Psychiatry, Psychotherapy & Psychodynamics

David Zigmond
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The courses *Psychiatry, Psychopathology & Psychodynamics* offer a clarifying overview of the language and modus operandi of psychiatry for non-medics. This is done within widely sourced comparative views and explanations of why humans suffer and how they may heal. These courses have been running more than thirty years.

This note-form summary has been requested by students to aid their anticipation and memory, and is written primarily for them.

Agenda outline

1. Roles and definitions
2. Ideologies and philosophies
3. The medical model (MM)

3a. MM cp/ct to other models. Healing and induction

4. Dis-ease *v* Disease. What is illness? Degrees and Chronicity.
5. Diagnosis and treatment in medical practice
6. Diagnosis and treatment in psychiatry

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7. The disorders:
8. Anxiety disorders
9. Depressive/Bipolar disorders

} Affective Disorders (items 8–9)

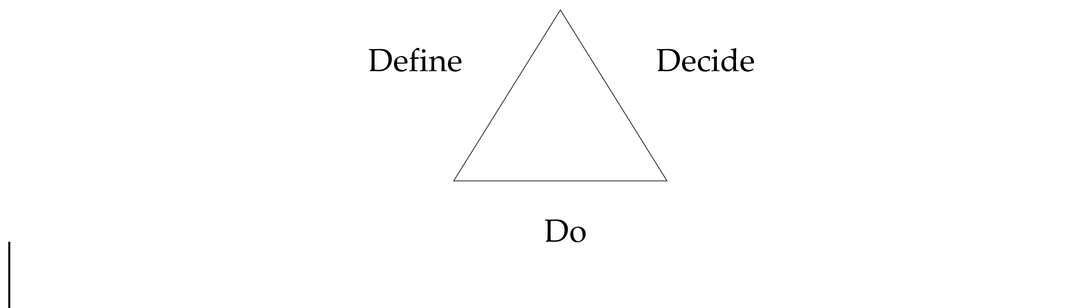
10. Psychosomatic disorders
11. Addictive disorders
12. What is psychosis?
13. Psychotic disorders
14. Mixed disorders
15. Personality disorders
16. High risk: how to identify and what to do

The Agenda

1. **Roles and Definitions** ie psychiatry, psychology, clinical psychology, medical practitioners. Rorschach *v* psychometry.

2. **Ideologies and philosophies**: Atomism, monism and holism/engineering *v* growth/treatment *v* healing/event *v* experience/subjective *v* objective/meaning *v* meaningless/public *v* private/manipulation *v* stewardship/responsibility $<$ to / for

3. & 3A. The Medical Model (MM) ≡ Sort, fix or send:

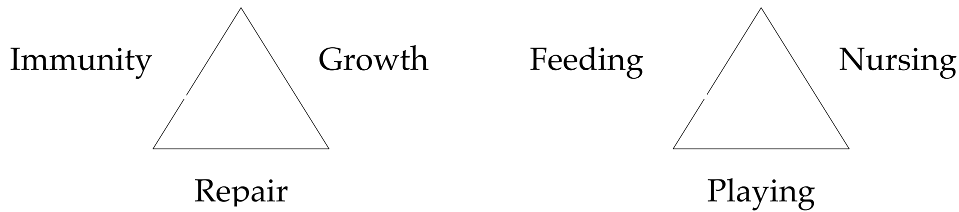


Medical Model	**Therapeutic Healing**
>> Objective	Subjective ⇆ Objective
Generic/Disease	Idiomorphic/Dis-ease
Language: Scientific/Medical	(Inter)personal language
Responsibility ≡ 100% doctors'	Shared responsibility
External resources = treatment	Internal resources* = healing
Biological mechanism/determinism	Personal agency/choice
Personal meaning marginal	Personal meaning central
Relationship conductive/instructive/ peripheral	Relationship inductive/central

Science ⎣________________⎦ Art

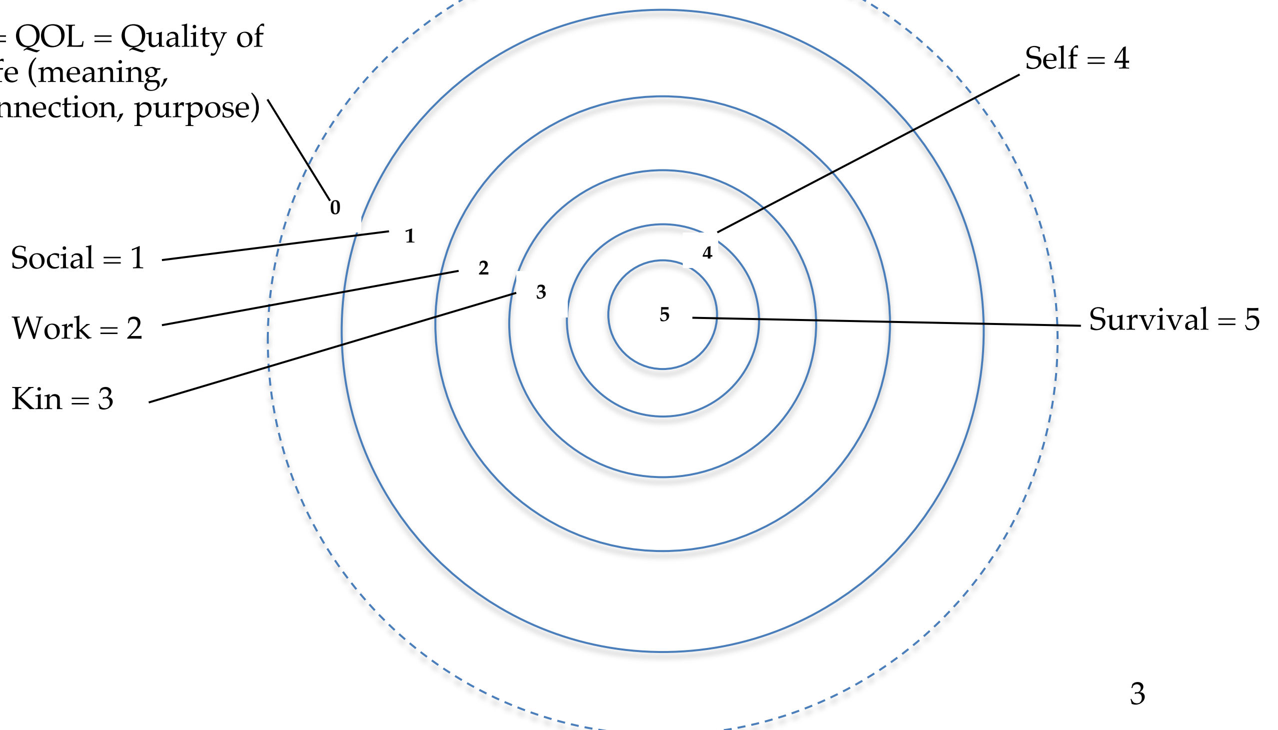
An oxymoron?: 'psychological treatment'≅(brainwashing?)

Internal resources:



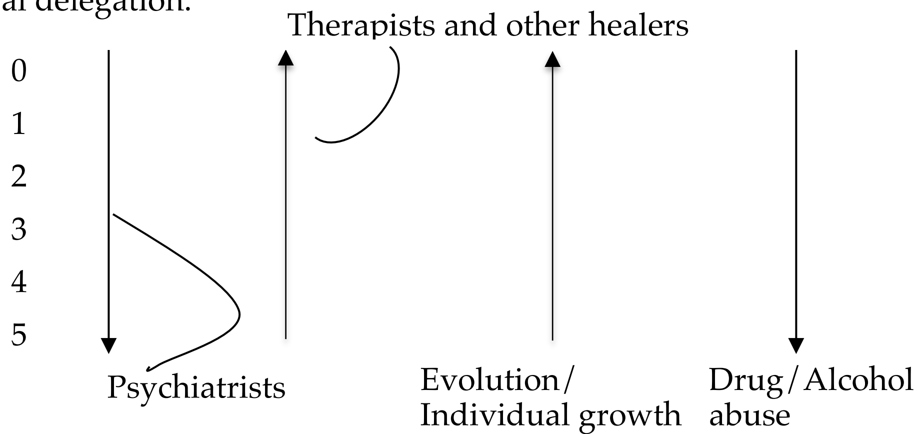
4. Dis-ease	*v*	**Disease**
Functional		Structural
Ego-syntonic		Ego-dystonic
Meaning more accessible		Meaning less accessible
> Healing		> Treatment

Illness = significant functional compromise requiring help or concessions from others.



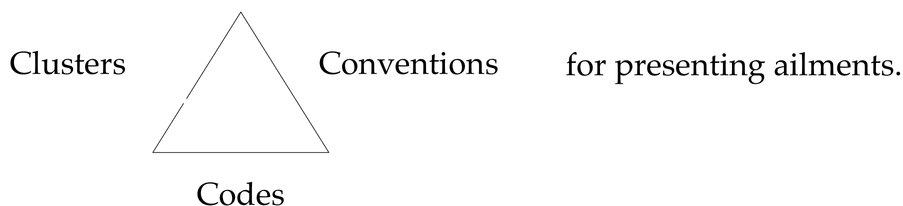
Acute and chronic – definitions

General delegation:

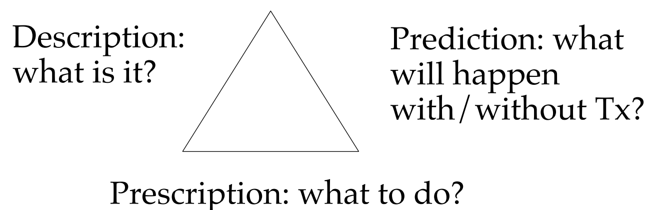


5. Diagnosis and treatment in medical practice

Diagnoses are objectively organised:



They exist for the purposes of:



Diagnoses and the prescribed treatments are the indispensable bedrock of physical medicine. They are incontestably effective in many acute structural conditions (eg Appendicitis, Hip fracture, Lobar Pneumonia), but less effective (by definition) with chronic and functional conditions.

6. Diagnosis and treatment in psychiatry

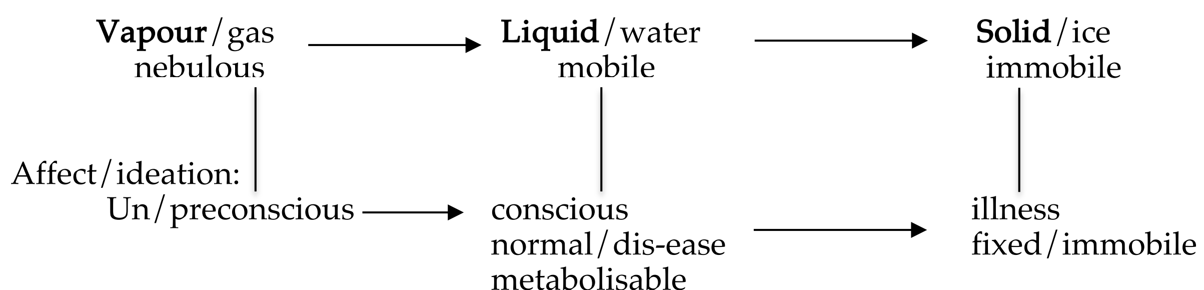
Psychiatry is *not* about physical disease: it is about **individual anguish** or **social discord**. It is usually more about **dis-ease** than disease. These dis-eases are expressed as various form of BAMI (= behaviour, appetite, mood and impulse) disorders.

Psychiatry's **subsumption to the Medical Model (MM)** has apparent (only) precision that appeals to management, administration, and those with fiscal or legal responsibilities. Generally, however, the Medical Model has many failings of description, prediction and prescription when attempting to eliminate BAMI-type problems.

There are notable exceptions to this (eg severe BPD or Acute Reactive Psychosis), which will be discussed.

In psychiatry the complaint often comes *not* from the designated patient, but from **others** who may be fearful, confused, inconvenienced or intolerably stressed by their behaviour. This is much rarer in physical medicine.

Phase/Form eg H_2O:



Despite long and stalwart efforts to make psychiatry into merely another medical speciality, this has succeeded far more in administrative and academic nosological design than in therapeutic effect.

The 'treatment' of individual or social dissonance can rarely be as effective as myriad medical interventions.

The many bad (and good!) jokes about psychiatry are both often deserved and many bring relief. But none can abolish the **great puzzles** and **responsibilities** delegated to psychiatry.

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7. **The Disorders** are when any BAMI cannot be adequately contained and countered by the individual (internal resources) or his group (social resources).

8. **Anxiety Disorders**. Anxiety = *fear of what is not there*. It is an almost **universal** and **unique tax** that humans pay for **imagination**. All anxiety may be thought of as derivative of one or more burdensome sentiences, our **four basic existential anxieties:**

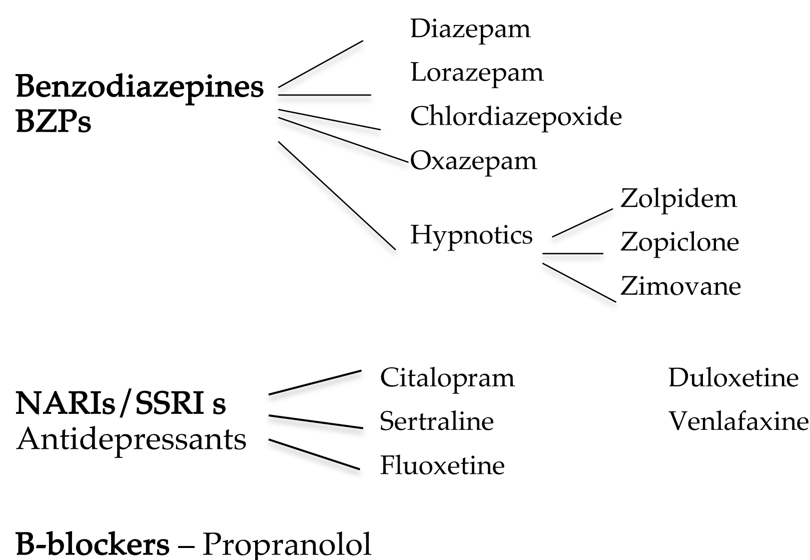
1. mortality
2. aloneness
3. insignificance
4. meaningless

Most of our individual and social behaviour can be seen as **devices to contain, counter or project these anxieties. Anything** that helps us with these crucial devices is **therapeutic**; anything that stymies or destroys them is **pathogenic**. No consultation, no matter how medical, can effectively ignore this principle when dealing with another anxious human.

All non-medication approaches to relieve anxiety (eg yoga, meditation, group therapy, various body contact and counselling therapies) honour this principle, though usually not explicitly.

Doctors prescribe when a) the patient's pressure or expectation is difficult to resist and/or b) they do not have the time, setting, motivation, skills or interest to pursue personal and human perspectives. An overworked part-time GP working in a giant practice to corporately-managed schedules and deadlines is likely to – understandably – default to prescription.

Most common UK **anxiolytics** are



B-blockers – Propranolol

All relatively safe: severe S/Es are very rare, idiosyncratic intolerances are more common and sometimes inevitable with any group of drugs. **Dependency** is a possible problem only with BZPs: the far more likely problem is the **overlooking of the human meaning of the symptom** in the quest to quickly despatch or eliminate it. In this respect it is the **lost human contact** and opportunity that does the most damage: the drug is here, usually, the secondary culprit.

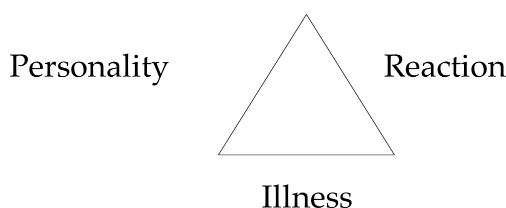
9. Depressive/Bipolar Disorders

Depression is also another burden of human consciousness; another price we pay for **imaginative memory**, again for **what is not-there**. We become fixated on loss and lack – what *was* there or *should* be there, how we and the world *should* be.

Depression exerts a high price by so disinvesting in what *is*: the *here and now*. Depression becomes **anti-libidinal**: the plug is pulled on our Mojo. This is akin to Freud's **death instinct**.

This antilibidinal force can be graded with the previous illness model (see) ie:

Mania/hypomania can be considered as:



0-1: More a spiritual/emotional problem. Very much counselling territory.

Rx/MM of doubtful benefit.

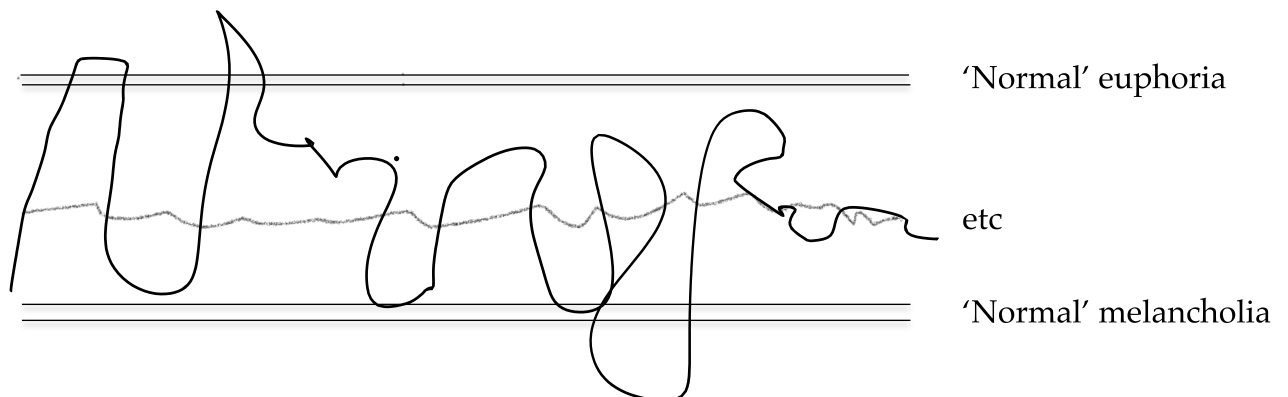
2: Intermediate state

3-5: Increasingly akin to physical illness.

Guidance for Rx
- 1st episode – 3/12
- 2nd episode – 6-12/12
- 3rd episode – ? several years

Common problems
- compliance
- rapid withdrawal
- (inevitable (?)) overdiagnosis

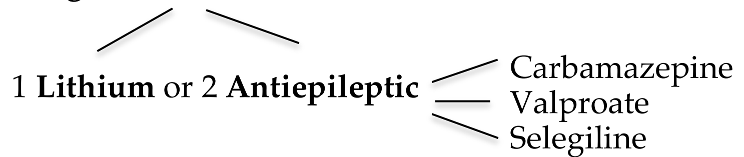
Cyclothymia ⇄ **BAD** (neé Manic Depression)



Mania/Hypomania

- The reverse of depression = **hyperlibidinal**: can become **psychotic**.
- When severe (level 2-5) then increasingly like physical illness.
- Levels 0-1 may be more like a **defense** (against fear, vulnerability, mortality).
- Is **consumerism**/growth economy etc a societal manic defence against existential anxieties?
- **Severe mania** = **serious psych.risk**. Acute episode:
- Needs
  - Containment/supervision
  - Major tranquillisers/antipsychotics
    - Olanzapine
    - Quetiapine
    - Risperidone etc

- 3rd acute episode often requires **long-term mood stabiliser** = LTMS

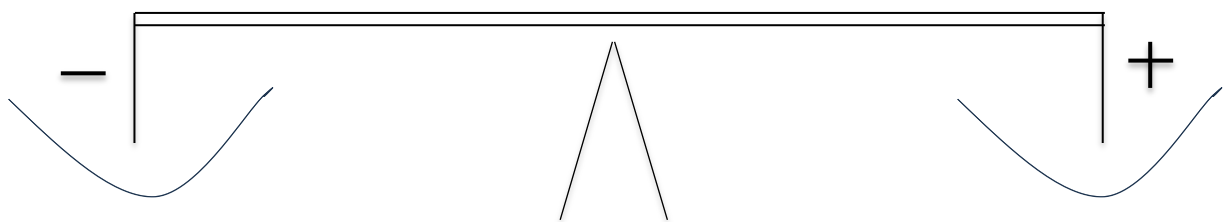


- Good rapport essential for **LTMS** safety.
- 'Supportive PsychoTx' often helpful here.

10. Psychosomatic disorders = PSM(D)

- Monism > atomism. Holism. Meaning. Semiotics.
- Everything (potentially) has PSM component. Questions are how, how much, is this now useful to Dr / Pt ?

A Sickness | **B Health**

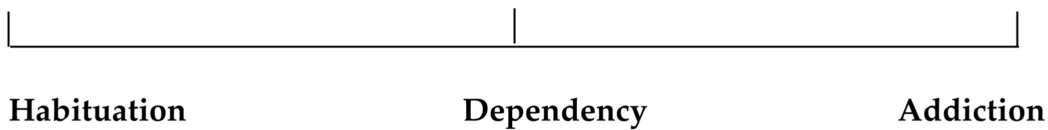


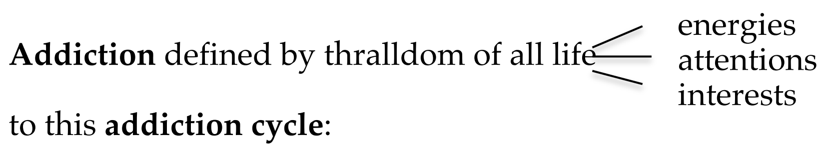
A Sickness	B Health
(Genetics)	(Genetics)
Unavoidable environment	
Alienation	Connectedness
Exclusion	Inclusion
Humiliation	Valuation
Powerlessness	Empowerment
Sensory impoverishment	Sensory enrichment
Meaningless	Meaning
Pathogenic	**Psychotherapeutic**

- *'What you're prone to is what you will get'*, and will often depend upon whether B > A, or not.
- Arcane topographical interpretations are rarely helpful (in my view).
- Best epidemiological evidence for PSMD = relationship of incidence of illness (all sorts) to significant life-events.

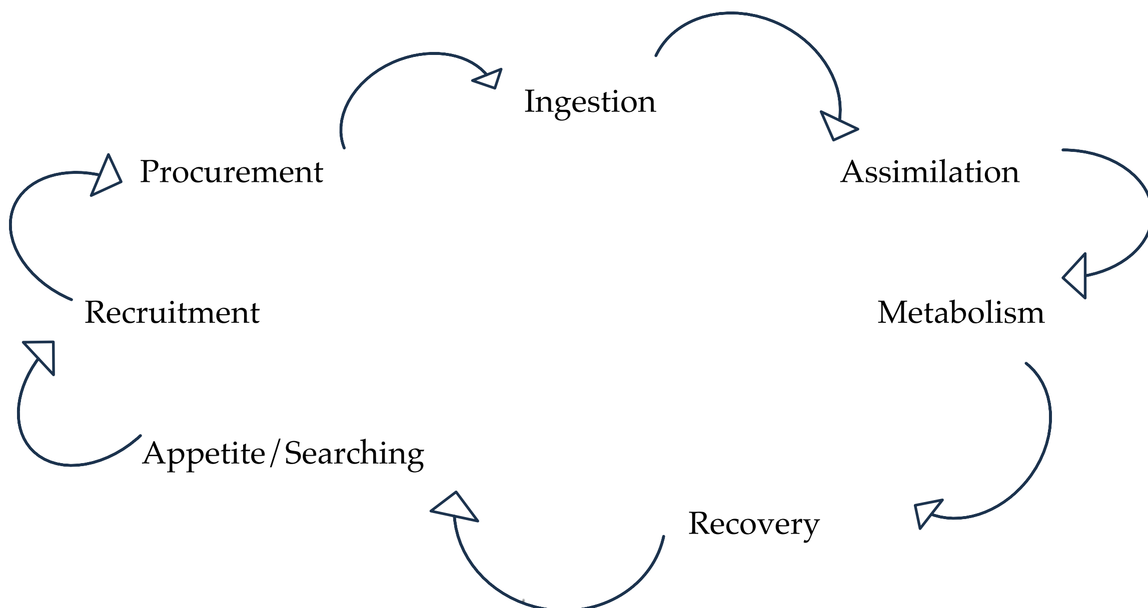
11. Addictive disorders

Defined more by the **behaviour pattern** than the substance.





Addiction defined by thralldom of all life to this **addiction cycle**:



The addict divides all others into three:

A. Colluders/active agents = 'Friends'

B. Bystanders/neutrals = Insignificant/valueless

C. Opponents/blockers = 'Enemies'

– By definition, addicts cannot have creative interests/relationships/employment.

– Some addictions are clearly more dangerous than others, eg IV heroin *v* Bingo.

– The addict may see addictive agent as life-essential.

– Addiction displaces 4 existential anxieties, but temporarily/precariously.

– Beware **'vacuum phenomenon**': addict needs to find other **purpose/meaning** before recovery is stable.

12. What is psychosis?

– Freud: 'Dreams are the 'Royal Road to the unconscious'.

– Jung: 'Psychosis is a dream, from which the dreamer cannot awake'.

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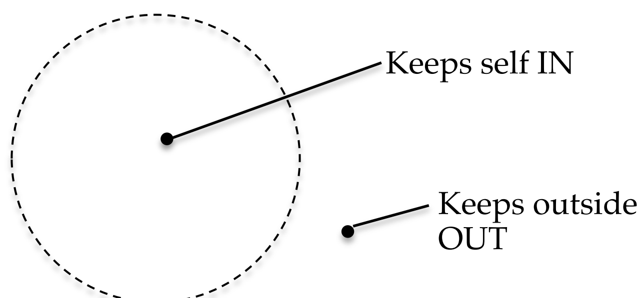
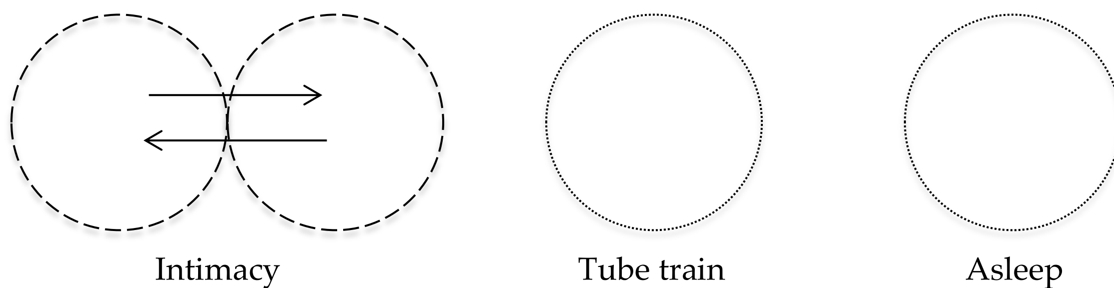
Neurosis	**Psychosis**
Inside *v* outside clear	Inside *v* outside unclear
Insight +	Insight –
Working rapport easier	Working rapport more difficult

– The mind's **semi-permeable membrane** = **SPM**



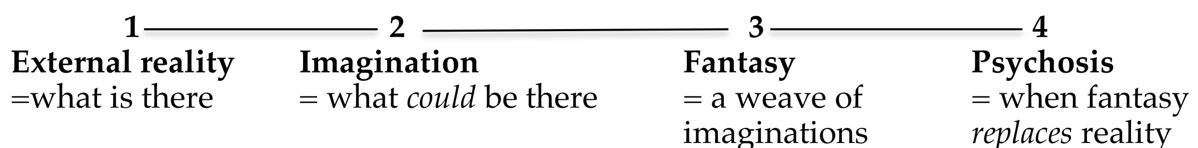
– Is **adjustable** with others/situations:



– **Flexibly adjustable** SPM important in mental health. The ability to discern and navigate the difference between internal and external realities excludes psychosis.

– The psychotic can find he **cannot cope** with thoughts/feelings of his internal reality and he then **externalises (projects)** them. This **misattribution** is thus a consequence of **membrane dysfunction.**

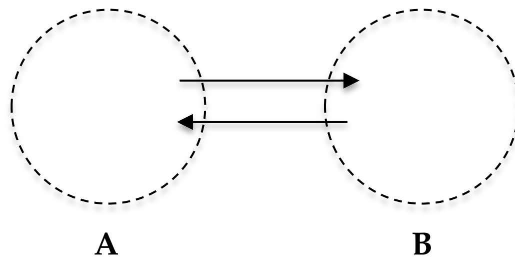
– Our internal-external perception span:



– What we cannot accurately designate (for whatever reason) can easily become misattributed, eg ambiguous situations confronting a tired or distracted brain, 'things that go bump in the night'.

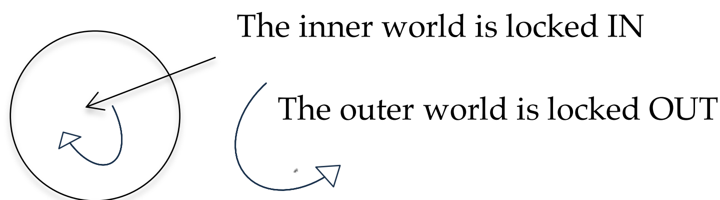
– Our internal worlds are all crazy. The question is can we reality-test them/correctly designate them?

– Good / sane intercourse:

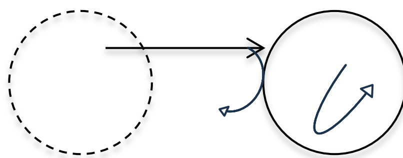


Both A and B can differentiate between their own internal and external world, and those of the other.

– The **psychotic** has a **rigid / impermeable SPM:**



– Intercourse is difficult:

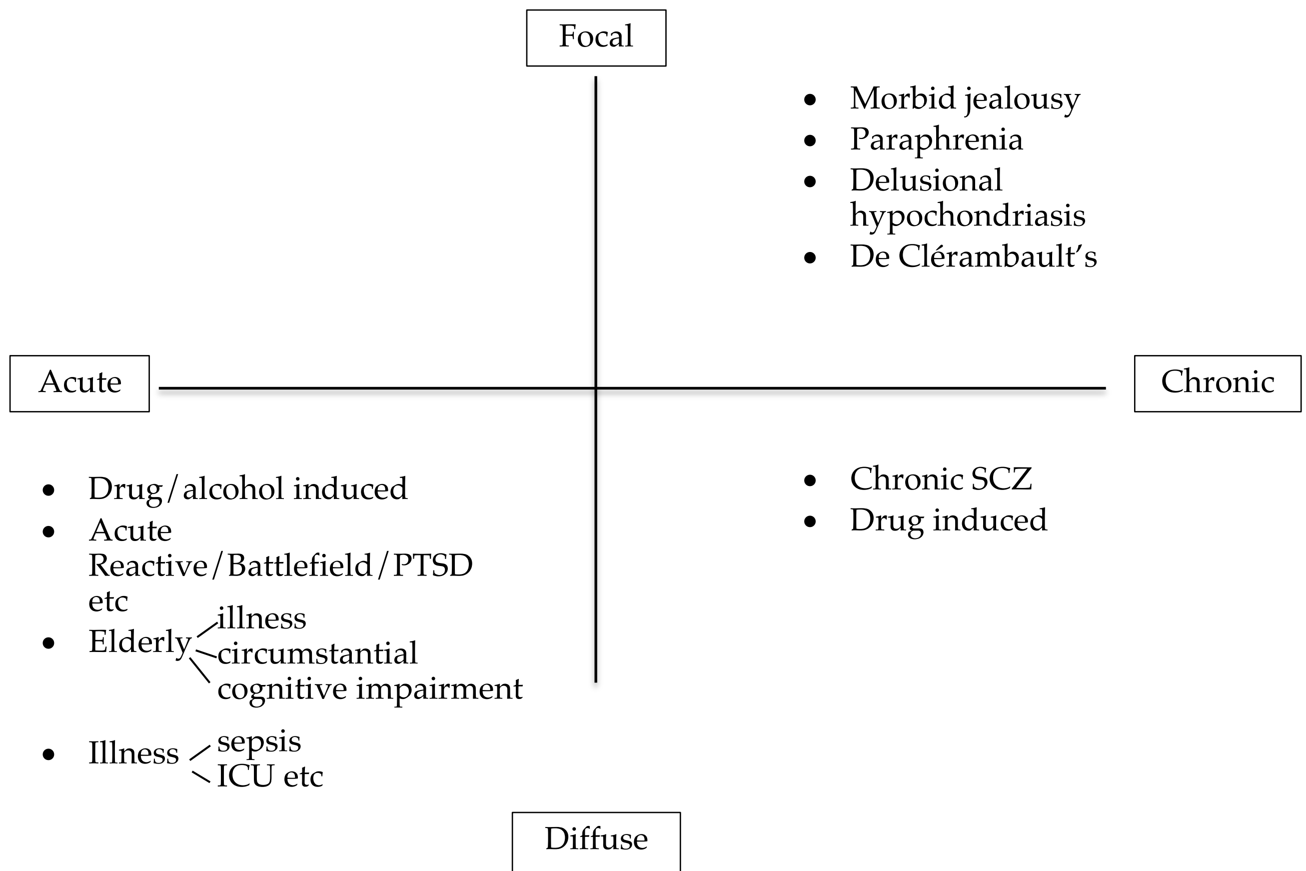


– The scrambling of internal and external domains is evident in:

perception – hallucinations

conception – delusions / thought-disorder

affect – 'inappropriate'$\equiv$incomprehensible



- Psychosis can occur whenever the **brain is overwhelmed/impaired** and cannot manage its internal/external filing system efficiently.
- In the **elderly** this is more likely because of:
  - Physical illness/impairment
  - Sensory loss – vision, hearing
  - Cognitive loss – understanding/recognition/processing
  - Social loss/isolation – work, family, neighbours/partners etc
  - Medications

- Generally Acute Psychoses have better **prognoses** than Chronic SCZ.
- Antipsychotic drugs (as in Mania) essential for acute/severe distress. Also longer-term containment/comfort of the same.
- Psycho Tx – supportive, exploratory, may buttress, expedite, even heal

14. Mixed disorders

– Psychiatric diagnoses ('illnesses') are rarely as reliable, reproducible, robust of accurate as physical diagnoses.

– They are best thought of as being like using a **paint colour chart** to describe or define the natural world. Nature will rarely conform exactly to the chart, and will also change according to the light and other context. So that chart is a rough and fallible guide only.

– **Compound diagnoses** are often more accurate and wiser. Examples:

- Agitated reactive depression
- Hypochondriacal depression
- Mixed manic-depressive-paranoid psychosis
- Schizoaffective illness
- Borderline Personality Disorder
- Mixed Personality Disorders/Cluster B

15. Personality Disorders = PD

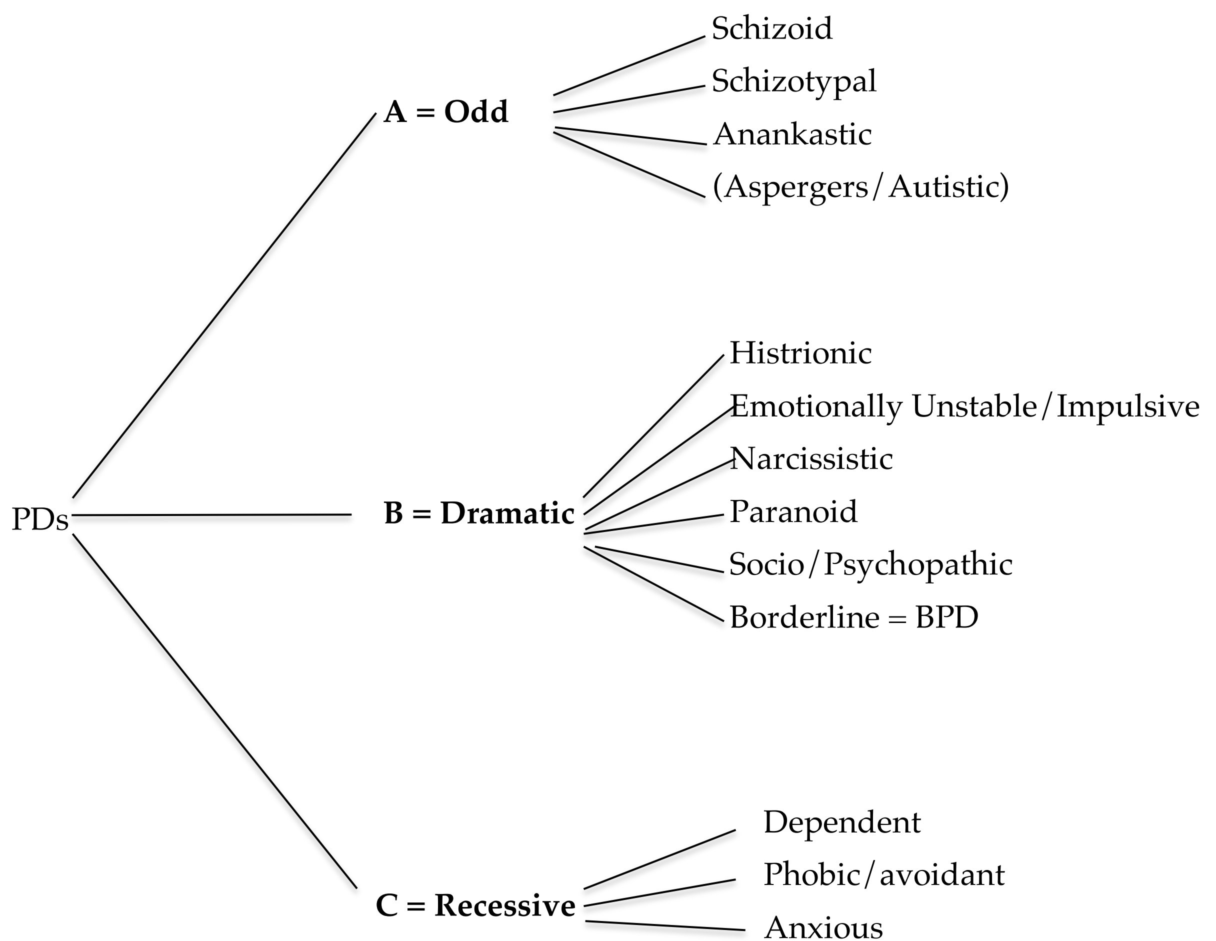
– PD is a **stable pattern** of **discord or misfit** with others causing distress, confusion, fear or disruption to others or themselves. This pattern is **widespread throughout their lives** and has been **present from early adulthood**.

– The problematic behaviour is *not* thought of a treatable, episodic mental illness in an otherwise well-functioning personality. Nor are they considered to be adequately explained or dealt with by criminal justice.

– The diagnosis can only be made with confidence after consideration of **several years' history** from **many sources**.

– Generally only BPD (see below) is 'treatable'.

– The list



– BPD:

- Chimeric/Borderline – PD / Affective / Minipsychotic
- **Lack of secure sense** of identity/object constancy
- Constantly **tests out** relationships: BPD = 'insecure attachment disorder'

- ‘Nature abhors a vacuum’ ⟶ Addictions/dramas/psychotic imaginings etc
- ‘I Hate You: Don’t Leave Me’. ‘When I bleed I know I’m real’
- PsychTx with BPD ≡ sailing a dinghy in a storm

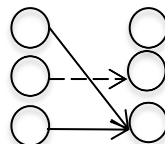
16. High risk: how to identify? What to do?

High risk factors:

- Hx of DSH/violence/impulsivity.
- Serious psychotropic Rx: Mood stabilisers/antipsychotics.
- No loving support network. Isolation.
- No meaningful work.
- **Poor rapport**. Avoidant eye contact.
- **Unreactive** depressive thinking, speech, mood and body language. No sense of building an ‘internal bridge’ until the next session.
- **Ominous ambiguities** eg ‘I’m not sure I’ll be here next week, anyway…’
- **Explicit disclosure** (rare)

What to do:

- Emergency +ve messages



contact – GP (If patient known)

CMHT (If patient known)

A&E (Most probable)

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