Psychology of Everyday

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Lecture – 02
Psychology & Psychiatry

Dr. Bajpai, I wanted to ask you something very specific which I think many people would have doubt about. We know of clinical psychologist we right now also talked about it, and we also have a psychiatrist.

Yes.

So, besides their training that they undergo in terms of practice how do you differentiate between the two?

See psychiatry also evolved almost at the same time as modern psychology evolved. Maybe, but a terminology came much before that I think it was reil R E I L who called the thing psychiatry because the whole thing comes from the Greek word even psychology come from there.

Which was psyche which was soul, so mind was nowhere?

Because even the understanding of mind was understanding of soul right. So, psychiatry evolved almost hand to hand with the psychology of the last 100 years. So, when especially the most prominent names of Breuer and Freud who was actually trained as a neurologist, and they started treated hysteria right with the psychological mechanisms.

Psychoanalysis was trying to probe deep into the mind that is when unconscious came in

And catharsis and dreamwork and all that stuff which we know about psychoanalysis. So, they were although Freud's of very few patients. So, Freud was treating them believing in his model of unconscious and conscious, and they were trying to treat people mind and brain were not understood as it is not understood fully even today. But Freud even at that time had a project on neurology on neurons. So, he was trying to find out the mechanisms of this conscious and unconscious based on the neuronal structure of the brain. He had that vision which is coming through now.

Whether this is a resurgence of Freud now. But what happened after Freud some people rejected Freud and what came was a behavior therapy.

(Refer Time: 02:41) that nothing comes from within, you are acting to an external stimulus.

Behavioral so this was all part of psychology remember, but it was used to treat phobias and anxiety.

(Refer Time: 02:57).

Right and even at that time Kreplin and all these people they were the first group of people who brought psychiatry to focus and they were diagnosing illnesses like schizophrenia, dementia precox and all that.

In fact, Albert Einstein's one son had schizophrenia and he was hospitalized in Switzerland. But those days schizophrenia was called dementia praecox it always has a downward course and it would lead to total cognitive disability and all.

So, psychiatry always was trying to treat people who were mentally ill.

But it is it was easier said than them because people were ab, so what do you think is a mental illness? If you talk about normalcy, we will talk about it, but people who are deviant suppose. So, lot of them the confusion was that whether they are criminals or they are mentally ill.

Because culturally also in a lot of tribes and all they were abnormal behavior episodes or which people who take drugs and (Refer Time: 04:12) and opioids, they all so all those things were always there. In fact, Ayurvedic probably had a branch which was called (Refer Time: 04:20). So, even they recognized abnormal behavior. So, like psychology which was philosophy, all the psychiatry and psychology were stemming from the same thing. So, psychiatry took upon treating abnormal behavior. So, the major thrust, when all these treatment mechanisms were being used by psycho psychology, psychiatry was already existing, but the boundaries were pretty blurred.

Is that say there was a predominance of usage of drugs in the stream of psychiatry?

Now, when the when it the whole thing changed with the advent of drugs, because not very far, it is just 20 years back. And the drugs were discovered serendipitously, they were being used for something else and something happened like reserpine antihypertensive use to cause depression. ECT one of the very popular shock thing was an accidental thing right. So, when drugs came in, then the difference between psychology and psychiatry became sharp.

But still, people say for instance right now you are also mentioning cognitive behavior therapy for instance.

Yes.

Rational emotive therapy for instance.

Neuropsychiatry.

Whether you are a psychologist, you are a psychiatrist.

Yes.

If you are in practice.

Yes.

You use these techniques.

So, what I am going to tell as you said in your previous introduction that most people do not like psychiatry is basically a with a medical background.

But a good psychiatrist has to train himself in psychology, he has to train himself in the neurology in medicine, in medicine in neuroscience in everything, because for him to differentiate that what has to be treated with medicines and what has to be treated with psychological mechanisms is very important.

Exactly.

What is neurological, what is medical? So, I would say a psychiatrist actually should know more neurology than the neurologist, he should know more medicine than the physician and more psychology than the psychologist.

So, both things came to hand to hand. So, the medical part of writing medication and all comes with the psychiatrist. And as psychiatry studied illness, after illness, after illness, then they devised what we use to call or we still use call classificatory system, international classification of disease which is in its eleventh edition and US had a diagnostic and statistical manual. So, this was a categorical diagnostic system ha, there were categories like mood disorder schizophrenia psychosis. This DSM - Diagnostic and Statistical Manual has is a dimensional thing it has axis 1, axis 2.

(Refer Time: 07:17).Axis 1 has a categorical diagnosis, axis 2 is a developmental thing, axis 3 is medical then the global assessment of functioning and family situation. These came in very early. Why was it important? It was important because see there is a there is a very subtle difference between psychiatry and psychology. When you say intelligence suppose in psychology, and if you just say intelligence to somebody sitting in US it may mean anything unless you are using a formula of quantifying it right.

Psychiatry arising from the medical branch, the communication has to be the same like when you say diabetes, diabetes should mean diabetes across the world right that is why otherwise how will you how will people treat it. Because the onus of treatment of abnormal behavior came primarily to psychiatry after Freud and behaviorism that is why the classificatory system had to come in, and that is where arose the need of because we still do not know the causes of many psychiatric illnesses of the rather most of them.

But in 40, 50 years we have devised very, very effective drug treatments.

Also, say like over a period of time.

Differential diagnosis has increased yeah. So, people have become now far more I should say they are far more now equipped to even draw a (Refer Time: 09:04) between

Yes.

Say disorder 1 versus disorder 2.

Absolutely, absolutely. So, initial if you look at the initial 30, 40 years, the diagnosis is a very gross diagnosis. And actually, I would I can tell you briefly is you know very simple. There is an organic, organic means everything is organic, it is in the brain. But real organic meant that you can have a cause for some abnormal behavior. You can have

a fever, you can have a seizure, you can have trauma, you can have a brain tumor which diagnosis became better with CT scans and MRIs and pet scans and all.

Then if it was not organic, it was it is used to be called functional. Within the functional itself, it could be psychotic were schizophrenia and bipolar, have I am telling you simplest classification in one line, but it still stands at this level only.

It is functional, it is psychotic, mood disorder, schizophrenia, it is nonpsychotic, it can be anxiety, it can be mood, again depression or something. And the third group was personality disorder which we have diagnosed much later is broad psychiatry was functioning within this. As people observe a large scale epidemiological study happened, then it was not known whether schizophrenia is happening only in US or in Africa or India, it is the work of all those people who went to the community and studied, now that we know it was discovered that illnesses are universal.

Is it that say around 50, when the mental health movement took in places at

Right.

Various places around the world.

Right, right.

Especially in Europe.

Yes.

It was then when you know much more knowledge about.

Abrasions in the behavior started coming. So, and especially you know the aftermath of the Second World War.

Yes, yes.

When extreme cases of symptoms would appear

Yes.

Which psychology or psychiatry had never encountered in the past.

Right. So, it was a see initially it was jail.

In which even before jail they were lot of persecution of this people use to happen right which hunting, then jail. Then, jail somebody, people realize that jail is not the place for these people they are different, they do not have they have a problem. So, they were sent to mental hospitals.

What they use to call it as a lunatic asylum.

Then the social moment said that they are not lunatic, they are mentally ill, but this understanding has come really later in the 30, 40, 50 years maximum, although means Nimhans the premier institute opened in the 50s. So, Europeans had realized that then the moment was to close down this lunatic asylum and rehabilitate people into the society because they are ill, they are not devious or they are not. So, along, so these social changes were already happening with the changes in drug treatment. So, drugs then this whole emphasis on the medication you know what we found that even if we did not know the cause we knew how to treat it.

And that is the crux right now. They are very very effective medicines to the tune that some illnesses has changed their course which was almost very very malignant type of illnesses which would take the person down in like schizophrenia. The progress for schizophrenia has improved tremendously. People take medicines like good medicines less side effects, but all this has come by huge cost law of experimentation of giving medication which causes lot of side effects to people, they created other mental illness. So, this trial and error, trial and error, but this trial and error was not blind that is what is very important. The categories of illnesses when we discovered that there is a 1 percent risk of schizophrenia all across the world, everywhere.

If one sibling has, then the risk goes up. If two siblings has, the risk goes up. When two parents have risk goes up. So, all of us have the same genetic makeup. So, these illnesses probably have come in our genes from evolution right.

I want to take you back right now while talking about psychology, psychiatry, you did mention that there were there was an attempt which to a greater extent has been successful in few countries; especially in India, it has not been so successful. When you make a mix of mental health professionals.

Yes.

So, psychiatrist and psychologist are only two elements.

Right.

We have the psychiatric social workers and we have the psychiatric nursing practitioners.

Right.

So, they also have

Role.

Important role to play.

Right.

And especially the psychiatric social workers who would be more instrumental in assisting in the assessment of the disorders.

Right.

And as well as they would be instrumental in extending the therapeutic intervention that is programmed.

Right.

And they would ensure largely how good a person if finally rehabilitated in society.

Absolutely.

So, this is a.

I (Refer Time: 14:46) about to tell you this. This was very interesting in 70s and 80s I think when they were studying the prognosis and long term factors. And all actually the prognosis of acute psychosis-like acute psychosis when diagnosis which came from third world. India was also in third world at that time. Sudden onset of psychosis which would resolve in few days, so that criteria for schizophrenia was 6 months initially, now it is 1 month. So, what resolves within few days is acute psychosis.

Now, somehow all this power dynamics goes in and people keep changing labels and all, but acute psychosis was a real thing, we see it in a practice. The prognosis of schizophrenia was better in third world countries. Why, because even India was different at that time if you remember in 70s and 80s.

They were joint families; they were large family support system. Now, we it will be interesting to see after 20 years with India modern India.

Modern India emerging as other countries.

Where families have largely broken off what will be the prognosis of these people. But at that time it use to be good.

Now, it may be good because of the medication. If you keep taking medicine, but what are the support systems. Therein comes the psychiatric social worker right, because they are the people who can go and teach and really encourage people to bring out their resources to handle the patient.

They would also have played, and they must be till today also they are playing an important role even in terms of knowledge dissemination.

Absolutely.

Because what we consider as a particular disorder.

Yes.

In a little what you call sugar-coated format.

Yes.

They would be conveying this information. So, the scientific information translated into kind of information which would be easy to grasp.

Right.

By the

Right, right.

Non-technical populations.

Right, right. See again as in psychology you said it becomes social psychology this and that. So, there is lot of blurring of boundaries, but mental health as far as we talk of mental health, whether we talk of illness or prevention and or prevention of illness or mental health enhancement, it is a very very composite multidisciplinary effort.

So, one of the perfect models which work is I have been lucky to get trained in Nimhans, Bangalore. So, adult psychiatry unit has a psychiatrist and psychologist, and psychiatric social work and psychiatric nursing. So, whenever a person is discussed there, it is not just a medical treatment or just the psychological aspect, it is a composite whole which is being discussed, and then roles are allocated. Unlike medicine where the doctor can just prescribe, so it will be very, unfortunately, psychiatry becomes like that, because in psychiatry just giving medicine is never going to work.

I would just like to highlight this thing. As a student when I saw the practice of psychiatry, as you said now right now that if you convert psychiatry also just into practice your medicine.

Your medicine yes.

My old experience is now at a large number of people would practice as if they are in search of certain keywords.

Yes.

Features or symptoms whatever what do you want to use. And based on those couple of symptoms they would prescribe medicine which could be for say 30 days time period.

Yes.

And then said it again you revisit the clinic after these many days.

Yes.

Without going into the details of.

So, that is the.

Issues that you are referring to right now.

That is because that I mean I should confess it, we should not hide that. Training is very very desperate.

At least you have not been able to devise one curriculum. The other is because I as I said we do not know the causes of illness.

Like a medical classification of diseases is based on cause. For example, if you have what should I say a fever for example, right or if you say you have a swelling in hand. Now, how would doctor look at swelling, he would look at what it is it because of infection, is it because of trauma?

Is it because of some endocrine disturbance?

Is it because of some something else. So, these are causes. And then he would investigate those causes and treat them. Psychiatry is different if a person is having hallucinations, delusion, lack of insight, poor personal hygiene for 1 month, he will become schizophrenia where is the cause.

So, or if vis-a-vis a person is having depression, if a person is having the sadness of mood, loss of appetite, crying spells, you immediately try to whether this category or that category. The problem which you just mentioned in passing was that finer boundary is illness have also started changing their role the big pattern

No, these days we rarely see pure schizophrenia, pure depression is all mixed up. Now, schizophrenia can have depression, a depressive some person can have psychotic symptoms you understand like OCD. So, what I am saying. So, for most psychiatrist what is important is to treat, and they are in tremendous pressure to treat.

Because they are seeing so much misery. And so the shortest and the easiest course is to clarify in the head what is the nearest diagnostic category with this person fits in.

Right? Because the moment you say then it becomes easy for the doctor to decide whether he want to give an antipsychotic or whether he want to give in a.

One reason perhaps could also be that we have skewed distribution of the patient-doctors population.

That is also to say you have very

But

less number of psychiatrist versus the kind the number of.

Yeah know, but.

Psychiatric patient.

It is more actually, it is still deeper. And you would understand as a psychologist that when you are asking about the symptoms, what are the tools a psychiatrist has, the like for psychologist the tools are psychometric tests for most of them yeah. Or forming or talking to a person you formulate your framework of which frame work you are going to use a psycholytic frame, or you are going to use a behavioral depends on your orientation.

Psychiatrist in spite of knowing all this psychology and this and that is too less, see what is the crux of psychiatry, the crux of psychiatry is a diagnostic process. For the diagnostic process, we do not have although we have lot of MRI this that but believe me there would be hardly two or three percent of psychiatric diagnosis which are made on any tests.

So, when people come and say [FL] doctor you have not got any test done, how can you know it is depression, we say we do not have a test, someday we may have. So, we are almost on a hunt for last 40 years for biomedical markers EEG markers, MRI markers. There is a hell lot of physics and mathematics which is working these days to find out, but till now we have not we cannot say actually that you get this test done and we will know.

But interestingly now let me bring in psychology and the assessment tools that psychologist use.

I will just.

Say for instance.

I will just complete.

So, what I was saying, then it will be easy for you to connect. So, the tool still remains what we call psychopathology. Now, the psychopathology business came from existential philosophy and all that. Phenomenology, phenomenology means if what is the experience you are having in your head, the cause comes different.

So, somebody comes and say that I am sad and I want to die that is a phenomenon, it is a depressing effect. You have to treat that. Somebody says that I get fearful, so that is the phenomena. Why is part 2 of the story? Somebody says that I hear voices talking to me right, which say that you are guilty that and there is no voice source that is the hallucination that is the phenomena. Why he is feeling guilty maybe something else, do you understand?

So, a psychiatrist in that short time or longer time has to differentiate between the phenomena, because based on this phenomena, he will put him into diagnostic categories. But there is life beyond diagnostic categories because patients do not read the book before coming. So, they will have schizophrenia with depression this and that. So, it is up to the psychiatrist to diagnose, and then because once you decide the category it becomes easier for you to treat.

So, the problem is with most psychiatrist is that they are after all they are from medical set up. They have to behave like a doctor. What does a doctor do, treat. So, to once you decide phenomena diagnosis, then you treat. Then out of interest, out of your own understanding, you would not to go deeper like lord Krishna said why Arjun you get up and fight that was the treatment, but he said no let us go there. So, then you can look into why it is happening, but these are people who go deeper are the people who were most psychologically oriented.

So, the question that I was trying to put forth you was that say there are lot many tools used by psychologist to quantify the level of depression.

Yes.

Becks depression inventory for instance.

Very popularly used across nations. How effective these tools can be or are in practice for a psychiatrist?

See more psychiatric clinics at least in countries like India and a very very crowded. And they are very high-pressure jobs you know life is there. And you treating liver, you can still be detached, but somebody is crying you cannot be. So, in clinical practice for treatment and all I do not think many people use it, they are used where research is involved, diagnostic confusion happens.

When there is an unclear diagnosis. Like older test you would remember they may take a perception, Rorschach, all those projective tests were a device to they were based on psychoanalysis only.

Yeah.

To bring out the unconscious or the person. So, they were used more frequently actually.

Now, pressure inventories hamilton depression are more of quantification of is they are not very diagnostic, some people use it, but ultimately that they do not see let us be very clear. If a psychiatrist cannot make a clinical diagnosis sitting front to front nothing else will happen.

You may get confused, but you still should have a differential diagnosis in your head.

It is very rare that we get somebody who we are not able to diagnose. It happens at institute level everywhere, then we go and bank on.

Kind of psychological assessment.

Psychometry and.

Also perhaps could there will be a reason that the state the mental state of the patient or the person who suffers from a given state, is not conducive to participate in any of the psychometric tests?

Absolutely no. If psychosis obviously not a lot of illnesses where a person is not in this test.

But even in a depression.

Now, a depressed person will not be willing to participate you know in the psychological assessment.

The scales can help him quantification

Ha, but for academic purposes.

For.

For research purposes.

No, in clear or from measuring the prognosis, but I do not, if you ask me I my friends may become angry with me, but let me tell you it is not of much use in clinical work. Because if you and me give a serious hamilton depression is scale 90 percent people in this country with diagnosed depression.

So, we will take up this issue you know because we have now we will be touching upon the social and cultural side of psychiatry.

Yes.

And psychology later on.

Later on yes. So, we should understand there is a probably this should be our point where we have to bring into the common life because what we call as depression has definite criteria clinically. What people use the term as I am depressed is something else.

So, when somebody says I am depressed, I am anxious, I think we should not take it at the face value, we should clarify what does that person mean by depressed. Because again as in psychology there are lot of pop psychology which is come up, these terminologies have become so commonplace that even a kid knows.

Yeah, perhaps, see now with the exposure that you get through different kind of media.

Yes.

You are aware of the words without knowing the layers of it.

Right. So, fortunately, the technical side of

So, for, so depression just means sadness, no, it does not, because so and then they will come for treatment. So, lot of people who go to physicians into neurologist and all, they go and get treated. And in India, everybody can write antidepressant.

But once you start what you do not know when to stop it.

Because over years we have owned the skills and refined mechanism by which we know how long one medicine has to be continued.

And this is what is you should observe also that that is the difference between good treatment and bad treatment.

Bad treatment.

Doctor knows what he is writing rational pharmacology, how long when to stop.

Just going and getting depression treated, it actually it does not work.

So, maybe I think you know now that we have

Yes,

Try to say see the commonality and the difference.

Yes.

In the approach that psychologist and psychiatrist who will adopt.

We will talk about.

Let us take some real-life example in the coming sessions.

Absolutely.

Where we would be trying to decipher human behavior.

Absolutely.

From more bit more specific details rather I should say.

Yes, thank you.

But then still the details would be non-technical as far as possible

Absolutely, absolutely.

So, real life example trying to understand it from a common person’s perspective.

Thank.

And I should thank Dr. Bajpai for drawing this line of distinction between what a psychologist would try to look at and what a psychiatrist would try to look at. And in the coming sessions, both of us would try to take real-life examples and try to see it from both the perspective.

Absolutely.

Trying to make it as far as non-technical, but still easy to understand kind of a thing.

Thanks.