

## Enigmas in Psychiatry

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Many practitioners of medicine find psychiatry “woolly” and difficult to grasp or understand. This article focuses on “Enigmas in Psychiatry” and hopes to clarify some of the mysteries surrounding psychiatry and shed some light on the difficult concepts that the novice practitioners may have to come to grips with.

In medicine, we are taught and trained to diagnose and treat diseases as far as possible according to known aetiology. However in mental disorders, in cases when aetiology is less certain, we talk of predisposing, precipitating and perpetuating factors. Hence the holistic view of the human person is that he possesses physical, psychological, social and spiritual attributes that are inter-related, interactive and integrated in function. In other words, the individual and his environment, his body and his mind and the different aspects of his mental functions are integral in health and in illness. Disturbance in any one aspect would affect the well being of the rest, causing stress and distress to the individual as a whole. Psychiatric conditions evolve in the presence of biological vulnerability, psychological adversity and social stressors.

### Enigmas in Diagnosis

The first “enigma” to note is that the World Health Organization and many governments use ICD-10 for coding, statistics, healthcare and fiscal planning. ICD-10 provides clinical descriptions and diagnostic guidelines.<sup>1</sup> However for psychiatric conditions, the academic community globally has moved to using the Diagnostic and Statistical Manual (DSM) for teaching, research and publication. The DSM adopts a consensual and syndromal check-list approach that is largely atheoretical.<sup>2</sup> Thus, although we discourage the splitting of the body and the mind, in the process of specialisation we have not only divided the body into subspecialties by organs or systems, we have also split the mind into sub-categories.

Psychoses are major mental disorders. Advancements in genetics, molecular biology and neuro-imaging have brought a better understanding of these conditions. However, epidemiological studies show similarity between schizophrenias and bipolar disorders in their age of onset and chronicity. In monozygotic twins, one could suffer

from schizophrenia and the other suffers from bipolar disorder. Therefore, the environment must have a role to play. In recent years, there is also some blurring of the diagnosis between schizophrenia and bipolar disorder because of some commonalities in symptomatology and prognosis. In fact it has not been resolved whether schizophrenia is a neuro-developmental or a neuro-degenerative process, or a combination of both.

Schizophrenia, while a singular diagnostic category, is recognised as a heterogeneous group of psychotic symptoms. The clinical diagnosis has come round a full circle from the time of Kraepelin and Bleuler. To Kraepelin’s dichotomy, dementia praecox or schizophrenia is chronic and deteriorating while manic-depressive psychosis is cyclical with recovery. Bleuler who coined the term schizophrenia (i.e. splitting of mental functions) describes its primary features as loosening of association in thinking, blunting of affect, autism and ambivalence in motivations. They predate the subsequent description of negative syndrome of schizophrenia and the current argument for cognitive impairments and deficits in executive functions. To Bleuler hallucinations and delusions are accessory symptoms but they have developed into Schneider’s First Rank symptoms found in positive syndrome of schizophrenia and much relied on for its clinical diagnosis. These first rank symptoms include auditory hallucinations, thought broadcasting, passivity phenomena and delusional perceptions and all capture the positive, paranoid-hallucinatory symptoms of psychosis. And some of these symptoms may be found in patients with bipolar disorder. None of the first rank symptoms is pathognomonic of schizophrenia; they lack specificity (Oliver Freudenreich, 2008).<sup>3</sup>

Over a decade ago, based on Harvard School of Public Health’s 5 years of research and World Health Organization’s (WHO) worldwide collaboration it was found that by the year 2020, severe depression would be the world’s second largest killer.<sup>4</sup> It also found that depression accounted for a full 10% of productive years lost throughout the world. Yet these substantial costs to society may be unnecessary. When correctly diagnosed and treated, mood disorders usually respond well: 80% of those with mood disorders could be successfully treated. Since then we have

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been hearing the recurring campaign or theme that depression has been grossly under-diagnosed and under-treated (presumably with medications). There is no explanation on why there should be such epidemic proportions of depressive illness projected up to 2020. There is no mention of probable psychosocial stressors and their management. It is interesting to note that about the same time in mid-1990s there were 2 other significant events that occurred in the history of psychiatry: the World Psychiatric Association (WPA) encouraged national associations to look into the patient's rights to treatment; the new generations of anti-psychotics and anti-depressants were launched and made available in many countries.

Anxiety may be said to be the “mother of psychopathology” in the psychodynamic sense. Therefore, it has been said that there is no depression without anxiety and vice versa. Anxiety is frequently a trigger, reinforcer or exacerbating factor and associated with many mental disorders. The list of anxiety disorders and other mental disorders in DSM has increased in numbers in successive editions. Given that DSM avoids theoretical discussion of aetiologic cause, it is essentially empirical and consensual in its classification. Thus, the earlier entity “psychosomatic disorders” (which connotes psychological causes of somatic symptoms and neurotic disorders, and infers neurological origin of psychological symptoms) is omitted. This omission may lead the user to unwittingly adopt a symptom checklist approach to making a diagnosis. Co-morbidity becomes common when no effort is made to inquire into the chronological and developmental sequence of psychopathology. Often diagnosis is made based on secondary symptoms and the primary cause (if present) may be missed and left untreated. An exception, however, could be said of post-traumatic stress disorder (PTSD) and somatoform disorders where psychological factors are deemed to play a prominent role.

PTSD first appeared in DSM III (1980) and also ICD 10 (1992). It had probably existed in the past as “shell shock”, “battle fatigue”, “trauma neurosis” and in some “compensation neurosis”. However, its “aetiological” criteria in DSM have evolved from exceptional trauma that would affect almost anyone to milder traumatic events such as accident and assault. Furthermore, one could be affected by being a witness to such events experienced by others. Finally, such events so defined include an intense reaction involving intense fear, helplessness or horror. In other words, the focus is on the individual's reactions rather than on the “aetiological” event. ICD 10 has kept to the initial definition of PTSD that it arises as a delayed and/or protracted response to an exceptionally stressful event or situation such as a natural disaster or human violence that would affect almost anyone. Nevertheless, PTSD has become an increasingly popular disorder.

## Enigmas in Treatment

In clinical management, the brain and mind dichotomy is reflected in the proponents for physical and psychological methods of treatment. The psychopharmacological approach to treatment is to restore “normal” neurotransmission. The rationale is to augment what is deficient and to attenuate what is excessive through use of drugs that are agonists or antagonists in the systems concerned. Some studies now suggest that pharmacologic agents also act via neurotrophins, e.g. brain-derived neurotrophic factor (BDNF).<sup>5,6</sup>

Psychological treatment embraces a wide range of modalities, from classical psychoanalysis to cognitive and behaviour therapy to art therapy. Theories abound as to how symptoms originate and how they could be relieved. It is hypothesised that whatever the mode of treatment the mechanism is to effect a change in the morbid pattern of neuronal circuitry. This is achieved through strategic and systematic verbal, behavioural or experiential input to re-channel or bypass “prevailing faulty circuits” or create more “adaptive circuits”. Effort and practice (cf. compliance with medications) are necessary to maintain the new pathways and sustain improvement.

Therefore if the objective of psychopharmacotherapy is to restore normal neurotransmission, then it can be argued that the role of psychotherapy is to facilitate desirable neurotransmission. Moreover physical exercise, relaxation activities and enjoyable diversions or hobbies may provide breaks for dysfunctional circuits from excessive stress so as to recuperate and recover.

The United States' Food and Drug Administration (FDA) requires drug patents to be registered against diagnoses. The efficacy of the patent drug derives mainly from clinical randomised, double-blind and placebo-controlled drug trials which are carried out on diagnostic categories according to DSM's definitions and criteria, standard questionnaires or rating scales on symptoms, limited clinical patient populations, fixed periods of time, and complex statistical analyses. This forms the so-called evidence-based medicine. Strangely, in such clinical drug trials the response rates of common mental disorders such as anxiety, depression and schizophrenia, respectively, to each drug within the specific psychotropic class of anti-anxiety, antidepressant and antipsychotic investigated have been generally about two thirds.<sup>7</sup> The standard conclusion is that within each class of drugs the efficacy for each disorder is about the same i.e. antipsychotic A is as effective as antipsychotic B in treatment of schizophrenia and antidepressant X is as effective as antidepressant Y in treatment of major depression, so on and so forth. The main difference or selling point is in the side effect profile or adverse reaction of the drug.<sup>7</sup>

While it is often asked if drugs of a certain class, e.g.

antipsychotics, are the same in terms of efficacy, perhaps the more appropriate question to ask is whether all the patients who carry that diagnosis are the same. Patients may have the same diagnosis but respond differently to the same drug and in fact sometimes exhibit paradoxical reaction e.g. activation instead of sedation. They also have different psychosocial backgrounds and life events. Recently there has been a serious allegation that some renowned medical researchers have distorted their results or were misleading in their reports.<sup>8</sup>

Over the years despite the “two thirds response phenomenon”, diagnostic categories have increased and become more differentiated. This might suggest more specific nosological entities being defined. However, in practice psychopharmacotherapy has become less differentiated. Drugs approved by the FDA originally for specific mental disorders are now promoted to treat other categories of mental disorders that may probably have shared, common symptoms such as hallucinations, delusions, disturbed behaviours or suicidal risk. This is not surprising when the drugs used do not actually act specifically on so-called specific disorders but ameliorate overlapping symptoms in different disorders. This would also account for increase in polypharmacy. The expiry of the patent for a drug directed at a specific disorder may account for some of the crossing over of drug indications. It is therefore necessary to review carefully the diagnosis of mental disorder, clinical drug trials and the so-called evidence-based medicine in management. And it makes sense to treat empirically underlying psychopathology rather than specific diagnosis without nosological basis or by consensus of opinions. There should be a shift of paradigm to focus on psychopathology rather than simply diagnostic categories when conducting clinical drug trials.

Treatment algorithms or clinical guidelines are at best a guide of trial and error for the novice. The patient is not a repository of symptoms. It cannot be overemphasised that unless a thorough biopsychosocial assessment is made it is not infrequent that the diagnosis may be inaccurate or incomplete. Inappropriate treatment follows, the patient neither improves nor dies, and if he/she does not complain, the clinician is none the wiser.<sup>9-11</sup>

### **Enigmas in Rehabilitation**

Many definitions of the chronically mentally ill share some common features, including a diagnosis of mental illness, prolonged duration, and role incapacity. The ultimate goal of psychiatric rehabilitation is to help disabled individuals to establish the emotional, social and intellectual skills needed to live, learn and work in the community with the least amount of professional support. Very often rehabilitation work is like a religious calling and is therefore considered a vocation.

We know that disease causes disability that leads to dependency. There are various degrees of disability and dependency that may be temporary or permanent, partial or complete. However, mental illness is often chronic and results in chronic disability and long-term dependency. The patient needs food, clothing, shelter, transport, occupation and recreation just like anybody else. The questions are: who should provide these needs and how are they to be provided and where?

The aim of rehabilitation is to maximise the patient's functional capabilities and to minimise his residual disabilities through proper treatment and training. If the patient cannot become employable, productive and independent, it is hoped that he can at least look after his personal needs, e.g. grooming, washing and feeding. However, some would need permanent institutional care.

Treatment and rehabilitation are inseparable, and multi-disciplinary effort is essential. It also involves the family and the society e.g. their co-operation, accommodation and acceptance. Mental patients face particularly discrimination when seeking employment. Psychiatric rehabilitation requires constancy and continuity. Often too little is done too late. There are also different expectations from the family, staff, manager, employer and public causing conflict.

Much has been written about institutionalisation and its negative aspects. Consequently, mental hospitals had been closed down or downsized and community care and communal living advocated. However, the real forces behind the initial decision to de-institutionalise appeared to be political and financial rather than clinical. In the process, over-night, patients became inmates of welfare homes or prisons and freely roaming citizens in the streets. The good intention of better quality of life in the community depends very much on the availability of resources.<sup>12</sup>

On the other hand, the physically disabled are viewed with greater sympathy by all and rightly so. There are many voluntary organisations and lobby groups formed to advance their rights and interests. There are jobs created or reserved for them; there are special car park lots, wheel chair ramps, lifts, home delivery services, etc. People do not expect the blind to see, the deaf to hear, the paraplegic to walk like normal people and therefore bend backward to help and accommodate them. It is ironical that the patient who has a mental illness, or succumbs to stresses in life should again face stress of stigma on recovery.<sup>9</sup>

Stigma is essentially due to misconception of mental illness, together with difficulty or inability to relate to the other person. This leads to avoidance and rejection. However, familiarity with the disabled, the feared and the scorned through continuous education and engagement or exposure breeds understanding, acceptance and accommodation. The Institute of Mental Health (IMH) has

been most successful in taking in other agencies and facilities, businesses and shops into its premise, opening its door to volunteers and visitors, sharing its green park with the neighbourhood and public and thus facilitating its integration into the community.<sup>9-11</sup>

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