INVITED ARTICLE

APPROACH TO PSYCHIATRY - AN OVERVIEW

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INTRODUCTION

The statement that health is more than the absence of disease implicitly acknowledges the existence of the mental component of illness and well-being. It is natural to assume that the disease mentioned refers to medical disease with a recognised aetiology, demonstrable pathology and predictable course. However in mental disorder one tends to talk of predisposing, precipitating and perpetuating factors. Whether the individual suffers from medical disease or mental disorder there would be complaint of symptoms caused by disturbed structure or function. When subjective experience is corroborated by objective finding, an illness is present. It should be appreciated that mental illness is as real and incapacitating as physical illness. As the saying goes when a person dies of suicide he is as dead as another who dies of stroke or stab wound.

CONCEPT OF NORMALITY

Unless what is normal is known it is improper to talk about treating what is diseased or abnormal. In general, what is normal refers to the absence of pathology, a statistical average or an ideal norm. Thus what is normal or abnormal may vary from culture to culture and from one period of time to another. Besides, what is statistically deviant may merge into what is pathologically abnormal. Very often what is normal or abnormal is influenced by philosophy of life, religious faith, political system, economic factors and administrative convenience.

It is therefore important to ask what is the norm for each individual and what is the nature and degree of deviation. To know the answer one has to be interested in and be well-informed about life and how people live.

NATURE OF PSYCHIATRIC PROBLEMS

The disease oriented physician is concerned with tissues and organs and their vegetative functions. However, the living person has physical, psychological, social and spiritual attributes which are inter-related, interactional and integrated. Disturbance in any one aspect would affect the well-being of the rest, causing stress and distress to the individual as a whole. On the other hand support and succour to any one area would contribute to the strengthening and restoration of total health. Depending on the proportions of biological, psychological and social factors involved the patient may suffer from an obvious organic disease eg epilepsy, brain infection or tumour; a psychiatric illness eg schizophrenia, depression or paranoid state; a psychosocial reaction eg anxiety, phobia or adjustment disorder; or just a problem in living eg relationship difficulty, domestic crisis or stress at work.

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As a result there are medical, psychological and social theories and models of mental disorders. Consequently, the management may include medical treatment, psychotherapy, social intervention or policy making eg various legislations.

Apart from the common psychotic symptoms ie hallucination, delusion, thought disorder, abnormal mood and behaviour, psychiatric problems frequently present with somatic symptoms just as physical diseases often produce mental symptoms. The physical organs are like the hardwares and the mental faculties are like the softwares. Both must be in good condition to function together.

According to the nature of each case, the emphasis may be completely medical, psychological or social. But more often than not the problem requires a holistic approach and the solution needs a multi-disciplinary team. This is particularly true in the case of the developing young and the declining old whose problems are frequently multi-axial in nature. No single theory explains all and no single treatment is comprehensive.

SIZE OF PSYCHIATRIC PROBLEMS

Depending on definitions, criteria, methodology, demographic pattern, geographical area, cultural practice, economic development and life-style varying data have been reported. Based on mainly western figures, very roughly the prevalence of the major psychiatric disorders such as schizophrenia and depression are about 0.5% and 10% respectively. For the minor psychiatric disorders like neurotic disorders and others it is about 15-20% and mental retardation of various degrees occurs around 3%. The dementias would increase with the ageing population while the young are constantly exposed to the danger of drugs and abuses. Alcohol dependence is also a major area of growing concern with changing life-style. The disability and dependency caused may be complete or partial, permanent or temporary.

Goldberg and Huxley of UK studied the pathway to psychiatric care[1]. In a community survey of a random population sample of 1,000, 250 were noted to have some complaints. Of these, 230 exhibited illness behaviour and sought help at primary care level and 140 were detected to have conspicuous psychiatric morbidity. Only 17 were referred to the psychiatrist and 6 were eventually admitted to mental hospital. Thus the bulk of psychiatric morbidity is managed in the community.

PROBLEM OF TERMINOLOGY

Psychiatric terminology is still in a flux. Mental disorder is a generic term that covers all the mental conditions that fall within the specialty of psychiatry. In common practice, it includes mental illness, mental retardation, personality disorder, substance abuse and sexual deviancy. Mental illness is traditionally divided into psychoses and neuroses. Other terms like mental disease and disease of the mind are more legal in usage than medical in origin. Unsound mind is a legal term and is context bound to the legal issue at hand.

CLASSIFICATION OF MENTAL DISORDERS

Different countries may adopt different national systems of classification of mental disorders. The most widely used are the Glossary of Mental Disorders of the World Health Organi-

sation's International Classification of Diseases 9th Revision (ICD-9) and the American Diagnostic and Statistical Manual of Mental Disorders 3rd Edition Revised (DSM-III-R). ICD-9 and DSM-III-R will be replaced by ICD-10 and DSM-IV respectively in the near future. The nomenclature and classification of mental disorders or even their concepts and descriptions are therefore not universally uniform nor static. In Singapore the WHO ICD-9 is officially used although professionally and clinically DSM-III-R is becoming more popular.

In clinical practice variation in diagnostic labels are accepted so long as operational criteria are spelt out. It is important to be clear about what is a nosological entity, a clinical syndrome and a consensus of opinion.

COMMON MENTAL DISORDERS

Dementias

Dementias are organic psychoses. The course is chronic. The clinical syndrome of dementia is characterised by global deterioration of memory, intellect and personality. Early symptoms include forgetfulness, disorientation, anxiety, depression and erratic behaviour. Aetiologically, the dementias may be primary eg Alzheimer's disease and secondary eg multi-infarction of brain, encephalitis, hypothyroidism etc.

Psychoses

Traditionally, psychosis is a mental condition in which the symptoms are non-understandable and the patient is out of touch with reality and lacks insight. These criteria are however not absolute. To put it another way, there is a breakdown in conformity (at community level), breakdown in communication (at interpersonal level) and breakdown in control (at individual level). Thus the appearance and behaviour may be bizarre, intolerable and unacceptable; the speech may be irrational and incoherent; and as a result of abnormal experience and belief eg hallucination, delusion, mood state and thought disturbance, the psychotic may act out beyond self control.

Neuroses

The neurosis is often taught to differ from the psychosis in that its symptoms are understandable; the individual is in contact with reality and there is presence of insight. Although these criteria are not quite absolute, they do indicate that the feelings and reactions of neurotic states are common and shared by the normal as well. What separate the neurotic complaint from the ordinary experience are the intensity, duration and frequency of the symptoms.

Personality Disorder

Personality may be considered as the sum total of an individual's physical endowment, mental capacity, emotional experience and pattern of behavioural response. Together they manifest certain traits and tendencies which are enduring, predictable and are evident from young. These traits and tendencies may be an advantage or a disadvantage depending on the circumstances. However, some traits and tendencies when excessive and non-adaptive become a liability and cause distress and suffering not only to the individual but also to others. When this is persistent, a personality problem or disorder is said to exist.

PSYCHIATRIC CONSULTATIONS

Psychiatric consultation ranges from problem in living to neurosis, psychosis and organic brain syndrome. In fact, in liaison psychiatry it covers virtually the whole of medicine and human activities. Our psychiatric practice is phenomenological in approach. Accurate observation and reliable description of the development and progress of signs and symptoms are of paramount importance. There is no substitute for a complete and detailed case history. The stigma of mental illness is such that people often seek psychiatric treatment as a last resort. Patients, relatives and friends alike are therefore inclined to deny the mental afflictions and attribute them to some cultural beliefs or plausible explanations. It is therefore important to distinguish objective facts from subjective understanding or interpretation.

GUIDELINES FOR ADMISSION

Admission to the mental hospital may be voluntary or involuntary. When involuntary it may be on a Warrant of Remand from the Court or under the Mental Disorders and Treatment Act (1985). Under the Act, a person suspected of being of unsound mind could be compulsorily detained for treatment if it is believed that his unsoundness of mind poses a danger to himself or to others. Specific procedures must be followed.

HISTORY TAKING

Clerking should be systematic and complete as far as possible. Interview is best conducted in the language or dialect that is most familiar to both the doctor and the patient or informant. It is very important to ascertain all the time that what is asked is fully understood and what is answered is equally so. When in doubt always clarify and verify, and do not assume. Proper assessment requires a good history.

There is much to be learned from the past which can throw light on the present. Certain background tends to shape certain behaviour, and certain personality make-up tends to respond in certain manner. In many mental disorders they tend to run a recurrent course. Presence of family history and history of past episodes and treatment response are of enormous help. Chronological order of account or sequence of events is of utmost importance. Diagnosis is based on the primary disturbance rather than on the secondary manifestation eg delusional ideas from abnormal effect.

APPROACH TO DIAGNOSIS

It is important to realise that for every piece of behaviour there could be a number of reasons or explanations; and for every complaint or symptom there could be a number of differential diagnoses. One should not adopt a check list approach to diagnosis but rather should consider the whole clinical picture. The question of what are the facts of the case must always be determined. The following steps may be helpful:

1. The first question to ask is whether there has been a change (and when) in personality or behaviour and work performance.
2. Is the change normal or abnormal, understandable or non-understandable?
3. If abnormal and non-understandable, is it likely to be an organic or functional psychosis?
4. If organic, is it acute or chronic ie delirium or dementia. Substance abuse disorders presenting with confusional state may be due to intoxication or withdrawal.
5. If functional, is it schizophrenic, affective or paranoid. (Many paranoid disorders have underlying organic conditions)
6. When the change is understandable but the complaints are out of proportion in intensity, duration and frequency–neurotic conditions are likely. (However, when patients present with "inexplicable withdrawal or fearfulness, schizophrenia ought to be excluded.)
7. Remember to think of the underlying personality and to always exclude temporal lobe epilepsy, hypo/hyperthyroidism, frontal lobe syndrome, AIDS and effects of drugs.

MANAGEMENT

Psychiatric management consists of physical, psychological and social methods. Medical treatment is essentially symptomatic. Early treatment cannot be over emphasized.

REFERENCE

1. Goldberg D, Huxley P. Mental illness in the community - The pathway to psychiatric case. London: Tavistock Publications Ltd 1980.