribution of intelligence in a population. Most of its members fall within a particular range and qualify themselves as normal. But there are always a few who fall too low in their intelligence scores and also a few others who attain very high scores. Even though the former group alone may be considered as abnormal in a clinical setting both groups are qualified as abnormal according to the statistical norms as both groups deviate from the majority.

Another criterion which is considered in identifying abnormality is that of an "ideal state". Evidently this cannot be of any practical use as an ideal state, if at all present, is attainable only by a few persons thus disregarding the major bulk of the population.

In a clinical setting, the statistical criterion of abnormality is supplemented by another—presence of pathological symptoms which are a cause of distress either to the individual or to the community in which he lives. Thus, the practical criteria of abnormal behavior include:

1. Deviation from the social and statistical norms
2. Personal misery (anxiety, fear, depression, etc.) and maladjustment.
3. Personal inefficiency and immaturity preventing the individual from fulfilling his expected role in the community.

CAUSES OF ABNORMALITY

It will be over simplifying to say that behavioral abnormalities are the resultant of one particular event. This is because of the multiplicity of causes which are constantly interacting and are also dynamic in nature. In psychiatry unlike in physical illnesses (even where the paradigm may fail), there is no one to one correlation between cause and effect. Even in physical illnesses (for example, a systemic infection), a number of factors affecting the invading organism's virulence and the host's vulnerability operate modifying the illness presentation.

Multiplicity of Factors

It is customary to categorize the etiological factors as biological, psychological and social (Table 1.1). The biological factors include heredity with its different modes of inheritance and constitutional factors like infection (e.g. encephalitis), trauma (e.g. head injury), metabolic causes (e.g. uremia), vascular causes (e.g. infarction), degeneration (e.g. senility), neoplasms (tumors), etc. The psychological factors include defective growth and personality development, poor coping skills, wrong attitudes, prejudices, etc. Social factors include pathological family environment, sibling and peer group rivalry, economic and cultural deprivations (due to factors related to race, religion, gender, etc.), migration, social catastrophies like war, famine and epidemics and others.

Interaction of Causes

The various etiological factors do not work in isolation but interact mutually and constantly—one influencing the other and being influenced by another. During this process, they assume the roles of predisposing and precipitating agents. The predisposing agents start working earlier and pave the way for further developments either compensatory or decompensatory. The precipitating factors decide the epoch of disease manifestation by showing the symptoms. The precipitating causes of one instant may well be the predisposing factors of another instant and vice versa. Often the pattern of their interaction may be far from clear.

Table 1.1: Causes of abnormal behavior

Faulty make up

- Heredity
- Infections and infestations
- Trauma
- Metabolic causes
- Vascular causes
- Degeneration
- Neoplasms

Faulty environment

- Family pathology
- Sibling and peer group rivalry
- Deprivation and bereavements
- Unemployment
- Economic instability
- Marital disharmony
- Social changes and insecurity
- Migration
- Catastrophic events

Faulty adjustment

- Faulty learning
- Poor coping skills
- Inner conflicts
- Frustrations
- Prejudices

Dynamicity

The various etiological factors operate constantly and simultaneously. It is a dynamic process and the factors are not static. Some of them might have started operating even before the individual was born, say at the time of conception or while he was still in the mother's womb when they are qualified as hereditary or congenital respectively. After birth the individual continues to be influenced by them for the rest of his life. The disease is the end result of all such interactions and denote their combined effects on the individual and his adaptation to them—successful or not—at a particular time. Because of their nonstatic nature many use the term "dynamics of behavior" in preference to the word "etiology".

STRESS AND COPING

Stresses are the problems of adjustment operating at biological or psychosocial levels. Unless the individual adopts adjustive measures they may disturb the normal equilibrial state and the integrated functioning of the organism, this leading to pathological conditions.

Traffic accidents, infections, bodily afflictions, etc. are the examples of biological stresses. Sources of psychosocial stresses are frustrations, bereavements, conflicts, fear, anxiety, etc. Whenever there are stresses the body has inherent coping mechanisms to combat them. At a biological level compensatory mechanisms are mediated through the autonomic nervous system and the endocrine glands. Selye called this the general adaptation syndrome (GAS) and identified its three stages (Fig. 1.2), the alarm reaction, the stage of resistance and the stage of exhaustion. The third stage indicates that the organism is at the point of decompensation.

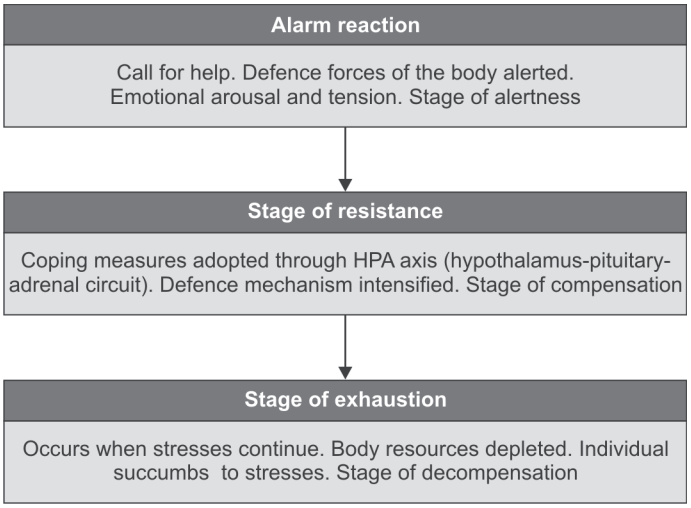

Fig. 1.2: General adaptation syndrome

DEFENCE MECHANISMS

As at the biological level there are coping mechanisms at a psychological level also which help to maintain the integrity

of the self. Freud called them ego defence mechanisms as they are defences employed to protect "ego" or the conscious mind. The individual may not be aware of their presence as they operate at an "unconscious" level. Every individual at one time or other resorts to them. This is "normal" just as the biological ones are. Some of the important defence mechanisms are the following:

i. **Denial:** Among the defence mechanisms denial is the simplest and the most primitive one. Here, the individual avoids an unpleasant reality by ignoring its presence. Thus, one who has a life-threatening disease of which he is aware belittles its seriousness by "forgetting" to take the medicines in time or to see the doctor regularly. Those who are afraid of death and its inevitability wears a seemingly resigned attitude and makes casual remarks as "death is inevitable" or "all those born shall die one day". The alcoholic denies his illness by believing that he has no serious problem as he drinks only in the evenings and not regularly.

ii. **Repression:** Thoughts, experiences or impulses invoking guilt feelings and which on retrospect produce shame and self reproach are pushed into "unconscious" through repression. When successfully repressed these feelings are denied access to consciousness. The individual "forgets" such painful events selectively and is unable to recall them by his conscious efforts. A person who loses all his belongings in a social riot, and who had to flee from his home may not even remember that there was a riot. One who is jealous of his colleague who is admittedly smarter than him "represses" his jealousy and assumes an extra cordial relationship with him (this known as reaction formation in psychology).

Repressed material does not remain dormant in the unconscious for long. It tries to enter the conscious realm through slips of tongue, "accidental" acts of the individual the purpose of which he does not know or through his dreams. It may produce "conversion symptoms" where a mental conflict is "converted" to a physical symptom (for example "hysterical" blindness).

iii. **Sublimation:** Sublimation is the process of channeling out ungratified desires and impulses to socially accepted activities. Thus, the woman denied of a maternal role due to failed marriage finds happiness in working for child welfare.

iv. **Rationalization:** In simple language, rationalization is "giving bad reasons for what we do on impulse". One hunts for arguments to justify his action and after finding them convinces himself that it was the real motive for his action. Going back to the alcoholic what all excuses does he find each time to justify his temptations! It is a new brand; it is a sin to waste as the glass was already filled. It is a social obligation; it would be an insult to his companions if he did not join them; it was a special occasion; it helps him to concentrate or to relax; it is only once this time and one does not matter; or it helps him to take a resolve not to touch it again. Countries go to war "not to grab the other country's land and resources" but because "they want to help the people in that country to set a model government".

v. **Projection:** In this mechanism, the individual projects his shortcomings and objectionable qualities (which he refuses to accept as having) on others and blames them for having these qualities. The greedy accuse others of greed. The student who fails in the examination believes that his teachers were unfair and failed him. Often the objects of projection are fate and bad luck—as "he would have succeeded if the providence was not against him".

vi. **Phantasy:** In plain language, phantasy is day dreaming. It is a mechanism universally resorted to when desires are thwarted. It is a retreat from the real world to an imaginary world where his needs are gratified and desires fulfilled. The mediocre student has phantasies of coming out in the exams in flying colors. The half starved man phantasies himself to be in a feast hall.

There are several other mental mechanisms which are resorted to for coping up stresses. As mentioned earlier, the individual may not be aware of the nature or even the presence of a stress. Similarly, the coping up mechanisms also may

operate at a conscious or unconscious level. Stress arouses various emotions—fear, or anxiety or anger and the subject may be aware of these emotional accompaniments only. In all cases the whole individual, not a part of it, reacts to the stress—physically and psychologically, that is the reactions are holistic. The reactions are also economical with the minimum expenditure of energy as possible so as not to deplete him of his resources unnecessarily.

The individual's tolerance to stress (or frustration) varies considerably. This partly depends on the severity of stress. Stresses are severe when they are long standing, multiple or repetitive. But it is the subjective evaluation of the stress or the importance attached to the problem by the individual which is crucial in deciding the severity of the stress.

When the coping mechanisms fail or decompensate either due to the severity of stress or the individual's poor stress tolerance the organism breaks down leading to various morbid conditions.

PATTERNS OF ILLNESS

These vary widely and are discussed in greater detail in the subsequent chapters.

Psychosis and Neurosis

Psychosis (pl. psychoses), neurosis (pl. nuroses), and their adjectival forms psychotic and neurotic are the terms which are very frequently used in psychiatry. Psychosis refers to a group of disorders which are severe and disabling due to their gross distortion of mental functioning. Distortion of mental functions occur at several levels.

Confusion and other disturbances of sensorium	Cause disturbances in attending to reality (meaning the real world)
Hallucinations	Cause disturbances in perceiving reality
Delusions	Cause disturbances in interpreting reality
Social withdrawal	Cause disturbances in interacting with reality

Because of these gross impairments, the psychotic has severe problems in relating to his environment and people around. He lives in a world of phantasy created from his misperceptions and misinterpretations believing that it is the real world and that his experiences are shared by others also. Look at the following example.

CASE 1

Sam, 23-year-old, went to Bangalore to attend an interview for a tool designer's post. Just before reaching the city he was woken up from his reverie by a male voice calling his name repeatedly. He looked around to find the source of the sound and discovered that it was coming from outside, outside the running bus, from near the window pane. The voice asked him not to attend the interview and to return home. Sam wondered what was happening when the voice ("reading my thoughts") explained that the interview was a hoax for recruiting young men who would be sent abroad and their heart and kidneys removed. The voice warned Sam to keep away from a man "in a red checked shirt" who was the pin of the racket. Reaching Bangalore Sam was afraid to get down from the bus because of the "man in the red checked shirt." He did not call his parents in Kerala nor his relatives in Bangalore to report of his arrival in the city. Also he did not attend the interview. After a frantic search for three days by the anxious relatives and with police help Sam was found hiding in an abandoned railway coach starving and emaciated, deprived of money and all his belongings. He did not dare to step out as "people were waiting to catch and hand him over to the man in the red shirt".

Some other features of psychosis are: (i) incoherent speech which results from disturbances of thinking. Thinking is fragmented and it has no direction. It may also get blocked in between, (ii) prolonged and excessive melancholy or exhilaration, (iii) grossly impaired memory, and (iv) severely disturbed social and personal functioning.

In neurosis on the other hand, the individual retains contact with reality as his perceptions and interpretations are not distorted with hallucinations and delusions. The characteristic symptom of neurosis is anxiety which signifies mental conflicts and maladaptive responses to stress. Symptoms like

"worry", "irritability", "tension", etc. are indicators of anxiety. "Forgetting" and obsessional thoughts and rituals indicate self-defeating attempts of the individual to overcome anxiety, whereas "depression" and fatigue are the residuals of prolonged tension. The individual is distressingly aware of his symptoms and recognizes them as irrational and pathological (ego alien) unlike a psychotic.

Organic Mental Disorders

The term organic is used to distinguish a group of disorders in which there is evidence of brain dysfunction causing or modifying the patient's symptoms. The dysfunction may be primary as when the brain is affected directly. Examples are trauma (e.g. head injury), infections (e.g. encephalitis), vascular (e.g. cerebral thrombosis), toxemias (e.g. drug intoxication), neoplasms (e.g. tumors of brain), degeneration (e.g. dementia), etc. It may be secondary as when brain is affected subsequent to a disease process elsewhere in the body. Uremia is an example.

The most remarkable features of an organic mental disorder are disturbances of consciousness, attention, memory, learning and intellect. However, there are instances where these functions are spared and instead disturbances of perception, thinking, feeling or general behavior are manifested as the presenting symptoms. The symptoms differ depending on their duration also. That is, the features of an acute organic disorder are entirely different from those of a chronic one.

Organic mental disorders may be psychotic or non-psychotic. In the former because of the perceptual and other disturbances the individual loses his capacity to relate normally to the environment as occurs in delirium. In the latter this capacity is retained. An example is sleep disorders due to organic causes.

Personality Disorders

Personality disorders are patterns of maladaptive behavior which produce personal distress, or impairment of social functioning or both. Unlike psychoses and neuroses which are time limited syndromes (having a beginning and an end), personality disorders are lifelong patterns which manifest as early as adolescence or early adulthood. They are also not

limited to any one area of special functioning like cognition or mood, that is they are pervasive affecting all areas of the individual's personality. Several clinically diverse conditions which are described in the later chapters are included in this category.

The Role of Motivation in Shaping Behavior

In ordinary language motivation refers to the reason behind a particular activity. In psychology the term is often used as a synonym for drive or activation. The motives are the forces that drive an organism into activity. They are either innate or acquired. The former fulfills the needs of the organism which are mostly biological like food, water, sleep and elimination. Security and pain avoidance are other innate needs. The lower animals and human infants are almost totally dominated by biological needs. Many human motives are acquired in a social setting like family and social groups through learning. Motives vary with culture. They vary in their intensity also. Motivation is often unconscious and the importance of unconscious motives in directing one's behaviour is extensively incorporated in Freud's theories.

Human needs have a hierarchical setting depending on the individuals level of aspiration. Starting from the basic biological needs they ascend to self actualization through intermediate steps like safety, love and self esteem (Fig. 1.3).

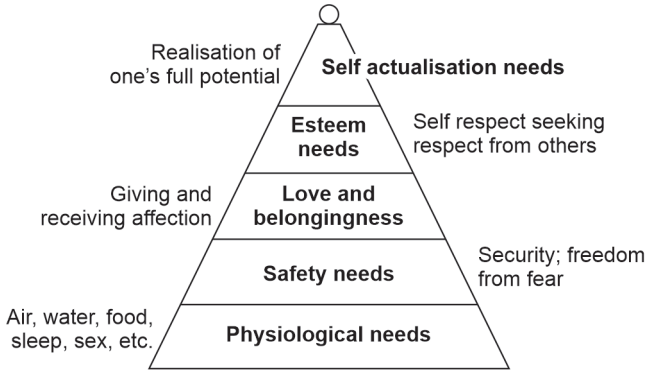

Fig. 1.3: The hierarchy of human needs according to Maslow (1908–1970). A five-tier model of individual needs from the basic biological needs to self-actualisation

Table 1.2: Some subspecialities in psychiatry

Addiction psychiatry
Specifically deals with problems related to addiction and addicts. Addiction by one definition is continued use of psychoactive substances despite physical, psychological and social harm.

Child and adolescent psychiatry
Speciality dealing with problems related to childhood and adolescence.

Community psychiatry
Psychiatric practice in the open community as against in a formal hospital setting.

Forensic psychiatry
Legal psychiatry is a subspeciality concerned with application of psychiatry for legal purposes. It deals with legal issues in which the psychiatric patient is involved.

Geriatric psychiatry
Study of psychological aspects of aging and specific psychiatric problems encountered by elderly people.

Liaison psychiatry
Deals with matters related to practice of psychiatry in a general hospital setting where the psychiatrist works in liaison with other medical specialists.

Military psychiatry
Speciality dealing with psychiatric problems in relation to military service and personnel.

Social psychiatry
Psychiatric speciality concerned with the effect of human environment on mental illness.

THERAPEUTIC TEAM IN PSYCHIATRY

Psychiatric disorders are complex and require a multi-disciplinary approach and treatment team. Its members are specialists in their respective fields. With team work there is pooling of skills which improves the quality of patient care. Team members have their goals defined but they work interdependently to achieve the common purpose. Table 1.3 lists the important and most essential members of the team.

Table 1.3: Team work in psychiatry—members of the therapeutic team

Psychiatrist

Medical graduate (MBBS) with postgraduate specialization in psychiatry (DPM, Dip NB, MD). Psychiatrists alone are licensed to prescribe medicines and to carry out other methods of somatic treatment.

Clinical psychologist

Non-medical therapist with a basic postgraduate degree in psychology (MA/MSc) and specialization in clinical psychology (MPhil/PhD). They administer the various psychological tests in addition to carrying out psychosocial methods of treatment.

Psychiatric social worker

Graduate in psychology or social work with postgraduate training in psychiatric social work. Besides carrying out some psychosocial methods of treatment, they assess and help to rectify faults in the patient's home and work environments. Also in liaison with community's social agencies they help to rehabilitate the patient.

Psychiatric nurse

Graduate nurse with postgraduate training in psychiatric nursing. In addition to dispensing medicines and care giving, she keeps patients under constant observation, particularly those who have specific problems (suicidal risk, aggression, self neglect, etc.). She also takes part in the group therapeutic programs conducted inside the hospital.

Occupational therapist

Graduates or postgraduates in occupational therapy (DOT/BOT/MOT). After assessment of a patient the occupational therapist selects a craft which is most suited for the patient's physical and psychological rehabilitation. Occupational therapy is often combined with recreational activities. New skills are learnt, self-confidence and competitiveness are enhanced and interaction with others is strengthened by occupational therapy.

Psychiatric aides

Male or female members of the nursing staff. They do not have a professional qualification as a nurse but are imparted orientation courses in ongoing in-service programmes and individual supervision by a qualified staff nurse. They assist nurses in caring to the physical needs of the patient (feeding, dressing, etc.).