



ETIOLOGY IN PSYCHIATRY, CLASSIFICATION/DIAGNOS IS IN PSYCHIATRY

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Objectives:

- To discuss the etiology of psychiatric disorders
- To list the main classification systems for Diagnosis in psychiatry
- To discuss the differences between ICD & DSM
- To describe the differences between primary and secondary psychiatric disorders
- To describe the differences between psychosis and neurosis

Etiology:

➤ *The Complexity of etiological factors:*

1. *Time factors:*

- Causes are often remote in time from the effect they produce

2. *Single cause:*

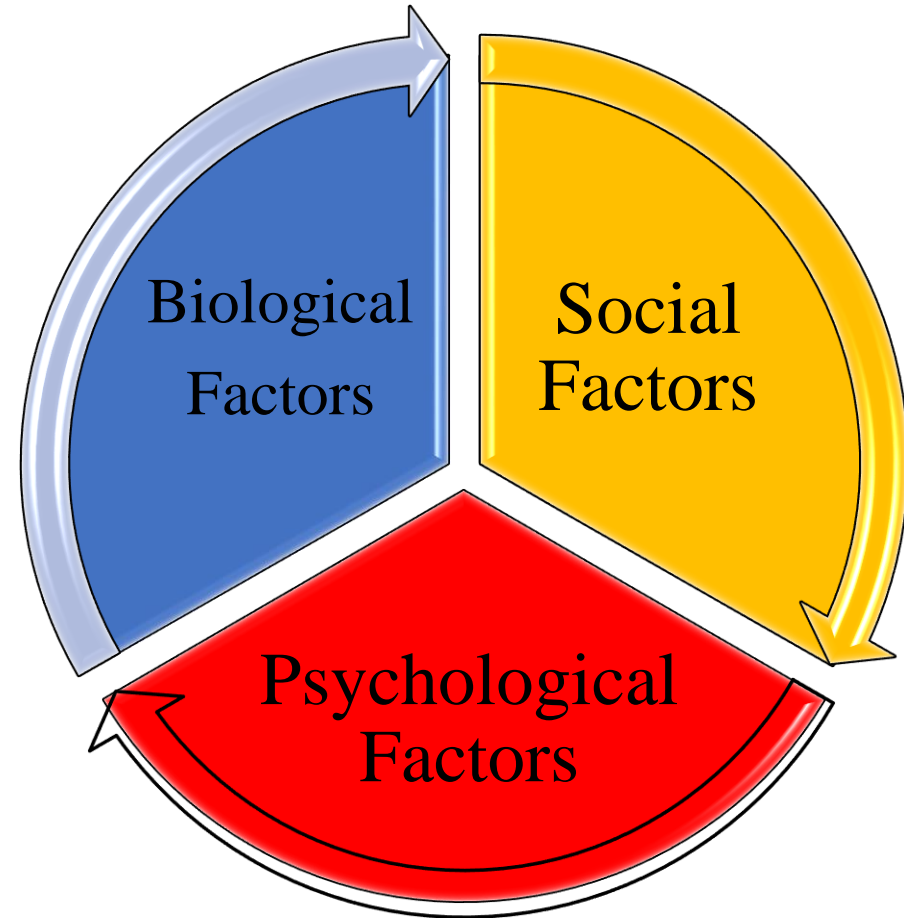
- May lead to several psychological effects e.g. deprivation from parental affection may lead to depression or conduct disorder in children and adolescents

3. *Single effect:*

- May arise from several causes e.g. depression may be due to accumulation of several causes like endocrinopathies, psychosocial stresses, and side effects of some drugs

Etiology in Psychiatry:

- Like other branches of Medicine, etiology of primary psychiatric illnesses is usually *multifactorial*
- Etiological factors can be classified into *biological, psychological, and social factors*: Bio-Psycho-Social Approach (Engel 1977)



Biological Factors

- ❖ **Genetic:** e.g. in schizophrenia
- ❖ **Neuropathological:** e.g. dementia
- ❖ **Endocrinological:** e.g. hyper/hypothyroidism
- ❖ **Biochemical:** the monoamine neurotransmitters
- ❖ **Pharmacological:** side effects of medications e.g. steroids
- ❖ **Metabolic:** DM
- ❖ **Inflammatory/ autoimmune**

Psychological factors

- ❖ **Thinking distortions**
- ❖ **Emotional dysregulation**
- ❖ **Behavioral problems**
- ❖ **Unconscious conflicts**
- ❖ **Others**

Social Factors

- ❖ **Family factors:** lack of social support, criticism, and over protection within the family
- ❖ **Life events :** Migration, unhappy marriage, problems of work, school, financial issues

Predisposing factors



Constitution



Precipitating Factors



Protective Factors

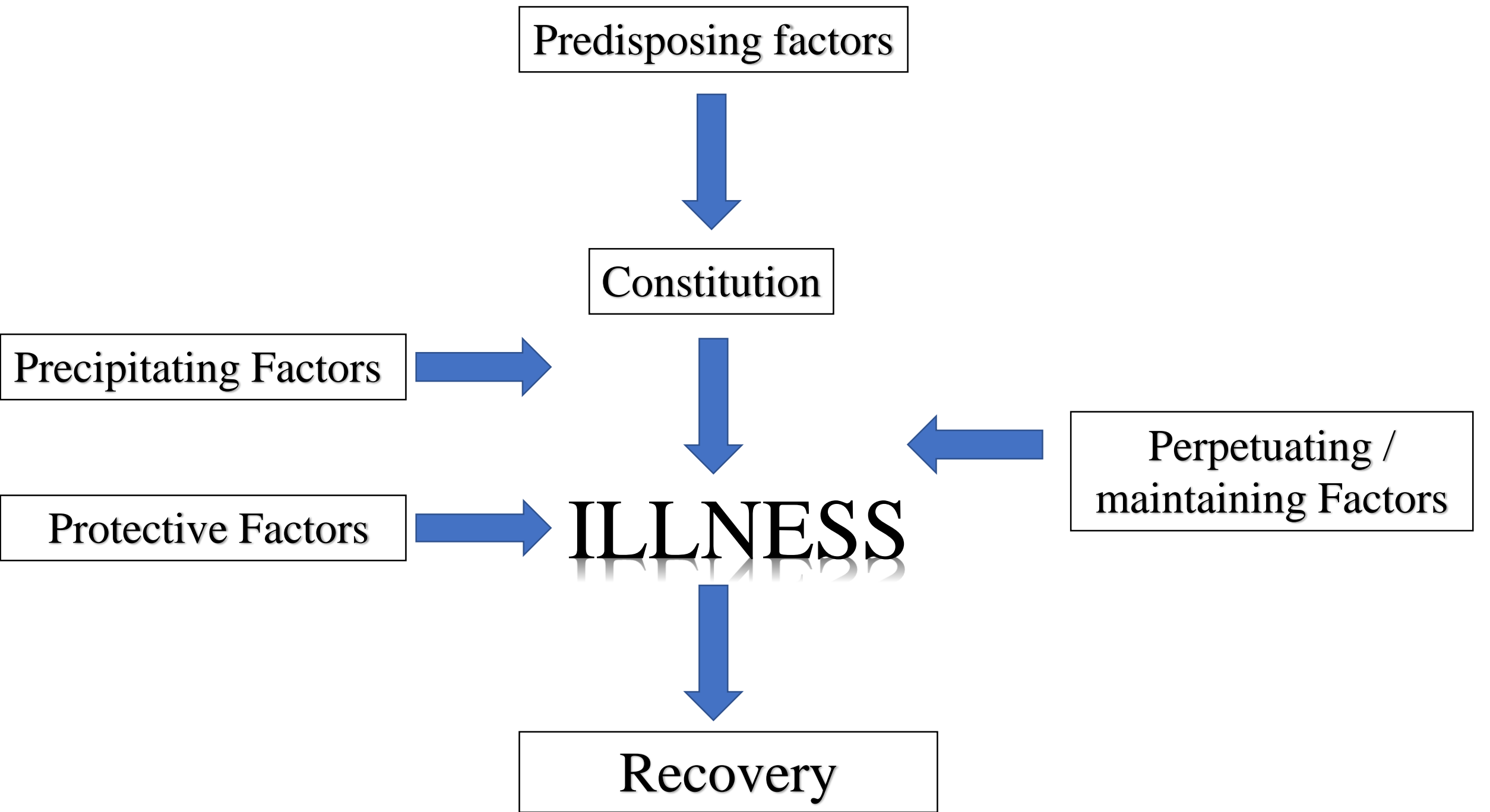


ILLNESS

Perpetuating /
maintaining Factors



Recovery



4P Factor Model	Biopsychosocial Approach		
	Biological	Psychological	Social
Predisposing	Genetic vulnerability, toxic exposure in utero, birth complications, traumatic brain injury	Attachment style, personality traits, isolation, insecurities, fear of abandonment since childhood	Domestic violence, poverty and adversity, unstable home life, divorce
Precipitating	Iatrogenic reaction, poor sleep, substance use/misuse	Recent loss, stress, reexperience abandonment/fears	School stressors, loss of significant relationship, loss of home
Perpetuating	Poor response to medication, chronic illness/pain	Personality traits, coping mechanism, beliefs of self, others and the world	Role of stigma to access treatment, poor finance, ongoing transition
Protective	Adequate diet, sleep, good genes, physical exercise, resilience, intelligence	Insightful and cognitive behaviour strategies, coping skills, psychologically minded	Community, family and faith support, financial or disability support, GP support

	Predisposing	Precipitating (Stressors/Triggers)	Perpetuating
Biological	<ul style="list-style-type: none"> • Genetic vulnerability • Family medical history • Birth defects • Developmental delays • Age • Race • Sex • Gender • Sexual Orientation 	<ul style="list-style-type: none"> • Onset of acute illness/infection • Onset of severe medical disorder • Major surgery or medical procedures • Physical trauma • Substance use/misuse 	<ul style="list-style-type: none"> • Substance use/misuse • Chronic physical illness • Immunosuppression
Socio-environmental	<ul style="list-style-type: none"> • SES/Poverty • Geographic region • Childhood experiences • Education level • Chronic job stress 	<ul style="list-style-type: none"> • Life events (having a baby, car accident, getting married, getting laid off from a job, academic struggles, divorce, etc.) • Social/esteem support • Interpersonal conflict • Natural disasters 	<ul style="list-style-type: none"> • Social/esteem support • Work/life schedule rigidity • Social stigma • Financial obligations • SES/Poverty • Unemployment • Social factors (secondary gain)
Psychological	<ul style="list-style-type: none"> • Personality traits • Temperament • Psychopathology • Distress tolerance • Family mental health history 	<ul style="list-style-type: none"> • Poor coping style/problem solving • Negative/maladaptive thoughts • Psychopathology 	<ul style="list-style-type: none"> • Coping style • Social support • Compensatory behaviors • Negative/maladaptive thoughts • Avoidance behaviors

Effect Nature		Effect			
		Predisposing	Precipitating	Aggravating	Maintaining
N A T U R E	<i>Bio</i>	E.g. Genetic predisposition e.g. panic disorder	E.g. First dose of cannabis abuse	E.g. Further abuse	E.g. Continuation of cannabis abuse
	<i>Psycho</i>	E.g. Abnormal personally traits with poor stress adaptation	E.g. Sudden or severe psychological stress	E.g. Further psychological stresses	E.g. Continuation of such stresses
	<i>Social</i>	E.g. Parental separation	E.g. Marriage	E.g. Marital conflict	E.g. continuation of marital problems

SUPERNATURAL

- Evil eye
- Witchcraft
- Possession



Islamic concepts

- ❖ **The effects of evil eyes, witchcraft and possessions on health in general is proven.**
- ❖ **They can be one of the major or minor etiological factors for any type of disease.**
- ❖ **The pathophysiology, symptoms and signs are not proven or certain.**
- ❖ **The faith healing (Rogiah) is:**
 - **One important preventive & treatment modality for all types of diseases.**
 - **Not a diagnostic tool**

Cultural concepts and practice

- ❖ **Some people deny the effects of evil eyes, witchcraft and possessions on health.**
- ❖ **Others exaggerate their effects and over blame them.**
- ❖ **The pathophysiology, symptoms and signs are related to specific kind of illnesses.**
- ❖ **Some faith healer are ignorant:**
 - **Use faith healing as a diagnostic tool.**
 - **Verbally and physically aggressive with patients.**
 - **Advice patients against medical management.**

Islamic vs sociocultural concept



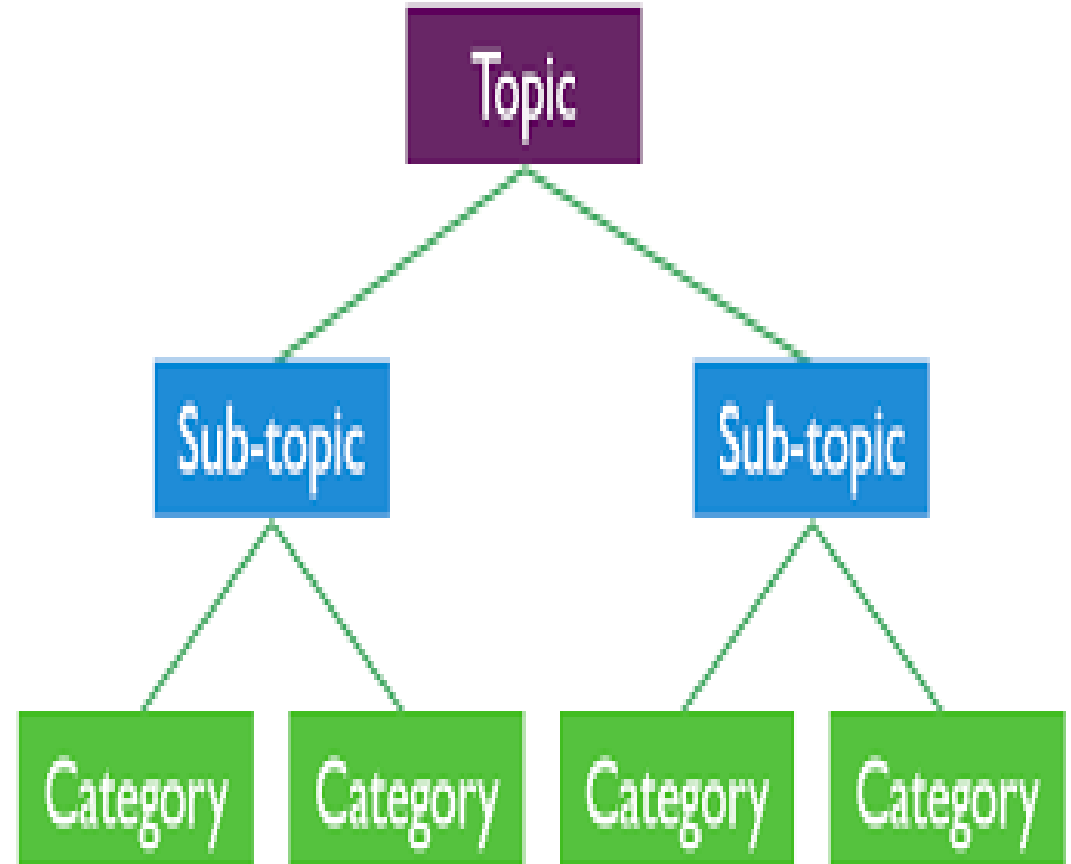
النظرة الاجتماعية لا تمثل الشرع

(لا تطابق تماما و لا تخالف تماما)

CLASSIFICATION/DIAGNOSIS IN PSYCHIATRY

Classification & Diagnosis In Psychiatry

- Depends mainly on **signs & symptoms** (psychopathology)
- Rarely we use external validation
 - lab tests ,brain imaging, ...etc
- **Clinical skills are essential**



Why to classify ?

- *Introduces order* and structure to our thinking and reduces the complexity of clinical phenomena
- *To distinguish* one diagnosis/illness from another
- *Facilitate communication* among clinicians about diagnosis, treatment, & prognosis
- *Help to predict* outcome (e.g. schizophrenia has chronic course)
- Often used to choose an *appropriate treatment*
- Ensure that *psychiatric research* can be conducted with comparable groups of patients

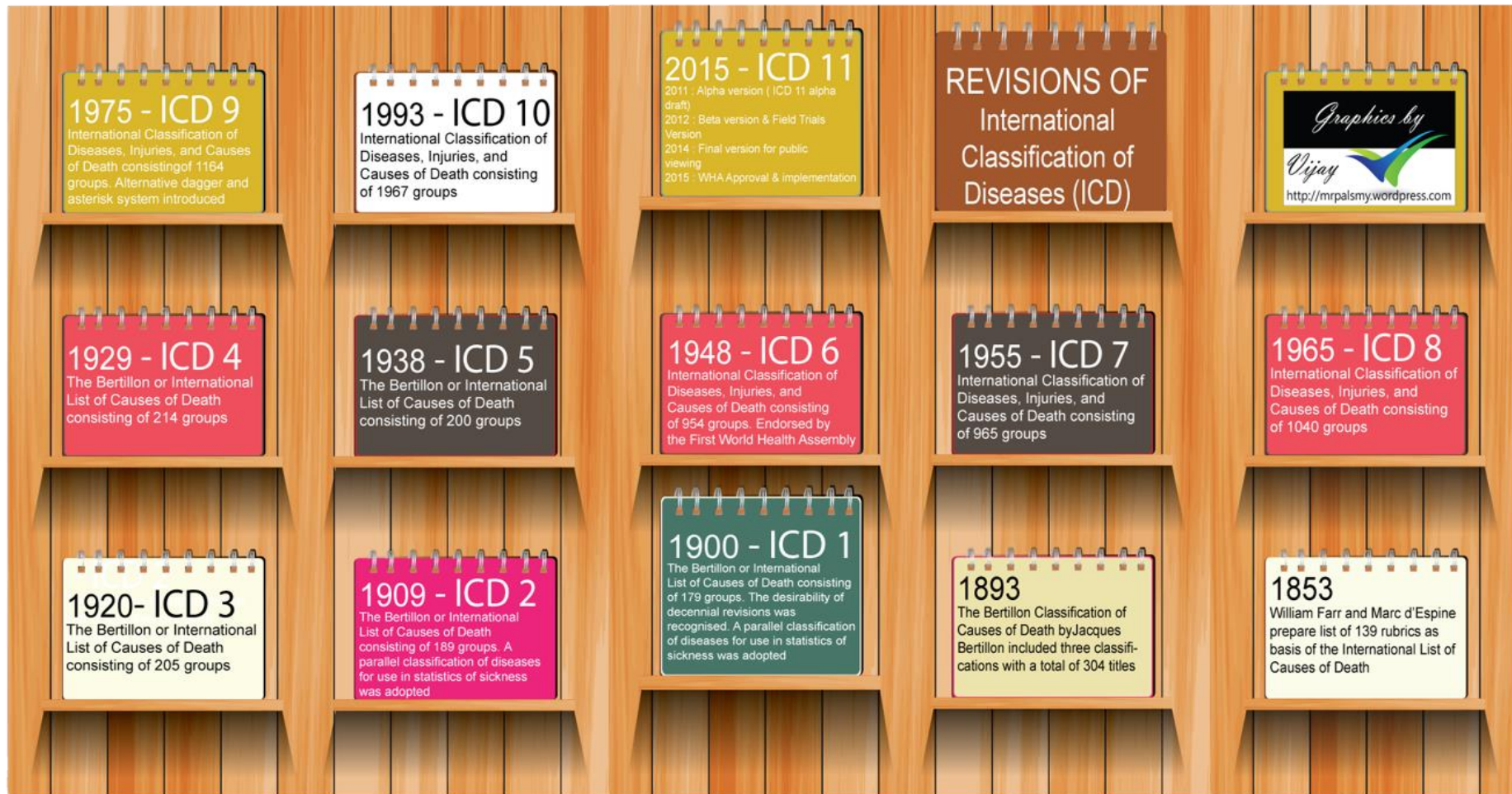
Definition of Mental Disorder

- A syndrome characterized by clinically significant disturbance in an individual's *cognition*, *emotion regulation*, or *behavior* that reflects a dysfunction in the *psychological*, *biological*, or *developmental processes* underlying mental functioning
- Mental disorders are associated with significant *subjective distress* or *impairment* in social, occupational, or other important activities



Classifications of diseases

WHO | International Classification of Diseases (ICD)



Diagnostic and Statistical Manual of Mental Disorders (DSM)

- Published by APA: a **common language** and **standard criteria** for the **classification of mental disorders**
- The manual evolved from **systems for collecting census and psychiatric hospital statistics**
- Developed by the US Army, 1952
- Five revisions since it was first published
- The last major revision was the fourth edition ("DSM-IV"), published in 1994, although a "text revision" was produced in 2000
 - **DSM-5 was published in May 2013**

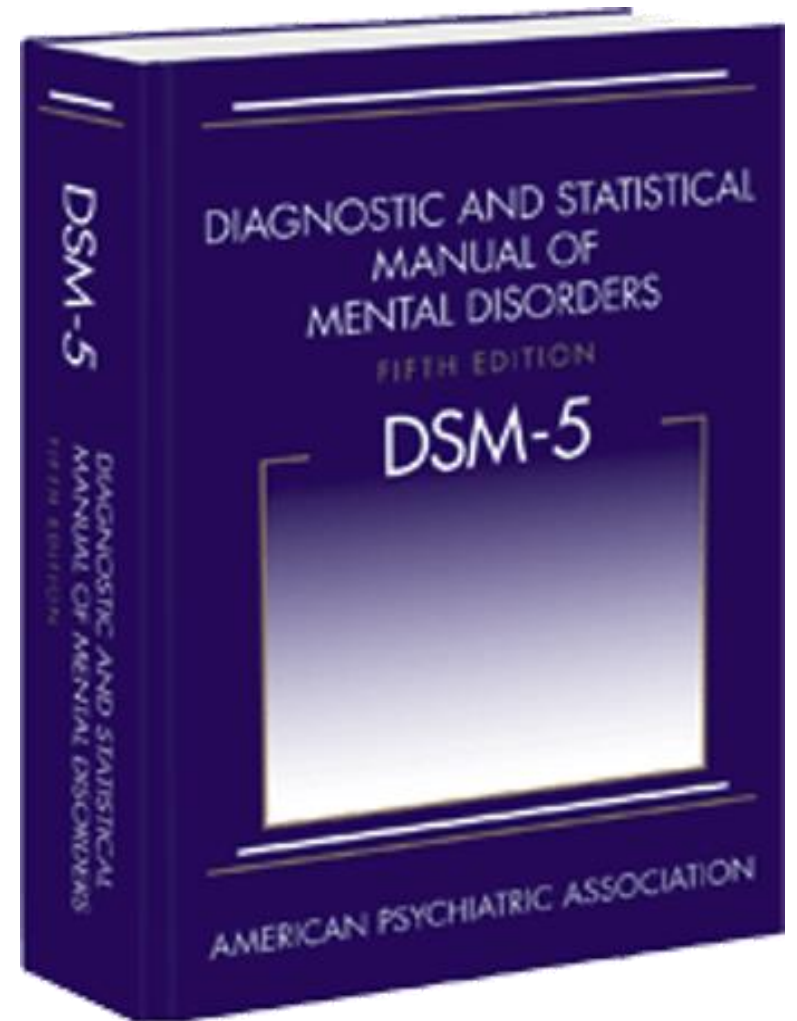


TABLE 1

CHAPTERS IN DSM-5

- Neurodevelopmental Disorders
- Schizophrenia Spectrum & Other Psychotic Disorders
- Bipolar & Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive & Related Disorders
- Trauma- & Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom Disorders
- Feeding & Eating Disorders
- Elimination Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse Control & Conduct Disorders
- Substance Use & Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders
- Paraphilic Disorders
- Other Disorders

The number of total disorders in DSM-5 has not increased significantly, but some disorders have now had their importance recognized by being allocated separate chapter headings (e.g. Obsessive Compulsive Disorder). The chapter on Neurodevelopmental Disorders is a new heading containing autism spectrum disorders, intellectual development disorder, and attention/hyperactivity disorder (ADHD). The chapter on Substance Use & Addictive Behaviours will now include gambling disorder. The importance of both Bipolar Disorder and Depressive Disorders is recognized by them being allocated to separate chapters.

Similarities between DSM-5 and ICD-10

- Both are **diagnosis** and **categorizing manuals** require two or more symptoms to make a diagnosis
- Both are **NOT self diagnosis manuals**; Intended for **use by qualified health professionals**, more specifically psychiatrists
- Both are **officially recognized manuals** used to categorize and diagnose mental disorders
- Attempts are on, to further harmonize between the two systems of disease classification



Differences between DSM-5 and ICD-10



FIGHT



DSM-5

- ❖ **DSM used mainly in the USA**
- ❖ **DSM is purely for mental disorders**
- ❖ **DSM issued by single national professional body- American Psychiatric Association**
- ❖ **DSM primary constituency is U.S. Psychiatrists**
- ❖ **DSM approved by assembly of APA members**
- ❖ **DSM is copyrighted and generates income for APA**

ICD-10

- ❖ **ICD Internationally**
- ❖ **ICD is larger manual, encompasses all types of diseases/disorders; Only chapter V is relevant for mental disorders**
- ❖ **ICD brought out of international collaboration; ICD produced by a global health agency with a constitutional public health mission**
- ❖ **ICD primary focus on classification is to help countries to reduce burden of mental disorders. Its development is global, multidisciplinary and multilingual**
- ❖ **ICD approved by World Health Assembly comprising of 193 member countries**
- ❖ **ICD is low cost and available free on internet**

DSM-5

- ❖ **DSM criteria very specific and detailed**
- ❖ **DSM always been multi-axial except now**
- ❖ **DSM used by licensed mental health professionals with advanced degrees**

ICD-10

- ❖ **ICD more of prototype descriptions with less detailed criteria and minimum background information to guide diagnosis**
- ❖ **ICD always been non-axial**
- ❖ **ICD accessible to wide range of health care professionals with wide educational backgrounds**

- **Conceptual differences; Ex: Bulimia nervosa is characterized by 'morbid dread of fatness' while DSM requires 'self evaluation'**
- **PTSD is much broader in ICD-10 than DSM-5**
- **Differences can cause problems in research comparisons**

Other Classification:



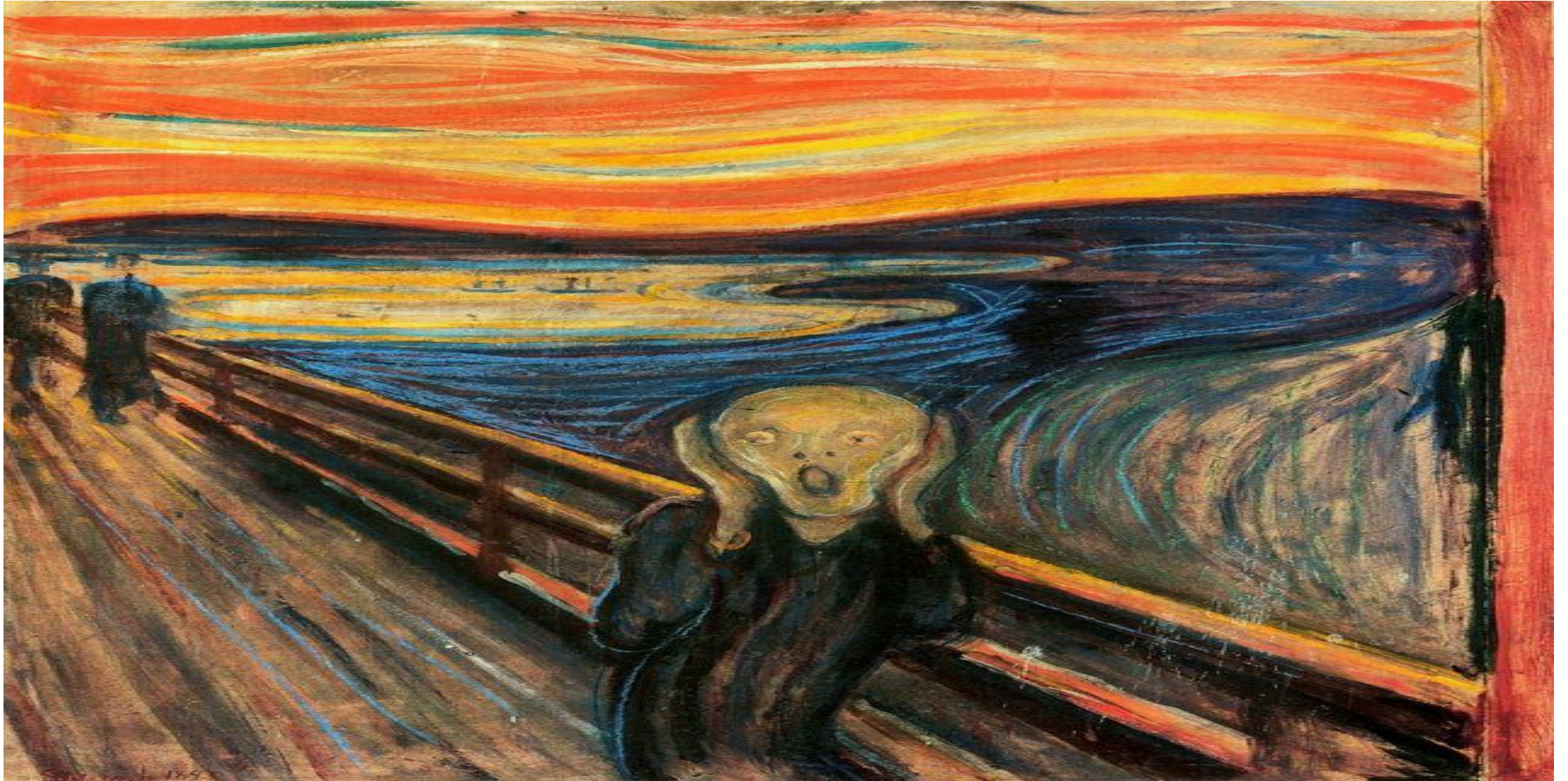
Neurosis Vs. Psychosis Classification

NEUROSIS	PSYCHOSIS
<ul style="list-style-type: none">❖ Intact insight & reality testing❖ Good judgment❖ Abnormal quantity of symptoms and there are No psychotic features❖ E.g. anxiety disorders	<ul style="list-style-type: none">❖ Impaired insight & reality testing❖ Impaired judgment❖ Presence of active/positive psychotic features like delusion and hallucinations & negative like poverty of thoughts & speech, lack of ambition, initiation and restricted affect❖ E.g. schizophrenia



Neurosis vs. Psychosis

Primary Vs Secondary Psychiatric Disorders



Primary Vs Secondary Psychiatric Disorders

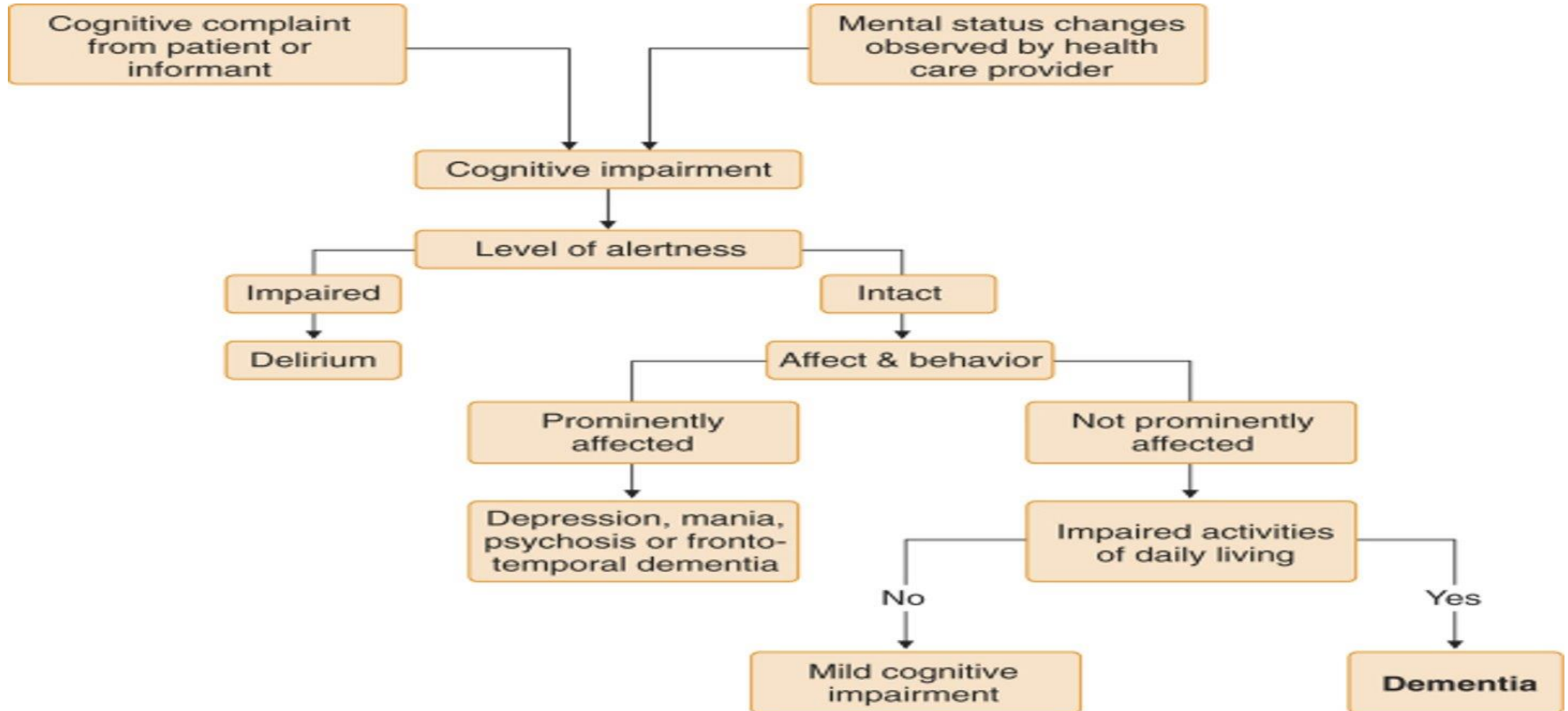
Primary	Secondary
<p>❖ Etiology is: Multi-factorial e.g. schizophrenia Major depressive disorder</p>	<p>❖ Etiology : one diagnosable systemic medical disease, CNS disease or substance e.g. Depression due to SLE or Psychosis due to amphetamine</p>
<p>In medicine: like Essential hypertension</p>	<p>In medicine: like secondary HTN due to renal artery stenosis</p>
<p>Clues suggestive of being primary :</p> <ul style="list-style-type: none">➤ Normal consciousness & vital signs➤ Presence of : Auditory hallucinations➤ Soft neurological signs➤ No related physical illness➤ Young age onset	<p>Clues suggestive of being secondary:</p> <ul style="list-style-type: none">➤ Disturbance of consciousness or vital signs➤ Presence of : non-auditory hallucinations e.g. visual➤ Hard neurological signs➤ Physical illness➤ old age onset

Positive Vs Negative Psychotic Symptoms/Features

Positive Symptoms	Negative Symptoms
<ul style="list-style-type: none">❖ Perception e.g. hallucination❖ Thinking e.g. delusions❖ Mood e.g. extreme euphoria❖ Behavior e.g. disorganized behaviour	<ul style="list-style-type: none">❖ Poverty of thoughts & speech❖ Lack of ambition , interest & initiation❖ Restricted affect❖ Self-neglect, Poor self care & hygiene

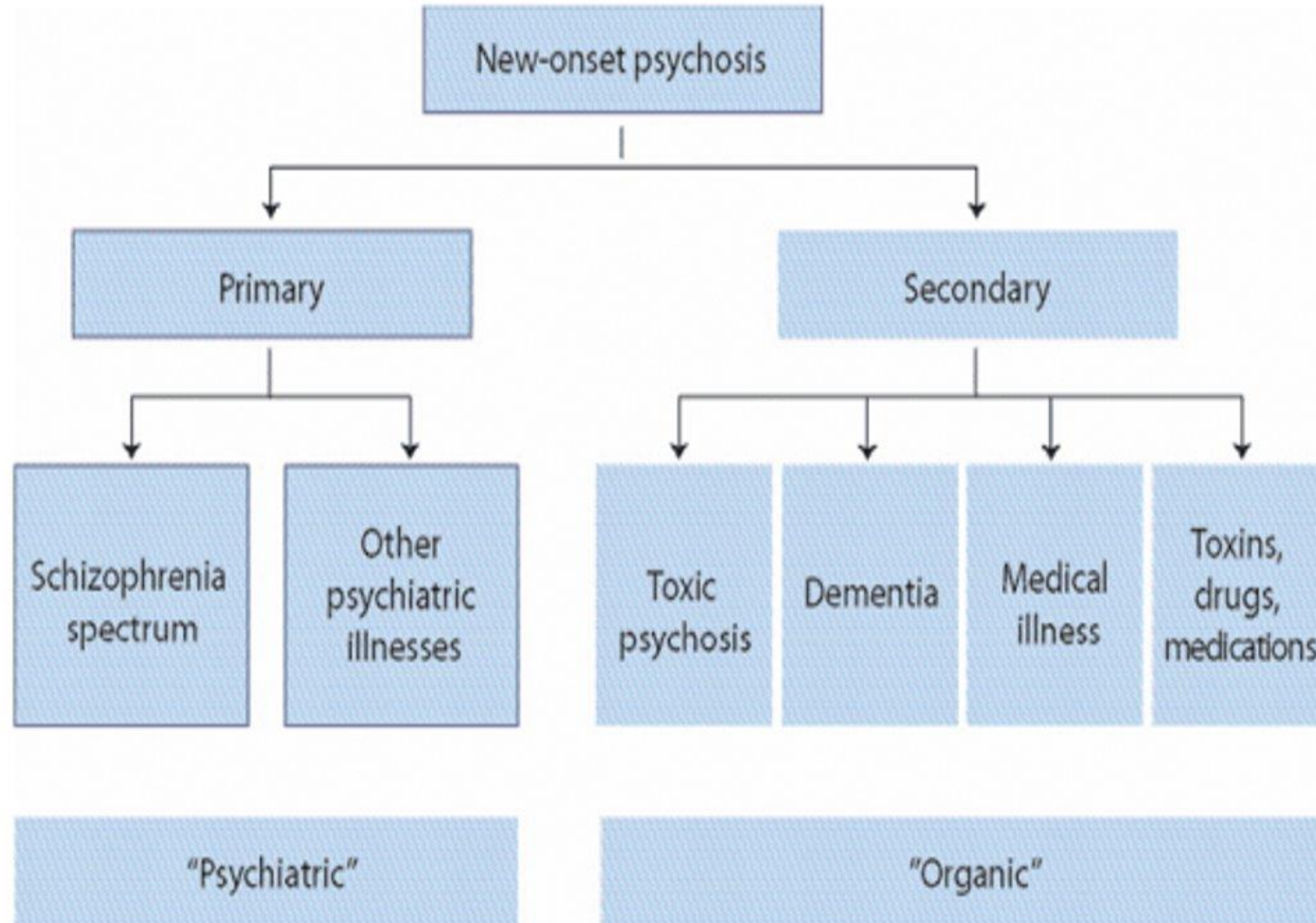


Diagnostic tree for Cognitive Impairment



Figure

Differential diagnosis of new-onset psychosis



Thank
you