Psychiatry an Overview
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Module-02
Diagnostic Process in Psychiatry
Lecture-07
Classificatory Systems

So, in the last lecture we talked about how, without technology using your brain as I said, the introduction to basis of behavior is that the best person to know and studied the brain is you, your mind and somebody that is mind, so mental status examination as I delineated in the last lecture last two lectures, is essentially of way of understanding the other person.

And once you have understood once you have looked at the phenomena and once you have understood that why this phenomenal have been called abnormal how do you decide at the end of it that whether it is normal or abnormal, so before I come to that process I would like to quote, Carrie Debrahon who says I have found both freedom and safety in my madness.

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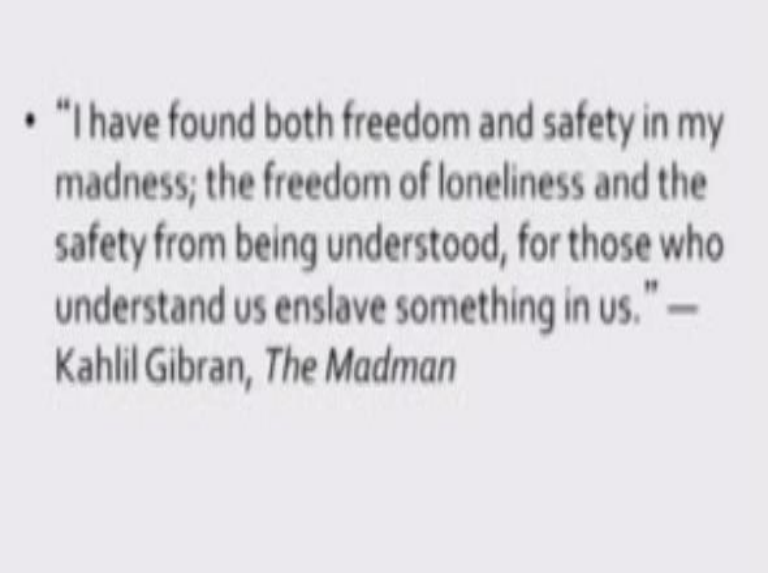

The freedom of loneliness and the safety from being understood, for those who understand us and slave something in us, he essentially says, how do you decide what is mad and what is free?

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John Nash we all know, on whose life beautiful mine was made and he died unfortunate death by an accident and the film like One Flew over the Cuckoo's Nest all this fill these life stories.

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Raise a basic question what is a patient and what is a person? Even if you know phenomenology all the phenomenology has been derived from labeling something is abnormal something is normal some thought process beyond a certain threshold based on morbid bases is a delusion, something as a hallucination but these are experiences of human mind at the end of it.

Maybe the disruption caused by anybody is abnormal or if the person is not causing any disruption is just living in his own world is abnormal so how to decide what is a patient and person, what is abnormal?

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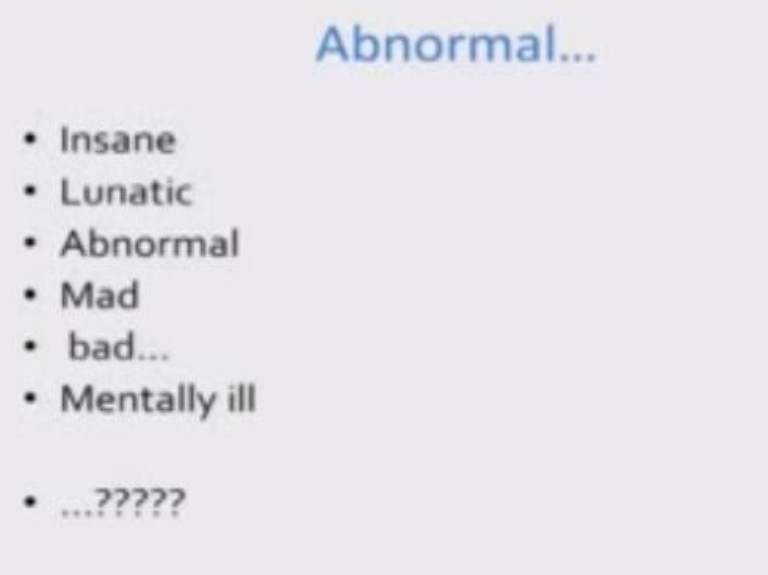

And this a whole list of words which have been used Insane, Lunatic, abnormal, mad, bad mentally ill and I don't know what will be the future terminology used for all these people who are exhibiting so-called abnormal behavior the words which have been used the treatment which has been meted out took them has been changing, according the context country they were put in prisons.

First they were, they where you know they were burned at altars they were exorcised they were put in prisons first and then they were released from the prisons and mental hospitals were made for them, now it is ongoing debate between philosophers and anti-psychiatry movement, so on one hand we practiced psychiatry according to the late rules and the systems and the labels which we have created and on the other hand the society and internally we all keep questioning, so these are the paradox of human life which maybe will get resolved, in future, but even if you are able to look at the cause of illnesses, we still define illnesses from the external factors, in the sense what is normal?

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Is normal, what is statistically normal you look at the IQ range.

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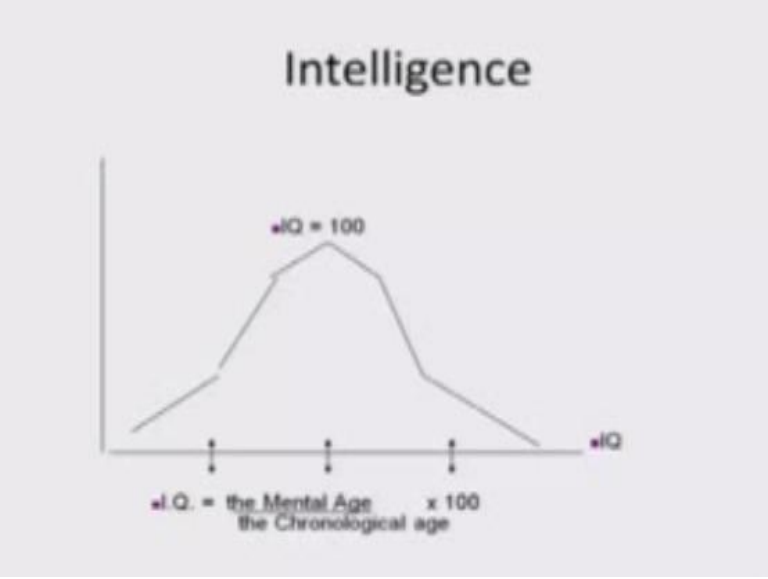

Take intelligence for that matter the Gaussian distribution bell-shaped curve, IQ hundred is average here and IQ 2 a standard division 1 is standard deviation and it distribute the whole population.

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But this we know it was shown to this data was used for exploiting people between for the racism and for separatists thing so what is normal, is it what most people do is normal, by that standard even Mahatma Gandhi would be abnormal because we all know his life but he was not, so a by a broad consensus by statistics by various studies all over the world.

And seeing people how they behave most people behave and how some others behave, how group of people behaves in their context it is a broad definition of mental health.

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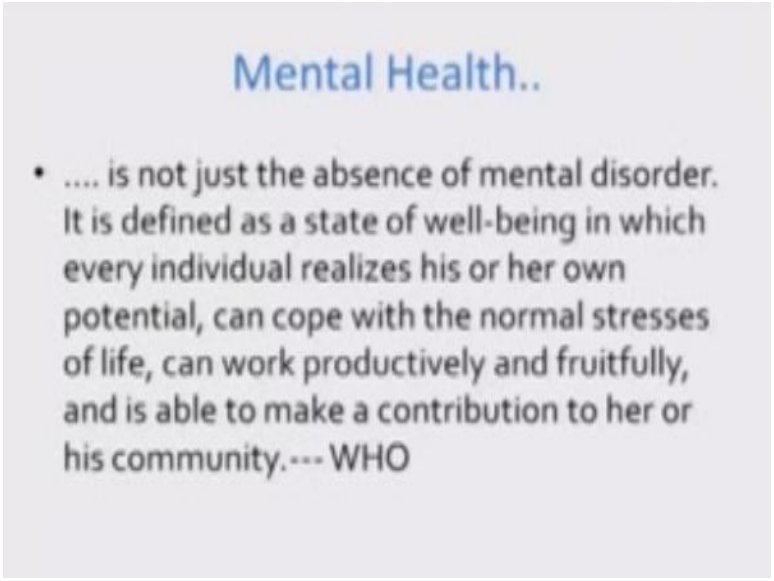

Is not just the absence of mental disorder it is defined as the state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses can work productively and fruitfully and is able to make a contribution to her or his community, at this if you say is normal and any deviation from this is abnormal, for functional purposes let's assume it is so what are the dip disorder is then?

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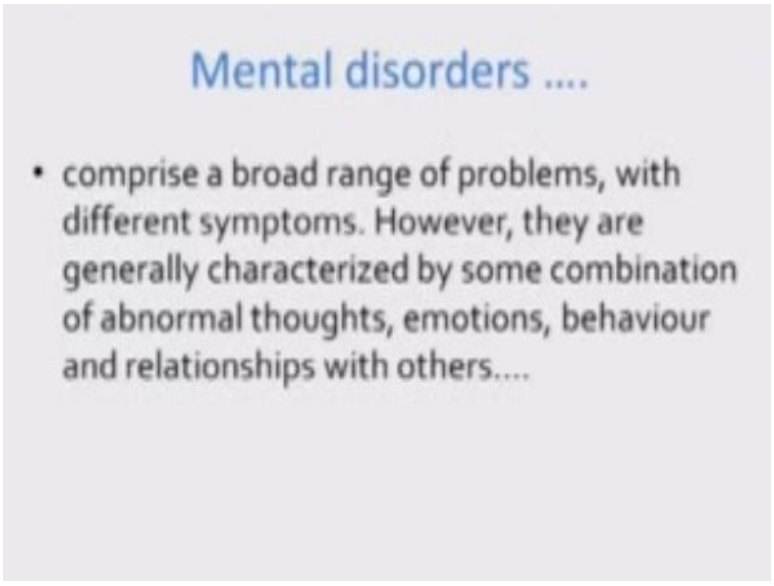

They comprise the broad range of problems with different symptoms, however they are generally characterized by some combination of abnormal thoughts, emotions, behavior and relationships with others so any disruption in thoughts like way the other people are thinking in their context, or emotions or behavior and relationships with that but it still having said this. It is still very complicated and it's still convoluted.

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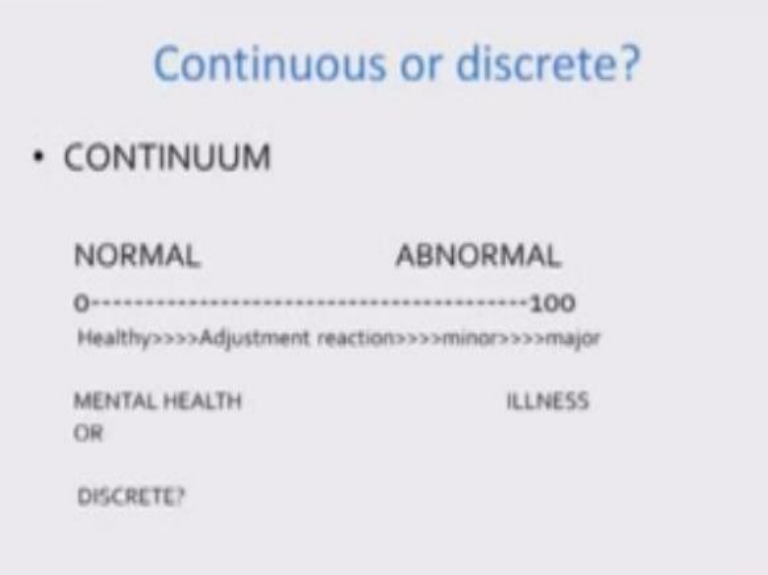

So this difficult to decide what is it, is it a continuum from normal to abnormal, whether everybody what abnormal have say in a higher proportion normal people having lesser proportion so it's a range from healthy to adjustment disorder 2 minor illnesses to major illnesses is that this or it is discrete that mentally normal people are different people then mentally abnormal people.

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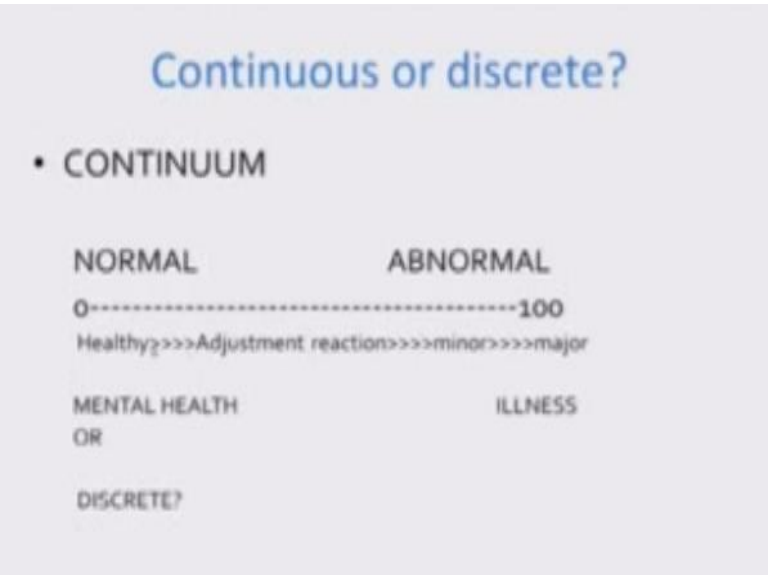

They have a different set of thought process and these people have a different set, is still debatable now by phenomenology if you go you'll say abnormal people have something with these people don't have, but delusions can go from a thought hallucinations can come from a perception at times we all have our internal imagery whether imagery is different from hallucinations, is difficult to decide.

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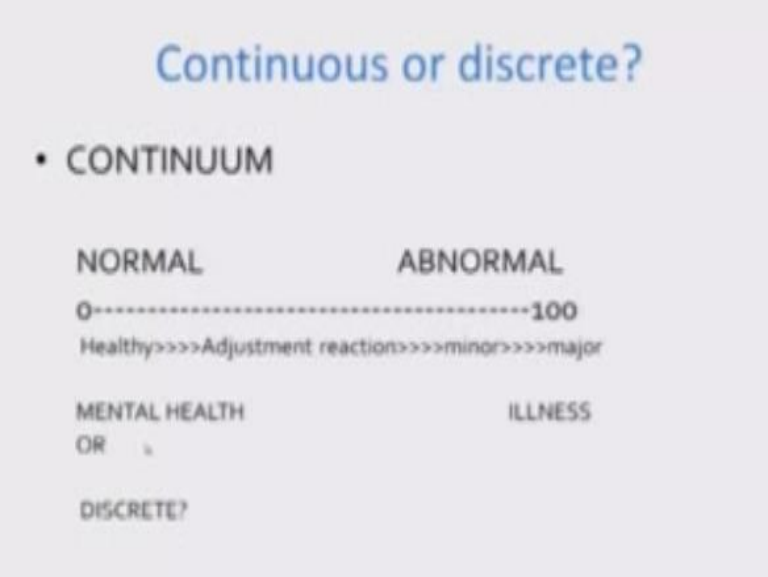

Imagery may have a well hallucinations do not but are they using the same pathway? Is a question which we still do not have an answer to, so this debate as it ranges.

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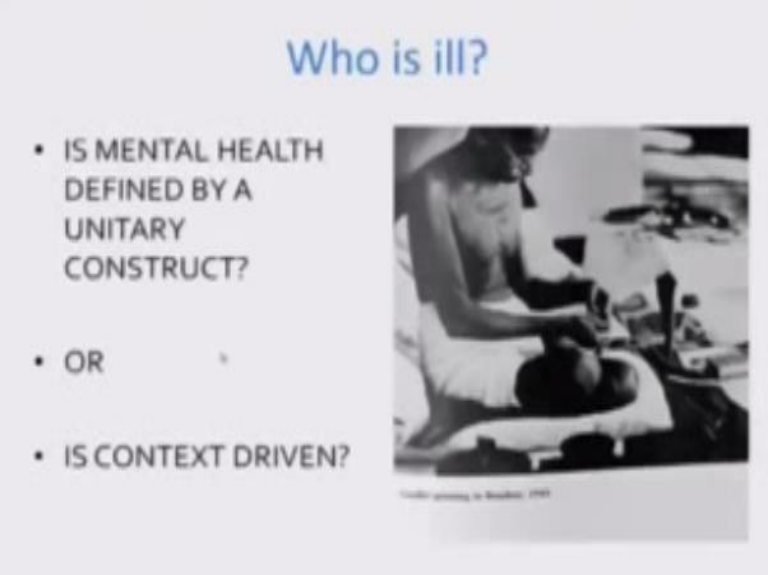

What we have done so whether we have again this big thing, is better well defined by a unitary construct it is not, as you said relationships, emotions, taught, this complexity, social, carrier, relationships, ambitions all things go on into deciding what it is all about.

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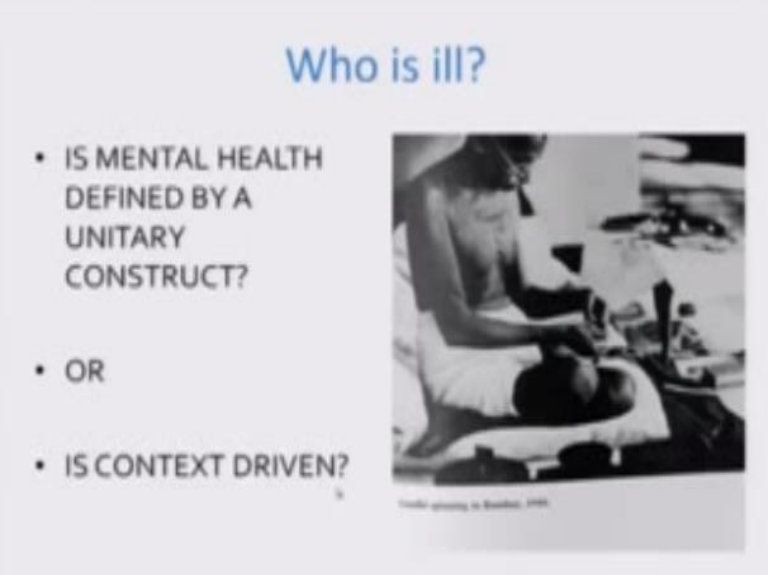

Or it is context driven, so if a certain person like Gandhi behaves in this context, it may be normal, so whether we define mental health as a absolute objective, construct and say

only this mental health or mental health is a fluid concept with depends on the context in which it is being talked about, so that raise another question what is a abnormal?

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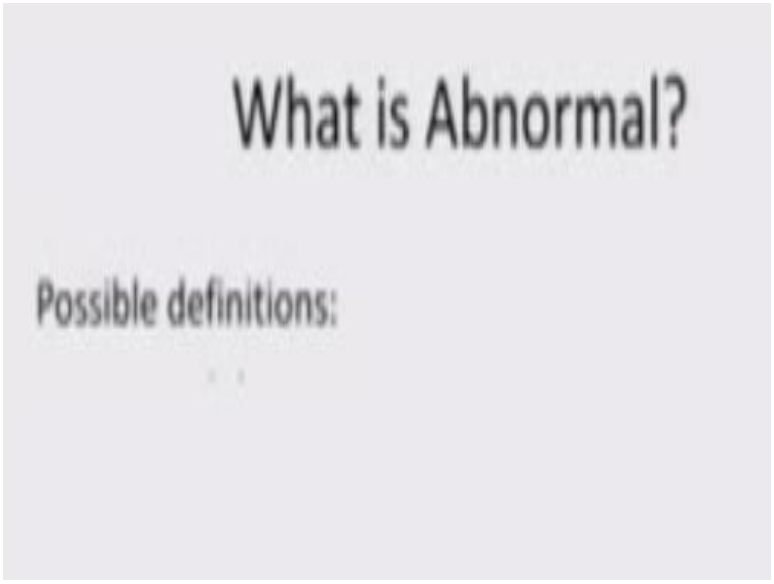

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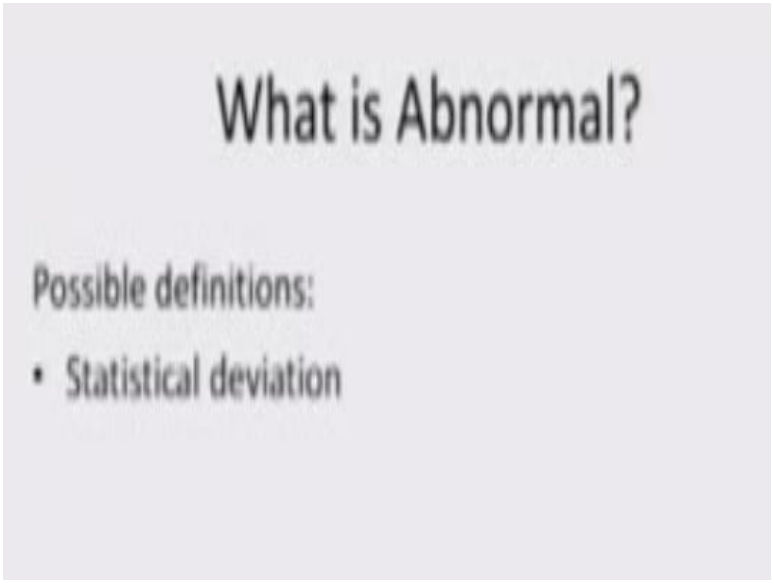

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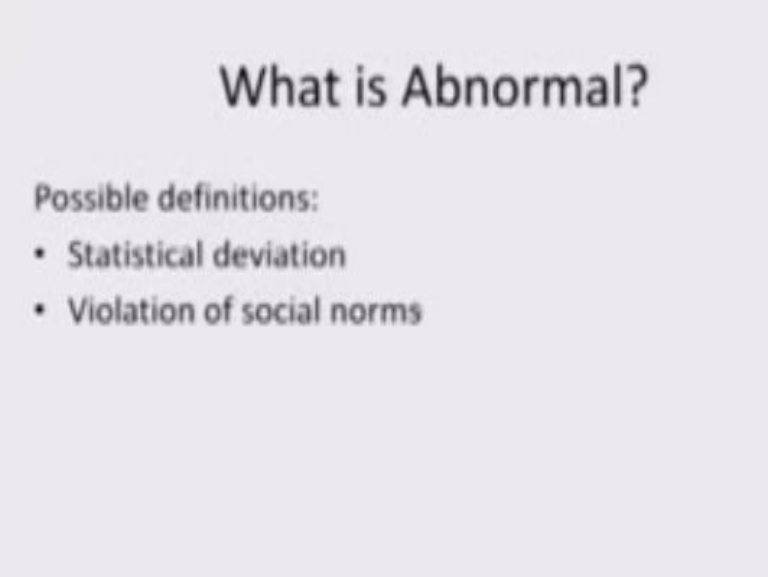

Possible definitions, statistical deviation, violation of social norms but not everybody who violation social norm is abnormal, whether wise course of justice would not exist, subjective distress, whether the person is uncomfortable with himself if that is the question of abnormality.

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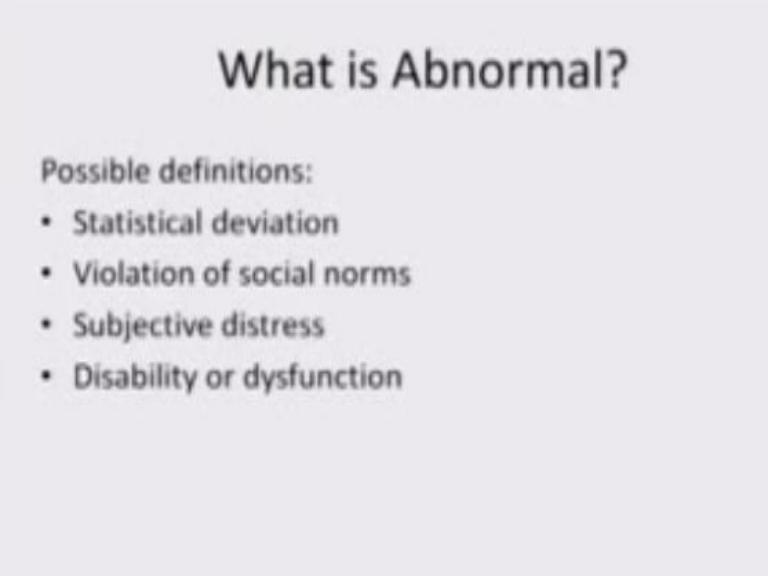

Disability or dysfunction, somebody is unable to can do mathematics or somebody is unable to has a damaged in the brain by which one nerve is not able to find a way through.

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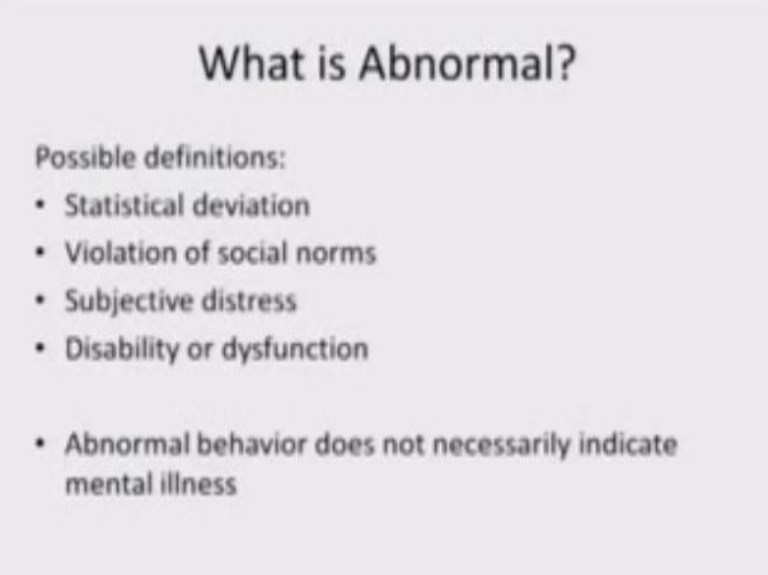

Abnormal behavior does not necessarily indicate mental illness so lot of abnormal behavior at times is temporary as I said in the previous lecturer it may be just a context-driven thing or a drug under the influence of drugs or alcohol but that and person bounces back within a short span to normalcy, now what is that normalcy is his normalcy in his context, so context again is very important, is no absolutes in psychiatry right now, except for bearing very few things so what so what is the need for classification.

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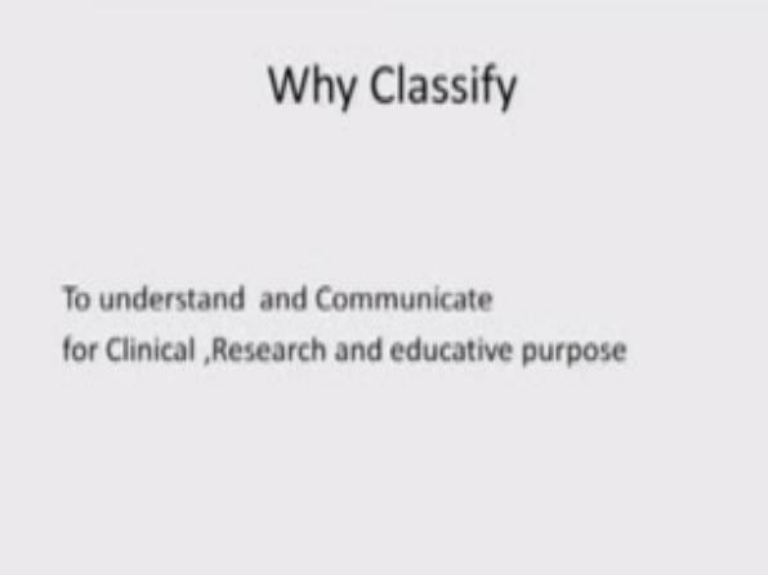

That the need for classification comes from to understand and communicate for clinical research and educative purpose, this is pretty clear.

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But this a difference between psychiatry classification and medical classification, medical classification is based on the cause, even a group of symptoms that causes syndrome we take it in the trauma and the troche metabolic, electrolyte disturbance,

infectious, cerebral vascular or vascular these are essentially headings which have caused because of vascular disturbance something has happened.

Because of infection something has happened, psychiatry classification is not based on that, it is more experiential and descriptive.

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So with the classifications which existence in psychiatry like Diagnostic and Statistical Manual DSM and its various versions and international classification of diseases chapter 5, they are have categories based on, the group of symptoms which have been pulled in, from all over the world with various epidemiological studies and descriptive studies, that differentiation between, medical and psychiatry, is this.

That these categories which we have formed, in psychiatry decides the treatment approach like if there is a app category of psychosis we treated with antipsychotics, there's nothing like this in medical that is a category which has to be treated with antibiotics, infection yes, but there’s no different treatment for say vascular the other Medicines so medical classification is based on cause, psychiatry classification and that is

a gap between medicine and psychiatry whether we are moving towards cause based classification is something which for next 20 years will tell us, but presently the diagnostic levels in our descriptive from the experiential mind state of the person.

And these categories are correlated with the treatment blocks that type of drug the group of drugs which are available, now it may sound very, very non-scientific that is, it appears like a mix-and-match do you have a category you have a group of drug, depression, antidepressant and is it totally subjective if or if we don't talk of subjectivity of one person we can talk about subjectivity of groups which are describing this, but there is a savior.

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The Savior is that epidemiology has shown that these descriptive characteristics exist in the world all across the culture that means irrespective of where the person is if you take a certain set of population that much percentage will having 30.

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That much percentage will have depression that much percentage will have schizophrenia, which may be coming from genetics because we all have a common genetic.

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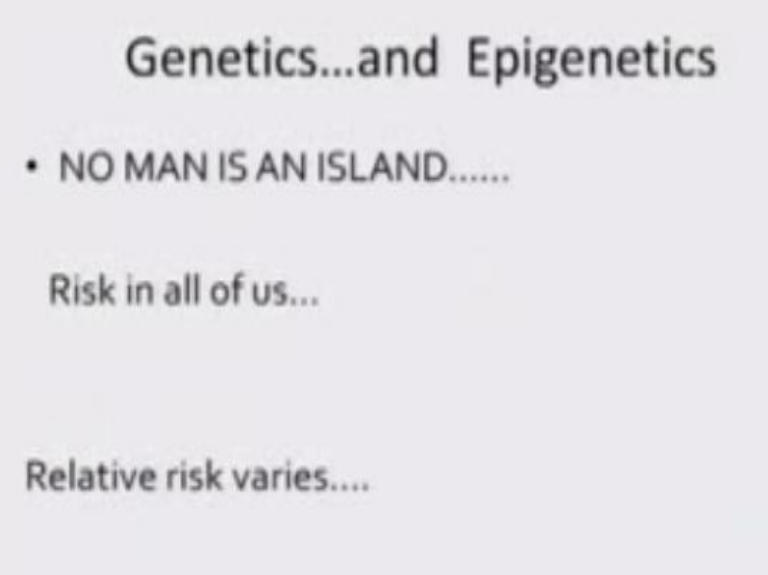

Pool atleast 74 thousand years back, when the modern man is started migrating from Africa after a the destruction of this huge Indonesian volcano very few people will left and from Africa migration genetics has proven it very well, so the risk of having illness is in all of us because of you know the Common genetic pool we know the common genotype, is a very little variation and that little variation causes illnesses but the relative risk varies like I may have a risk of one person schizophrenia if I don't have anybody in my family it may rise to 10 percent, if there's one person roughly.

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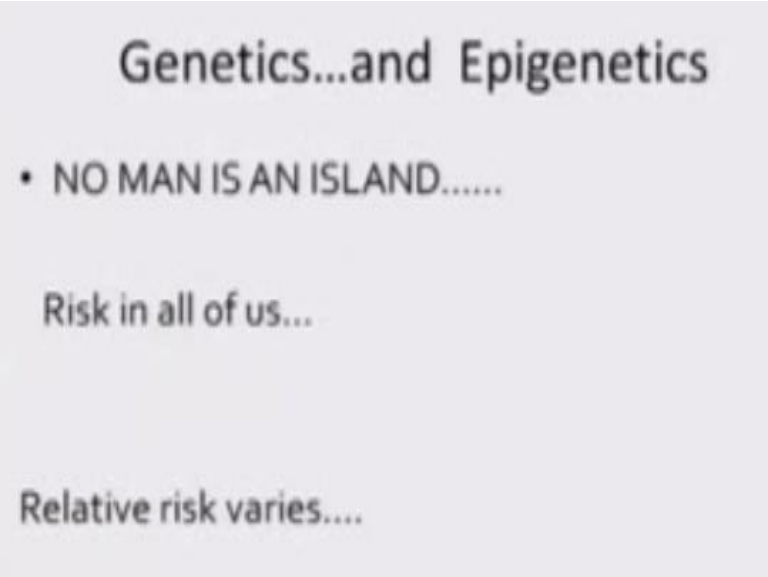

And Epigenetic decides whether the genetics is going to express or not.

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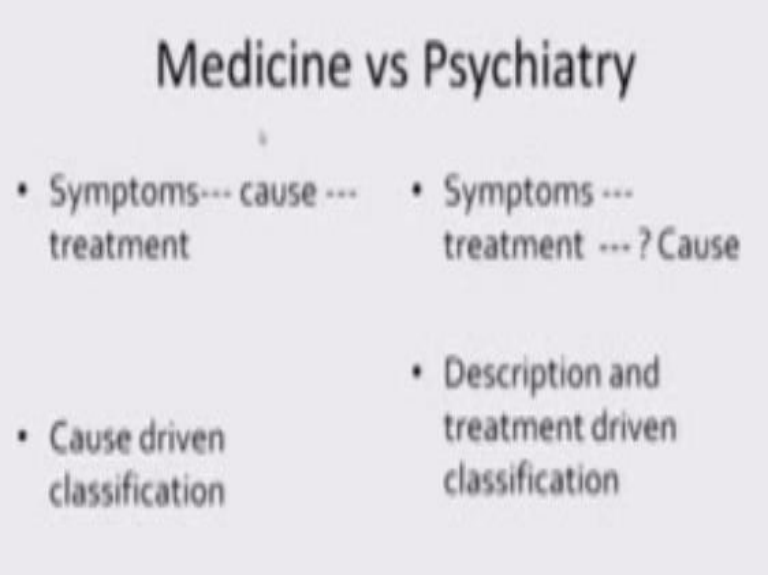

So as I said medicine is symptoms cause treatment, psychiatrics symptoms, treatment cause we still don't know, this is unlike neurology where we go on we can find causes of neurological list to a large extent through imaging another write up to mitochondria and some cases this is a cause driven classification this is description and treatment driven classification till now.

Maybe next 20 years of neuron biology and imaging and neurophysiology may we may be able to give you the exact location and the time frame of when does the hallucination happened and why does it happen, maybe we'll be able to give you some, a frame of network that ok disturbance in this network causes hallucination, so what are the Aetiology even if you look at it.

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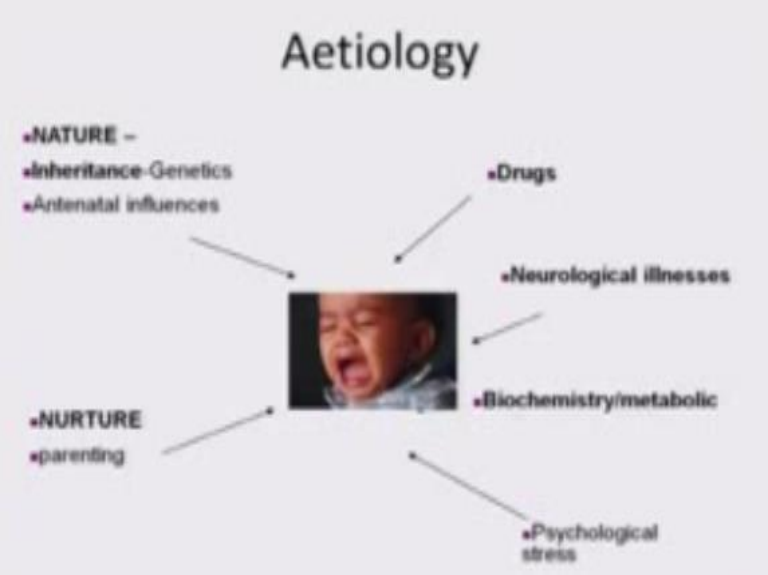

Nature, genetics and antenatal influence, nurture, parenting, drugs, neurological illness, biochemistry, psychological stress all this are Aetiology of psychiatric illness.

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What is the pathology, sign and symptom want to make a syndrome, disorder, disease and illness here is where the disability factor comes in.

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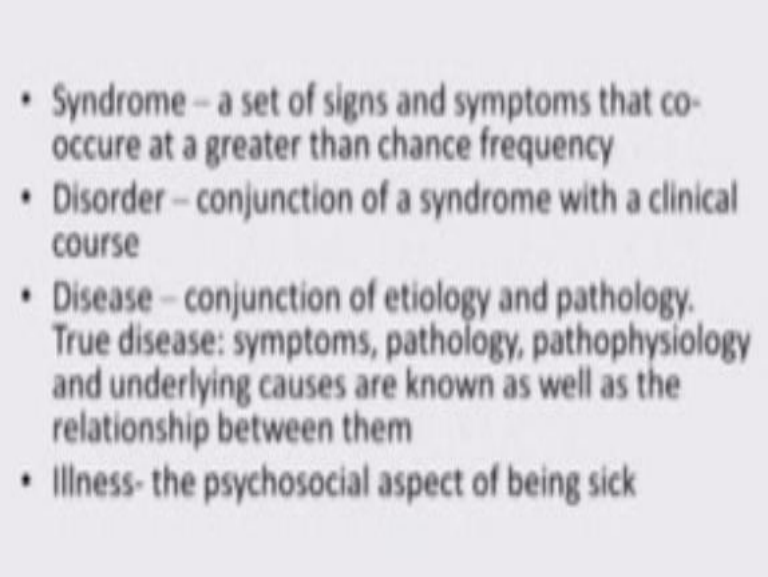

So we all know this syndrome is a set of signs and symptoms that co-occur greater than chance frequency, disorder is syndrome with the clinical course so this is a syndrome which goes on becomes a disorder, diseases Aetiology, pathology.

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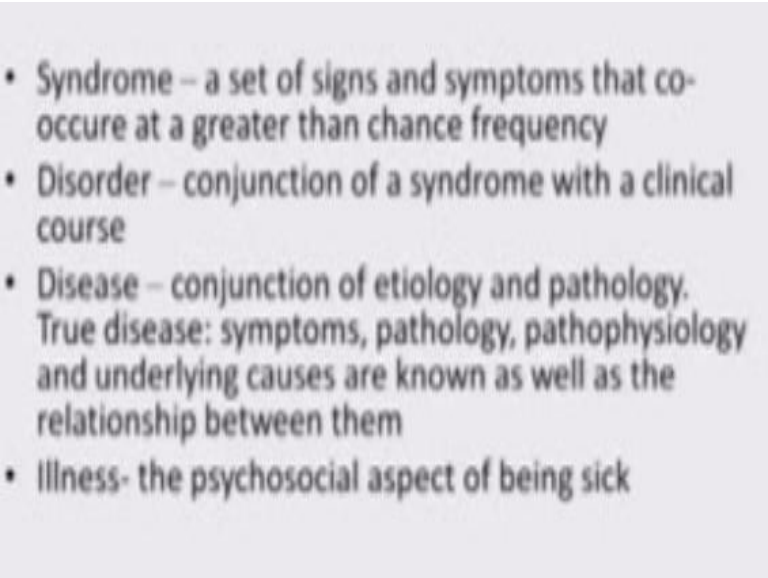

Pathos physiology, illness is where the disability comes in, psychosocial aspects of being sick, so mental disorders are broadly classified.

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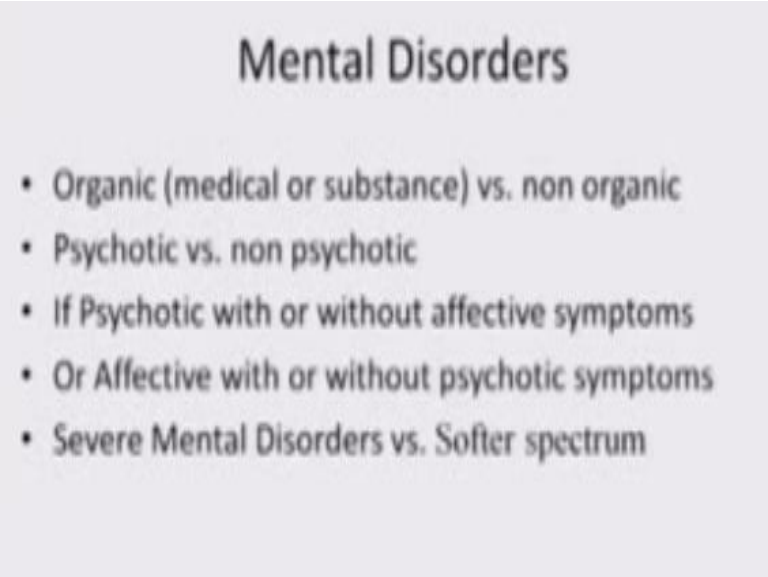

Across all classification if we pulling everything broad understanding of mental disorder is either they're organic where we can find out a medical or a substance what is not non-organic, psychotic verses non-psychotic, psychotic as we remember hallucinations, delusions, lack of insight, loss of touch with reality verses illnesses where the passes is in touch with reality.

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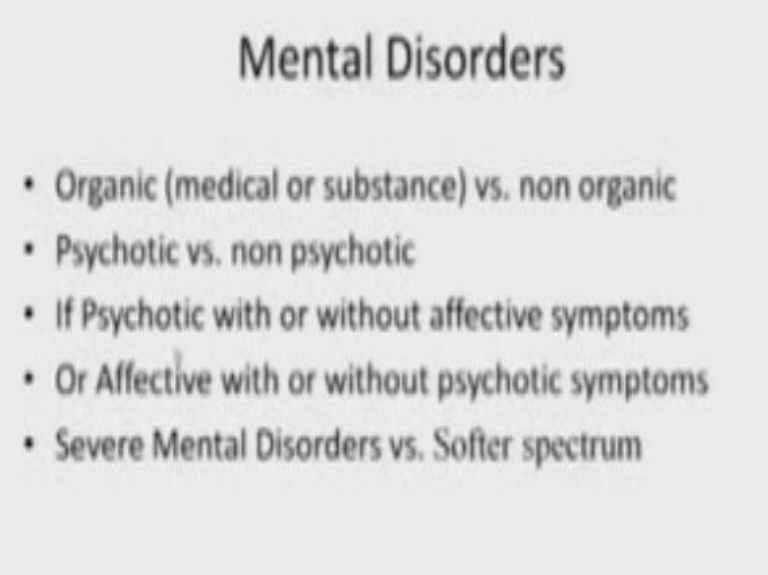

If psychotic with or without mode symptoms or if it is mode symptom with or without psychotic symptoms, this is a broad classification we still function on all to the labels and categories are many, severe mental disorders, which are less in number if we take a percentage vice versa software spectrum which are emerging more and more, thirty to fifty percent of people in all clinics across all medical disciplines are people with psychiatric illnesses.

Now these people are having psychotic illnesses primarily or they are co-morbid with other medical illnesses, we may call them but some people call them problems of living or social suffering, which are being medicalized but that is a political philosophical debate but anxiety depression, situational depression all this is part of software Spectrum severe mental disorders.

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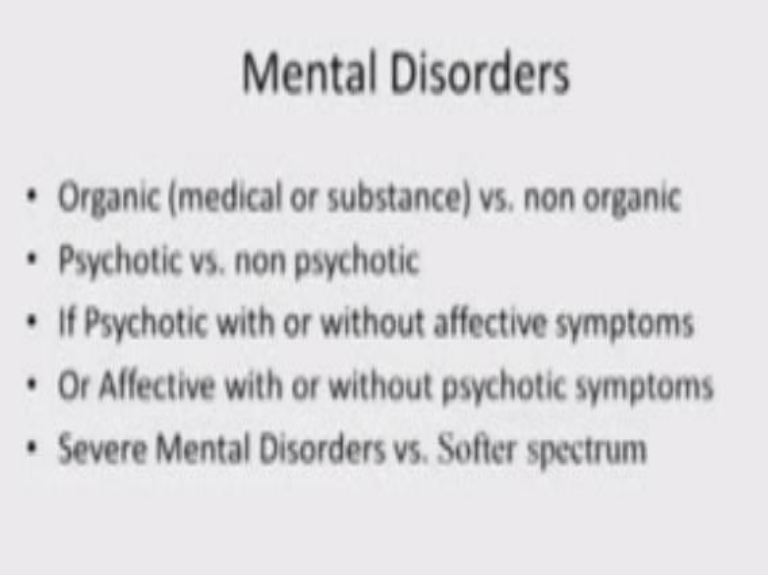

Obviously are schizophrenia bipolar so this is not that to other thing whether it's a categorical thing or dimensional thing, multiaxial system.

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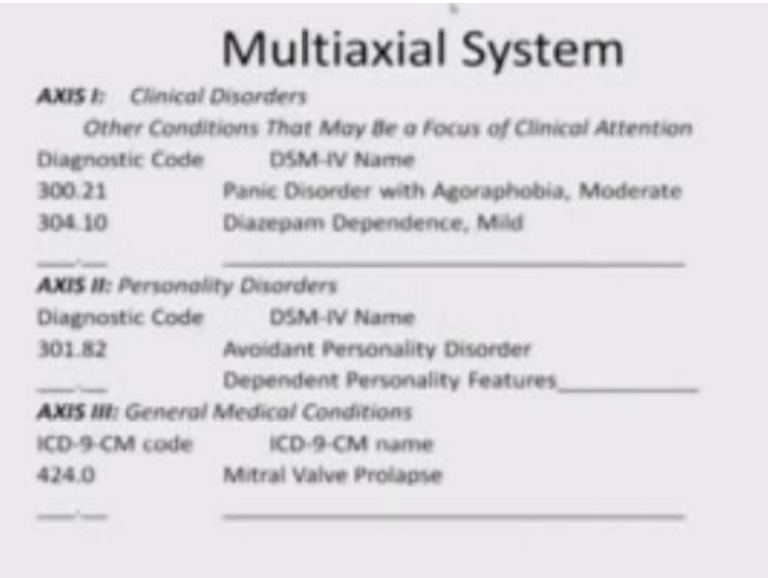

Did Diagnostic and Terrestrial Manual uses this axis one you have clinical disorders the category and description of that illness for example panic disorder.

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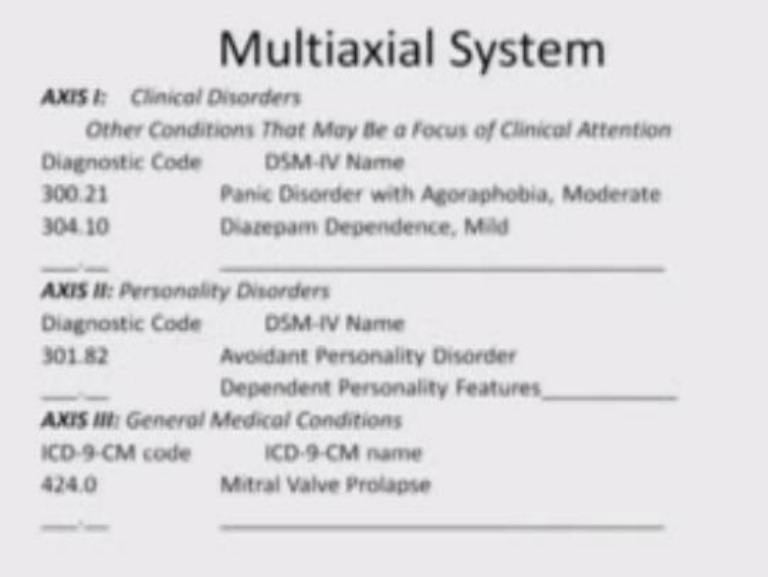

Access 2 so these illnesses are person is going normally has a onset of illness which comes in axis 1 what has been continuous say like a right from childhood somebody's behaving in a certain when kids behaving like a personality disorder, or say mental retardation for that matter developmental you can put.

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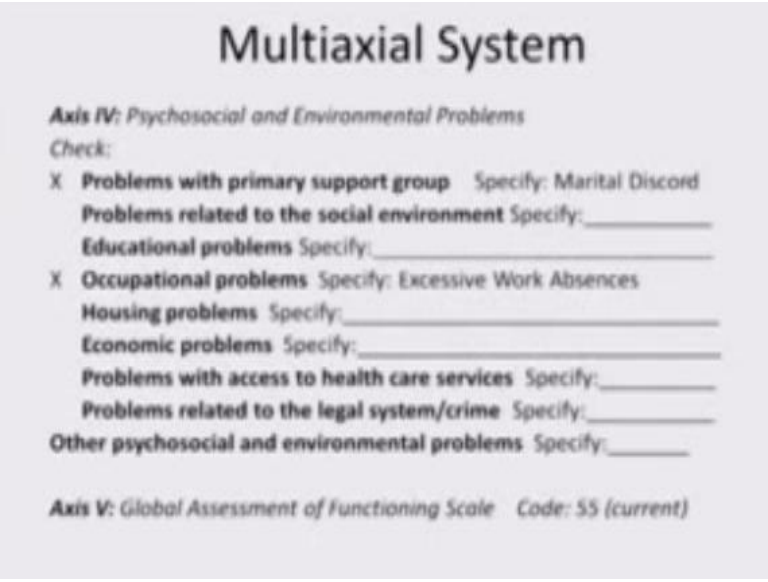

General medical coexisting conditions with it.

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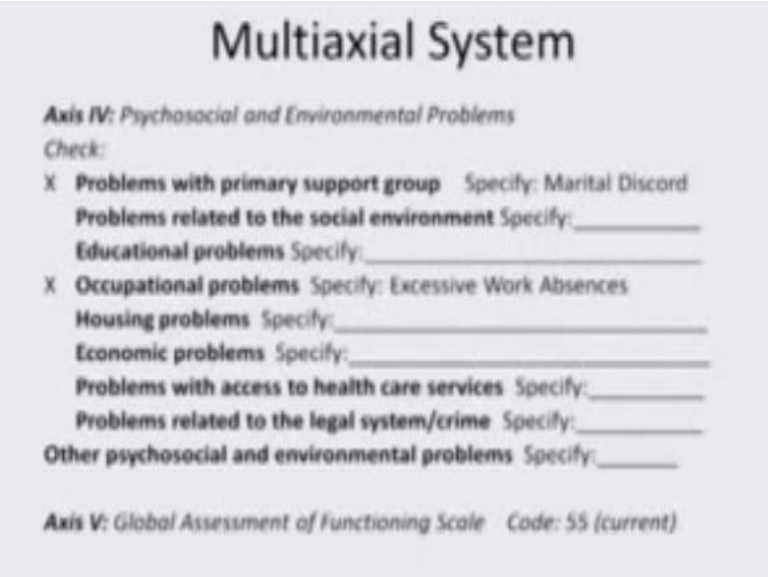

Axis 4 is about the environmental problem, problems with support group, marital discord, education, so this is the context of the environment and access five is global assessment of functioning scale this looks at the disability level, now we should know what impairment and disability, impairment is a dysfunction of argon or a process, disability is the dysfunction arising out of that impairment.

So impairment does not necessarily mean disability a person may be impaired but he may not be disabled.

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So what are the conceptual tensions classification we got this is also philosophically and everybody says with that psychiatry if the label people too much and whether they know how to diagnosis which is a which are some of them are valid questions some of them we still don't answer that conceptual tensions are phenomenology verses course.

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Was the Aetiology, Aetiology means the cause whether is descriptive or theoretical is categorical what's the dimension as I showed you, symptoms verses syndrome, reliability verses reality whether you want to lump into any things together or split them clinical verses research purposes.

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So whatever trying to, tell you that there are two categories called 2 classification system called DSM, Diagnostic and Statistical Manual which is used by United States of America and other countries and there is a WOHO from WOHO which is called international classification disease these which have categorical category that the categories it's a categorical classification.

Where you have description for schizophrenia, for mood disorders where we have created chapters like psychosis and mode disorders they are essentially descriptive we haven't we haven't linked causes to it on a multi axial level DSM diagnosis and categorical ICD but the dewier is still goes on because we haven't till, till now put down the, the basis of, the cause.

So is still is a match between diagnosis and treatment so will in the next two lectures will try to look at how beyond this mental status examination and after labeling do we do any medical process or try to investigate in some of the patients about the causes, thank you.