

Getting started

Psychiatry can seem disconcertingly different from other specialties, especially if your first experience is on a psychiatric in-patient unit. How do I approach a patient? What am I trying to achieve? Is he or she dangerous? How does psychiatry relate to the rest of medicine? This chapter is meant to help orientate anyone facing this situation. Like the rest of the book, it is based on three principles:

- Psychiatry is part of medicine.
- Psychiatric knowledge, skills and attitudes are relevant to all doctors.
- Psychiatry should be as effective, pragmatic and evidence-based as every other medical specialty.

What is psychiatry?

'Psychiatry is ... weird doctors in Victorian asylums using bizarre therapies on people who are either untreatably mad or who are not really ill at all.' Although remnants of such ill-informed stereotypes persist, the reality of modern psychiatry is very different and rather more mundane! Psychiatry is, in fact, fundamentally similar to the rest of medicine: the treatments used are primarily evidence-based, with success rates comparable with those in other specialties. Psychiatric patients are not a breed apart – psychiatric diagnoses are common in medical patients, and most patients with psychiatric disorders are treated in primary care. And psychiatrists are no stranger than other doctors, probably.

Psychiatric disorders may be defined as illnesses that are conventionally treated with treatments used by psychiatrists, just as surgical conditions are those thought best treated by surgery. The specialty designation does not indicate a profound difference in the illness or type of patient. In fact it can change as new treatments are developed; peptic ulcer moved from being a predominantly surgical to a medical condition once effective drug treatments were developed.

Similarly, conditions such as dementia may move between psychiatry and neurology.

The conditions in which psychiatrists have developed expertise have tended to be those that either manifest with disordered psychological functioning (emotion, perception, thinking and memory) or those that have no clearly established biological basis. However, scientific developments are showing us that these so-called psychological disorders are associated with abnormalities of the brain, just as so-called medical disorders are profoundly affected by psychological factors. Consequently, the delineation between psychiatry and the rest of medicine can increasingly be seen as only a matter of convenience and convention.

Traditional assumptions, however, continue to influence both service organization (with psychiatric services usually being planned and often situated separate from other medical services) and terminology (see below).

Where is psychiatry going?

Psychiatry is evolving rapidly, and three themes permeate this book:

- *Psychiatry, like the rest of medicine, is becoming less hospital based.* Most psychiatric problems are seen and treated in primary care, with many others handled in the general hospital. Only a minority are managed by specialist psychiatric services. So psychiatry should be learned and practised in these other settings too.
- *Psychiatry is becoming more evidence-based.* Diagnostic, prognostic and therapeutic decisions should, of course, be based on the best available evidence. It may come as a surprise to discover that current psychiatric interventions are as evidence-based (and sometimes more so) as in other specialties.

- *Psychiatry is becoming more neuroscience based.* Developments in brain imaging and molecular genetics are beginning to make real progress in the neurobiological understanding of psychiatric disorders. These developments are expanding the knowledge base and range of skills that the next generation of doctors will need. These developments do not, however, make the other elements of psychiatry – psychology and sociology, for example – any less important, as we will see later.

Why study psychiatry?

Studying psychiatry is worthwhile for all trainee doctors, and other health practitioners, because the knowledge, skills and attitudes acquired are applicable to every branch of medicine. Specifically, studying psychiatry will give you:

- A basic knowledge of the common and the ‘classic’ psychiatric disorders.
- A working knowledge of psychiatric problems encountered in all medical settings.
- The ability to effectively assess someone with a ‘psychiatric problem’.
- Skills in the assessment of psychological aspects of medical conditions.
- A holistic or ‘biopsychosocial’ perspective from which to understand all illness.

Useful knowledge

Formerly, patients with severe psychiatric disorders were often institutionalized and their management was exclusively the domain of psychiatrists. The advent of community care means that other doctors, especially GPs, encounter and participate in the management of such patients, so all doctors need basic information about these ‘specialist’ psychiatric disorders. Equally, all doctors need to recognize and treat the more common psychiatric illnesses, such as anxiety and depressive disorders. These are extremely prevalent in all medical settings, yet they are all too often overlooked and ineffectively treated.

Useful skills

Most psychiatric disorders are diagnosed from the history, and many treatments are based on listening and talking. So, psychiatrists have had to acquire particular expertise in interviewing patients, in assessing their state of mind and in establishing a therapeutic

doctor–patient relationship – with patients who may pose challenges in this respect because of the nature of their problems. These skills remain important in all medical practice. For example, all doctors should be able to:

- Make the patient feel comfortable enough to express their symptoms and feelings clearly.
- Use basic psychotherapeutic skills – for example, knowing how to help a distressed patient and how best to communicate bad news.
- Discuss and prescribe antidepressants and other common psychotropic drugs with confidence.

Without these ‘soft’ skills, the ‘hard’ skills of technological, evidence-based medicine cannot be fully effective. An impatient, non-empathic doctor is less likely to elicit the symptoms needed to make the correct diagnosis, and their patient is less likely to adhere to the treatment plan they prescribe.

Useful attitudes

Psychiatric diagnoses are still associated with stigma and misunderstanding. These stem largely from the misconception that illnesses that do not have established ‘physical’ (or ‘organic’) pathology are ‘mental’, and that such ‘mental’ illness is not real, represents inadequacies of character, or is the person’s own fault. Studying psychiatry will help you to challenge these attitudes. You will see many patients with severe symptoms in whom no ‘organic’ pathology has been established, but who have real symptoms and disability. You will be repeatedly reminded of the stigma that patients with psychiatric problems experience from the public, and sometimes from their relatives and even, sadly, from health professionals. Finally, you will be confronted with the reality of human frailty. Recognizing these issues and dealing with them appropriately – by developing positive, educated and effective attitudes – is another important consequence of studying psychiatry. You might conclude, as we have done that:

- Suffering is real even when there is no ‘test’ to prove it.
- Psychological and social factors are relevant to all illnesses and can be scientifically studied.
- Much harm is done by negative attitudes towards patients with psychiatric diagnoses.

Your own experience and personality will influence your relationship with patients – your positive attributes as well as your vulnerabilities and prejudices.

How to start psychiatry

The psychiatric interview

The first, key skill to learn is how to listen and talk to patients, in that order. The *psychiatric interview* has two functions:

- It forms the main part of the psychiatric assessment by which diagnoses are made.
- It can be used therapeutically – in the psychotherapies, the communication between patient and therapist is the currency of treatment (Chapter 7).

Psychiatric assessment

Because of its central importance, the principles of psychiatric assessment are outlined here. The practicalities are described in the next two chapters. Psychiatric assessment has three goals:

- 1 To elicit the information needed to make a diagnosis, since a diagnosis provides the best available framework for making clinical decisions. This may seem obvious, but it hasn't always been so in psychiatry.
- 2 To understand the causes and context of the disorder.
- 3 To form a therapeutic relationship with the patient.

Though these goals are the same in all of medicine, the balance of psychiatric assessment differs in several ways. Firstly, the interview provides a greater

proportion of diagnostic information. Physical examination and laboratory investigations usually play a lesser, though occasionally crucial, role. Secondly, the interview includes a detailed examination of the patient's current thoughts, feelings, experiences and behaviour (the *mental state examination*), in addition to the standard questioning about the presenting complaint and past history (the *psychiatric history*). Thirdly, a greater wealth of background information about the person is collected than in other specialties (the *context*).

Psychiatric assessments have a reputation for being excessively long. We take a pragmatic approach to the process of assessment. A *basic psychiatric assessment* is used to collect the essential diagnostic and contextual information (Chapter 2). Then, more detailed *diagnosis-specific assessments* are used if anything has led you to hypothesize that the patient has a particular disorder (Chapter 3). This two-stage *basic and diagnosis-specific* approach considerably shortens most assessments – to 45 minutes or less. It also happens to be what psychiatrists actually do – as opposed to what they tell their students to do.

Diagnostic categories

Solving a problem is always easier when you know the range of possible answers. Similarly, before embarking on your first assessment, it helps to know the major psychiatric diagnoses and their cardinal features. Table 1.1 is a simplified guide. As you gain experience, aim for more specific diagnoses that correspond to those listed in the *International*

Table 1.1 A basic guide to psychiatric classification

Category	Examples of disorders	Basic characteristics	Common presentations
Organic disorder	Dementia, delirium	Defined by 'organic' cause	Forgetfulness, confusion
Psychosis	Schizophrenia	Delusions, hallucinations	Bizarre ideas, odd behaviour
Mood disorders	Depression	Low mood	Tearful, fed up, somatic complaints
Neurosis	Anxiety disorders	Emotional disturbance	Worried, tired, stressed
Somatoform disorders	Somatization disorder	Unexplained physical symptoms	Chronic pain, fear of disease
Substance misuse	Opiate dependence	Effects of the drug	Addiction, withdrawal, depression
Personality disorder	Dissocial, histrionic	Dysfunctional personality traits	Exacerbation of traits when stressed
Learning disability	Down's syndrome, autism	Congenitally low IQ	Developmental delay, physical appearance

Classification of Diseases, 10th revision (ICD-10), which are used in this book (see Appendix 1). There is an alternative to ICD-10, published by the American Psychiatric Association, called the *Diagnostic and Statistical Manual of Mental Disorders*. It is widely used in research, and the controversial 5th edition (DSM-5) was published in 2013. The two systems are broadly similar. Whatever the classification, remember the underused category of ‘no psychiatric disorder’. A term such as ‘nervous breakdown’ has no useful psychiatric meaning – it may describe almost any of the categories in Table 1.1.

Psychiatric classification

The classification of psychiatric disorders has several problems that you should be aware of before you start:

- *Most diagnoses are syndromes, defined by combinations of symptoms, but some are based on aetiology or pathology.* For example, depression can be caused by a brain tumour (diagnosis: organic mood disorder), or after bereavement (diagnosis: abnormal grief reaction) or without clear cause (diagnosis: depressive disorder). This combination of different sorts of category leads to some conceptual and practical difficulties, which will become apparent later.
- *Comorbidity: many patients suffer from more than one psychiatric disorder* (or a psychiatric disorder and a medical disorder). The comorbid disorders may or may not be causally related, and may or may not both require treatment. As a rule, comorbidity complicates management and worsens prognosis.
- *Hierarchy: not all diagnoses carry equal weight.* Traditionally, organic disorder trumps everything (i.e. if it is present, coexisting disorders are not diagnosed), and psychosis trumps neurosis. This principle is no longer applied consistently, partly because it is hard to reconcile with the frequency and clinical importance of comorbidity.
- *Categories versus dimensions.* The current system assumes there are distinctions between one disorder and another, and between disorder and health. However, such cut-offs are notoriously difficult to demonstrate, either aetiologically or clinically, whereas there is good evidence that there are continuums – for example, between bipolar disorder and schizophrenia, and for the occurrence of psychotic symptoms in ‘normal’ people. However,

clinical practice requires ‘yes/no’ decisions to be made (e.g. as to what treatment to recommend) and so a categorical approach persists.

- *Psychiatric classification is not an exact science.* All classifications have drawbacks, and psychiatry has more than its share, as illustrated by the above points. Nevertheless, despite the imperfections, rational clinical practice requires a degree of order to be created, and most of the current diagnostic categories at least have good reliability, and utility in predicting treatment response and prognosis.

After the assessment: summarizing and communicating the information

Completion of the psychiatric assessment is followed by several steps:

- *Make a (differential) diagnosis,* according to ICD-10 categories (Appendix 1), using your knowledge of the key features of each psychiatric disorder.
- *Attempt to understand how and why the disorder has arisen* (Chapter 6).
- *Develop a management plan,* based on an awareness of the best available treatment (Chapter 7), how psychiatric services are organized (Chapter 8) and the patient’s characteristics, including their risk of harm to self or others (Chapter 4).
- *Communicate your understanding of the case* (Chapter 5).



KEYPOINTS

- Psychiatry is a medical specialty. It mostly deals with conditions in which the symptoms and signs predominantly relate to emotions, perception, thinking or memory. It also encompasses learning disability and the psychological aspects of the rest of medicine.
- Knowledge, skills and attitudes learned in psychiatry are relevant and valuable in all medical specialties.
- Be alert to the possibility of psychiatric disorder in all patients, and be able to recognize and elicit the key features.
- The major diagnostic categories are: neurosis, mood disorder, psychosis, organic disorder, substance misuse and personality disorder.