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First thoughts

In the stanzas (see Box 1.1), the satirist Alexander Pope captured the essence of the then ongoing European Enlightenment, inspiring his readers to use their sense of reason to replace irrationality in their exploration of the world. This period also saw the re-emergence of attempts to use the same methods of thinking to study mental illness, whose sufferers had then spent more than a thousand years as objects of fear and superstition. Pope's words resonate even today, nearly three centuries later, when—confronted with patients thinking 'too little or too much' or in 'chaos of thought and passion all confused'—we are still struggling to use science to guide the exploration of this 'riddle of the world'.

Psychiatry has often been derided as the Cinderella specialty—poorly funded, exiled to outside hospitals, a victim of rushed political experiments, castigated by anti-psychiatrists, its intellectual basis ridiculed, and the self-confidence of its practitioners lowered. As a trainee psychiatrist, you will have to cope with questions like 'are you a real doctor?' In addition, the general public (and sometimes other medical professionals) frequently misunderstand the types and severity of illnesses that you deal with. Either they picture you spending all of your time tending to Woody Allen-like self-obsessed, befuddled neurotics or guarding Hannibal Lecter-like murdering psychopaths. The reality is that psychiatrists deal with the most common human disorders which cause the greatest morbidity worldwide.

Psychiatry considers all aspects of human experience over the whole of the lifespan: elation, grief, anxieties, flights of fancy, confusion, despair, perception and misperception, and memory and its loss. We see the mother with a healthy baby, perplexed and frightened by her tearfulness and inability to cope, and terrified by her thoughts of harming her child. We see the family of a young man who have watched him become a stranger, muttering wild accusations about conspiracies, and we aim to be the doctors who know what best to do in these circumstances. The specialty of psychiatry is (or should be) the most 'human' specialty—devoted to the understanding of the whole person in health and illness. Indeed, it is the only medical specialty without a veterinary counterpart.

It is certainly true that the level of knowledge about causation and treatment of mental disorders is less advanced than for other branches of medicine. In some ways, however, this is an attraction. In other specialties, much of what was formerly mysterious is now understood, and interventions and diagnostic methods once fantastic are now quotidian. Psychiatry offers a final frontier of diagnostic uncertainty and an undiscovered country of aetiology to explore. Perhaps the lack of progress made in psychiatry, compared with the other specialties, is not because of lack of will or intelligence of the practitioners, but due to the inherent toughness of the problems. To put this another way, all scientists 'stand on the shoulders of giants'—in psychiatry, we have no fewer and no shorter giants, just a higher wall to peer over.

Box 1.1 The proper study of mankind

Know then thyself, presume not God to scan
The proper study of mankind is man
Placed on this isthmus of a middle state
A being darkly wise, and rudely great
With too much knowledge for the sceptic side
With too much weakness for the stoic's pride
He hangs between, in doubt to act, or rest
In doubt to deem himself a God, or Beast
In doubt his mind or body to prefer
Born but to die, and reasoning but to err
Alike in ignorance, his reason such
Whether he thinks too little, or too much
Chaos of thought and passion, all confused
Still by himself abuse, or disabuse
Created half to rise, and half to fall
Great lord of all things, yet a prey to all
Sole judge of truth, in endless error hurled
The glory, jest, and riddle of the world
Go, wondrous creature!
Mount where Science guides
Go, measure earth, weigh air and state the tides
Instruct the planets in what orbs to run
Correct old time, and regulate the sun
Go, soar with Plato to the empyreal sphere
To the first good, first perfect, and first fair
Or tread the mazy round his followers trod
And quitting sense call imitating God
As Eastern priests in giddy circles run
And turn their heads to imitate the Sun
Go, teach Eternal Wisdom how to rule
Then drop into thyself, and be a fool
Superior being, when of late they saw
A mortal man unfold all Nature's law
Admired such wisdom in an earthly shape
And showed a Newton as we show an Ape
Could he, whose rules the rapid comet bind
Describe or fix one movement of his mind
Who saw its fires here rise, and there descend,
Explain his own beginning, or his end?
Alas what wonder! Man's superior part
Unchecked may rise, and climb from art to art
But when his own great work is but begun
What reason weaves, by passion is undone
Trace science then, with modesty thy guide
First strip off all her equipage of pride

Box 1.1 (*Contd.*)

Deduct what is but vanity, or dress
Or learning's luxury, or idleness
Or tricks to show the stretch of human brain
Mere curious pleasure, ingenious pain
Expunge the whole, or lop the excrescent parts
Of all, our vices have created arts
Then see how little the remaining sum
Which served the past, and must the times to come!

From Alexander Pope (1688–1744). *An Essay on Man*. As reproduced in *Poetical Works*, ed. Cary HF (London: Routledge, 1870), 225–6.

What is disease?

Most mental diagnoses have had their validity questioned at several points in their history. Diagnosed by doctors on the basis of symptoms alone, some people find their presence difficult to accept in a field which has been almost universally successful in finding demonstrable physical pathology or infection.

Disease in medicine as a whole was not always based on pathology. The microscope was developed long after doctors began to make disease attributions. Thomas Sydenham developed the medico-pathological model based on symptoms, but it has grown to incorporate information obtained from post-mortem and tissue examination. This model of disease has become synonymous in many people's minds with a model based solely on demonstrably abnormal structure. Thomas Szasz (Box 1.6, p. 29) has criticized psychiatry in general by suggesting that its diseases fail when this model is applied.

This argument that psychiatric diagnoses are invalid still strikes a chord with many doctors and non-medical academics. When the *BMJ* conducted a survey of non-disease[1,2] (see Fig. 1.1), many people thought depression to be a non-disease, although schizophrenia and alcoholism fared somewhat better. It is clear from the graph that many conditions rated as real diseases have a characteristic pathology, although some do not (alcoholism, epilepsy). Similarly, many people regard head injury and duodenal ulcer as non-disease, although their pathology is well described. There are several models of disease in existence (see Table 1.1). No single model is adequate by itself, and diseases may move from one group to another. Models based on aetiology or pathology have been found to be the most useful, but the reality may be that 'disease' is a concept which will tend to change over time and has no real existence in itself.

Table 1.1 Models of disease

Model	Summary of assumptions
Medical-pathological definition (Sydenham, 1696; Szasz, 1960)	Assumes diseases are associated with a necessary cause (e.g. bacterial infection) or have a replicable morbid anatomy
Biological disadvantage (Scadding, 1972)	Assumes that sufferers from a disease have a common characteristic to place them at a biological disadvantage
Plan of action (Linder, 1965)	Assumes disease labels are justifications for treatments and further investigations
Syndrome with characteristic symptoms/outcome (Kendell, 1975)	Assumes diseases represent circumscribed concepts distinguished from others by a bimodal distribution of scores on a discriminant function
Disease as imperfection (Cohen, 1943; 1953)	Assumes diseases are quantitative or qualitative deviations from a desirable norm
Disease as 'concept' (Aristotle)	Assumes diseases are man-made abstractions with no independent existence

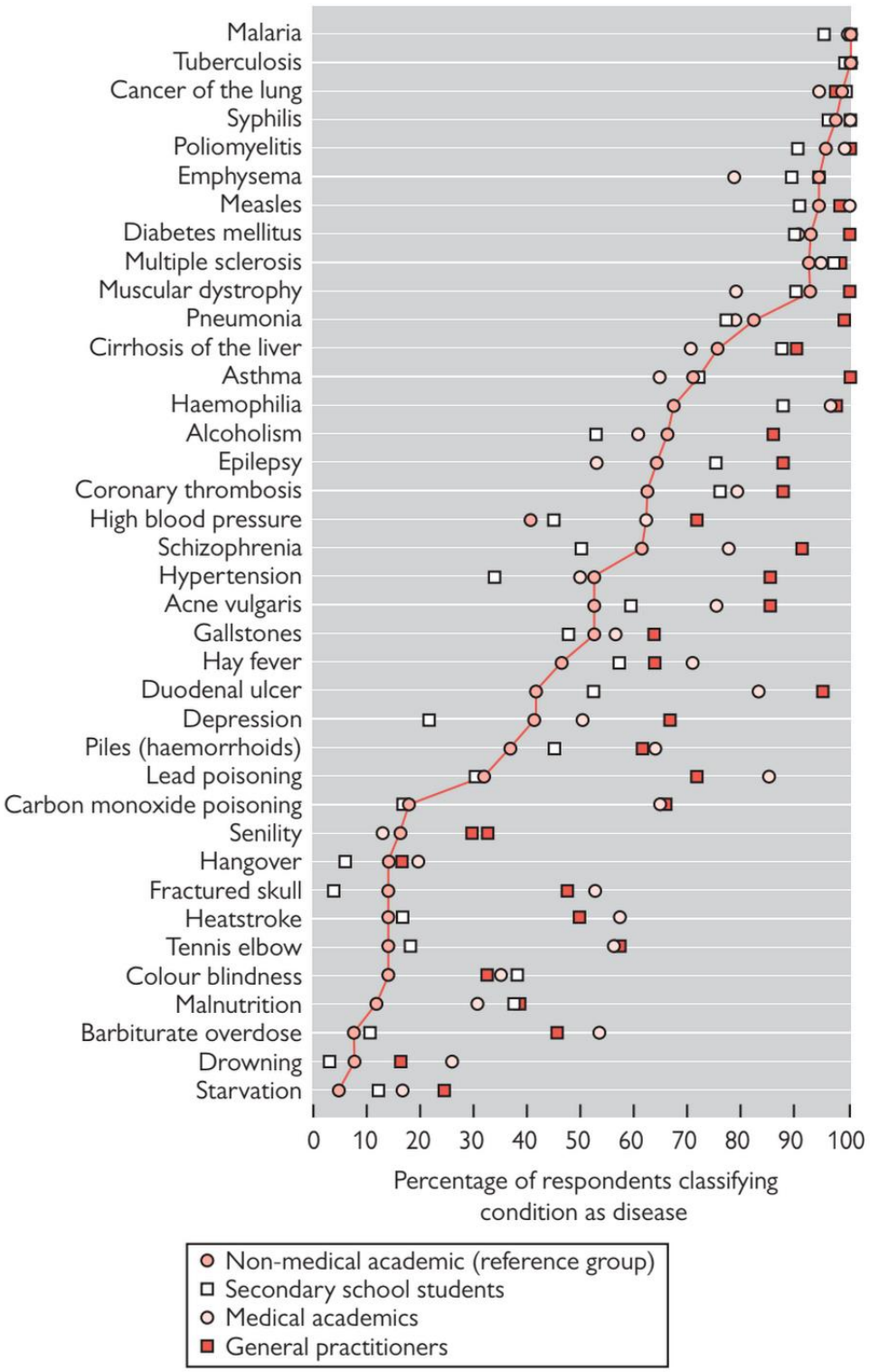

Fig. 1.1 Percentage of respondents classifying a condition as a disease.

Reproduced from Smith R (2002) In search of 'non-disease'. *Br Med J* **324**: 883–5 with permission of BMJ Publishing Group.

The role of the psychiatrist

What is illness?

Doctors, being generally practical people, busy themselves with the diagnosis and treatment of various types of illness. They rarely ask 'what is illness?' or 'what is health?' For several reasons, this type of questioning is more germane for psychiatrists:

- While all illnesses have subjective components, psychiatric disorders are usually completely diagnosed by the patient's subjective experiences, rather than objective abnormalities.
- There is a non-absolute value judgement involved in the diagnosis of mental disorder, e.g. wheeze and dyspnoea are abnormal and signs of disease, but some degree of anxiety at times is a common experience and the point at which it is pathological is debatable.
- Mental illnesses have legal consequences.
- It is important psychiatrists are clear about which behaviours and abnormalities are their province. Psychiatrists have been involved in human rights abuses in states around the world when definitions of mental illness were expanded to take in political insubordination.

Disease, sickness, and illness behaviour

The distinction between disease (or disorder) and sickness should be understood. Disease encompasses either a specific tissue lesion or a characteristic constellation of symptoms. Sickness, on the other hand, encompasses the suffering and functional deficit consequent on symptoms. One may exist without the other, e.g. a patient with undiagnosed, asymptomatic breast cancer undoubtedly has disease but is not sick; a patient with chronic fatigue syndrome may see themselves (and be considered) as sick but does not have an identifiable lesion.

Patients generally present complaining of symptoms, and this process is called illness or illness behaviour. Patients need not be suffering from a disease or disorder in order to do this, and sometimes illness behaviour may be abnormal (even when the patient does have a disease). Subject to certain social conventions (e.g. attending a doctor), they are then afforded the 'sick role', which allows them to relinquish some of their normal obligations. This is a man-made concept, encompassing the special rights and expected behaviour of both someone who is sick and the doctor who is treating them (see Table 1.2). Difficulties arise when a person adopts the sick role to gain the rights afforded to them, while neglecting their duties. Another concern relates to the process of diagnosis—causing someone who is not currently ill to adopt the 'sick role'. Doctors should understand their special responsibility to act in the patient's best interests and not to stray outside their area of expertise.

Clarity of roles

It is all too easy for psychiatrists to slip into other roles than that which is properly theirs—an expert in mental disorder. These may include: substitute parent, 'friend', guardian of public morals, predictor of future criminality, arbiter of normal behaviour. Psychiatrists have special training and experience in mental disorder and should avoid being drawn outside this

remit in their professional role. Psychiatrists are properly occupied in the business of diagnosing and treating significant psychiatric disorders. As gatekeepers to mental health resources, there are often pressures to validate distress or medicalize normal experience. Saying someone does not satisfy the criteria for a specific mental disorder does not mean that they do not have significant problems; rather, the problems do not fall within the scope of psychiatry and would be best dealt with by help or advice elsewhere.

Good mental health is more than simply the absence of mental disorder; it requires:

- A sense of self-sufficiency, self-esteem, and self-worth.
- The ability to put one's trust in others.
- The ability to give and receive friendship, affection, and love.
- The ability to form enduring emotional attachments.
- The ability to experience deep emotions.
- The ability to forgive others and oneself.
- The ability to examine oneself and consider change.
- The ability to learn from experience.
- The ability to tolerate uncertainty and take risks.
- The ability to engage in reverie and fantasy.

Table 1.2 The rights and duties of patients and doctors

Patient	Doctor
Rights	
Exemption from blame	To be considered an expert
Exemption from normal duties while in the sick role	To have privileged access to patient information and person
To expect the doctor to act in their best interests	To direct (and sometimes insist on) a course of action To validate the sick role
Duties	
To seek help	To act in the patient's best interests
To be open and honest	To maintain confidentiality
To comply with treatment	To keep up-to-date
To give up the sick role once well	To act, where possible, in society's interests

Diagnosis in psychiatry

Labels

People prefer to be seen as individuals, rather than members of a class: 'I'm a person, not a label'. This desire to recognize uniqueness is a part of the public reaction against race-, class-, and gender-related value judgements. Doctors, on the other hand, seem to love labels and classification and, in their enthusiasm, can appear like the Victorian butterfly collector who is only able to deal with life when it is named, categorized, and safely inert behind glass. Medical labels are based on characteristic combinations of symptoms and signs, but patient and doctor view these differently. Symptoms are important to patients because of their *individual* nature; this strange and atypical thing is happening to them. Symptoms are important to doctors because they indicate diagnosis and are features which make this patient *similar* to others we have seen or about whom we read.

Diagnosis

The naming of a thing is the first step towards understanding it. We seek to identify disorders (diagnosis) in order to be able to suggest treatments (management) and predict their course (prognosis). Ultimately, the aim is to identify the physical abnormality (pathology) and the cause of the disease (aetiology) and so develop means of prevention and cure. The ideal diagnostic system labels diseases according to aetiology. The aetiology of most mental disorders is unknown, and so we tend towards a diagnostic system based upon common clinical features, shared natural history, common treatment response, or a combination of all three. Diagnosis leads to the consideration of individual diseases as members of groups contained within a hierarchy—a form of classification system.

Why make a diagnosis?

Why allocate the patient, with his individual and unique history, experience, and range of signs to a single label, with the inevitable compromises and loss of information this entails? Diagnosis must be justified on a general and an individual basis. Generally, the process of establishing a diagnosis is essential to allow succinct communication with colleagues, to help predict prognosis, and to carry out valid research on pathological mechanisms and treatments. Remember, however, that allocation of a patient to a diagnostic category can only be justified if it will bring them benefit, not harm.

Classification in psychiatry

Over the past century, within psychiatry, there has been a debate about the value and method of psychiatric classification. On one hand, academic and biological psychiatrists worried that psychiatric diagnosis was insufficiently reliable and valid, with terms being used in imprecise or idiosyncratic ways; on the other hand, psychodynamic practitioners emphasized the importance of unique patient factors and the degree of detail lost by reductionism in diagnostic methods. The first concern was tackled by developing *operational criteria*—clearly defined clinical descriptions of the disorders, together with explicit inclusion and exclusion criteria and details of the number and duration of symptoms required for diagnosis. The second concern was met by *multi-axial diagnosis* where, in addition to the primary mental disorder coded on axis-I, additional axes code the patient's psychosocial problems, personality factors, medical health, and degree of disability (see Box 1.2).

Box 1.2 International classification

The International Classification of Diseases (ICD-10)

(➔ The ICD-10 multi-axial system, p. 1118)

Published in 1992 by the WHO, the ICD-10 is a general medical classification system intended for worldwide multi-specialty use. It includes 21 chapters, identified by a roman numeral and a letter. Psychiatric disorders are described in Chapter V and are identified by the letter F. An index of the disorders described in this book, together with their ICD-10 coding, is given on ➔ pp. 1088–1116.

Coding Disorders are identified using an open alpha-numeric system in the form Fxx.xx. The letter 'F' identifies the disorder as a mental or behavioural disorder; the first digit refers to the broad diagnostic grouping (e.g. psychotic, organic, substance-induced), and the second digit refers to the individual diagnosis. The digits that follow the decimal point code for additional information specific to the disorder, e.g. subtype, course, or type of symptoms. When used as second or third digits, '8' codes for 'other' disorders, while '9' codes for 'unspecified'.

Versions Four versions of the ICD-10 classification of mental disorders exist, suitable for different purposes. ICD-10: *Clinical descriptions and diagnostic guidelines* ('the blue book') is used by psychiatric practitioners and gives clinical descriptions of each disorder, together with the diagnostic criteria. ICD-10: *Diagnostic criteria for research* ('the green book') contains more restrictive and clearly defined clinical features with explicit inclusion, exclusion, and time course criteria and is suitable for identification of homogenous patient groups for research purposes. The *primary care version* focuses on disorders prevalent in primary care settings and contains broad clinical descriptions, diagnostic flow charts, and treatment recommendations. A *short glossary* containing the coding and brief descriptions can be used as a quick reference by practitioners and administrative and secretarial staff.

Axial diagnosis The multi-axial version of ICD-10 uses three axes to broaden the assessment of the patient's condition. Axis 1 describes the mental disorder (including personality disorder and mental handicap), Axis 2 the degree of disability, and Axis 3 current psychosocial problems.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

In May 2013, the APA launched the most recent version of the DSM. While ICD-10 is a wider general medical classification, DSM-5 describes only mental disorders. The two classifications are broadly similar, having undergone a degree of convergence and cross-fertilization in more recent revisions. Relevant DSM-5 terminology and old DSM-IV codes corresponding to ICD-10 disorders are given on ➔ pp. 1088–1116. DSM-IV used a closed numeric coding system of the form xxx.xx (mostly in the range 290–333.xx). DSM-IV was a multi-axial diagnostic system, using five axes: 1—the clinical disorder or the current clinical problem; 2—any personality disorder and any mental handicap; 3—general medical conditions; 4—current psychosocial problems; and 5—global assessment of functioning. This multi-axial approach has been abandoned in DSM-5 (➔ DSM-5 and all that …, p. 12).