Introduction

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Psychiatry, according to Johann Christian Reil (1759–1813), the German anatomist who first coined the term, consists of the meeting of two minds, the mind of the patient with the mind of the doctor. As the patient's story unfolds, the doctor's task is to recognise the pattern and to do so with compassion. Pattern recognition lies at the heart of the diagnostic process throughout medicine and none more so than in psychiatry, which lacks almost all the special investigations that help clarify diagnosis in other medical specialities. Thus, detailed knowledge of the key features of all the psychiatric disorders, both common and rare, is the core body of information that the psychiatrist will need to acquire during their training years. Because of this, we have provided detailed descriptions of each and every disorder as well as their diagnostic criteria according to DSM-5 and ICD-11.

Diagnostic acumen separated from therapeutic skill is of little use to patients or their families. When Reil first introduced the term 'psychiatry', he used the term in the therapeutic sense so that the mind of the doctor would act as a healing agent on the mind of the patient. Whilst the initial consultation serves to reach a diagnostic formulation and to establish a therapeutic alliance, all the later meetings between doctor and patient involve 'treatment' in the broadest sense: the development of a collaborative management plan. At one time, particularly in the first half of the twentieth century, the skills of psychotherapy were shrouded in the mystery of psychoanalysis and were very difficult to acquire without years of training, but today a large array of therapies for almost every condition exist, the necessary skills are far easier to learn, and their descriptions are distributed throughout this book. Drug therapy, which is also an essential component of good psychiatric practice in many cases, is well covered in Chapter 3.3 for depression and Chapter 5.3 for schizophrenia. An understanding of social, cultural, historical and economic factors influencing mental health is also essential, and in all chapters, we would emphasise that the disorders described are seen in this context. All planning of 'treatment' is founded on an ongoing effort to establish a collaborative therapeutic alliance with a unique individual person using this broad holistic framework.

The 2nd edition of this textbook was published more than 15 years ago in 2008. Since then, much has changed but also much has remained the same. What has barely changed are the core descriptions of all the psychiatric disorders. This body of knowledge is unlikely to change much in the coming period and, as this is the crucial body of knowledge needed for making psychiatric diagnoses, trainees will find acquiring this body of information will serve them well throughout all their years in practice. Minor changes in diagnostic criteria, nomenclature and classification are to be expected in both the DSM and ICD systems as more knowledge is acquired.

Psychiatric research, once the concern of a few elite institutions in Europe and the USA, has expanded rapidly, and today, numerous universities the world over have large and productive academic departments of psychiatry. Thus, for the first and second editions of this book, many scientific articles on most topics were available. However, in the last few years, there has been an explosion in both the quantity and quality of scientific psychiatry (see Chapter 1). There are now systematic reviews and meta-analyses on almost every specific intervention in psychiatry. These have been included in this book, making the factual basis for psychiatry widely available and far more solid than for our previous editions.

At the same time, specific psychiatric interventions can only take place in the context of a therapeutic relationship and a service delivering psychiatric interventions. Psychiatric services, by their very nature, involve numerous skilled professionals and others, and for most of their existence, there has been a struggle to secure adequate funding. There was an expansion of services in the early part of the millennium, but since that time, austerity has restricted the implementation of new developments. The closures of psychiatric beds released some, but insufficient, funding for community developments in the 1960s, 1970s and 1980s, and a similar process in recent decades has also occurred. This has placed pressure on a shrinking stock of inpatient beds leading to increased use of the private sector and numerous out-of-area placements. At times, a sense of crisis has enveloped the whole system, and this suggests this process of bed closure has perhaps gone too far (Chapter 20). Despite this, mental health now has a higher profile, and parity with physical health care is accepted. Though this has yet to be achieved, a spirit of seeing opportunities for improvement and working towards these opportunities is required. Doctors have had an important role in leading these changes over many decades. Supporting their patients and services through challenging times is a crucial role and is based on this combination of practical clinical

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experience, detailed theoretical knowledge and an ability to work alongside others.

There have also been substantial changes in the classification of disorders, with DSM-5 released in 2013 and even more radical changes in ICD-11 in 2019. In particular, changes in approaches to personality disorder have considered alternative terminology as well as a move to a dimensional rather than a categorical approach (Chapter 7.1).

Assessment, formulation and diagnosis are discussed as the basis for clinical skills (Chapter 2), and this is essential reading for those at the start of their careers. Then, each of the major disorders are explored in relation to clinical features, causation and treatment (Chapters 3–7). Some new categories have emerged with ICD-11, such as functional neurological disorder (previously, conversion disorder) and bodily distress disorder (previously, somatisation disorder; Chapters 6.5 and 6.6). Catatonia is now classified under its own heading in ICD-11, and its presentation is discussed in various chapters, including those on affective disorders, schizophrenia and neuropsychiatric conditions. Two new chapters have been added on neurodevelopmental problems, including autism and ADHD. The growing realisation (or rediscovery) that serious psychiatric disorder is associated with a high all-cause mortality and a shorter lifespan has led us to include a separate chapter on the physical health of psychiatric patients. The subspecialities of neuropsychiatry (Chapter 8), sleep disorders (Chapter 11), eating disorders (Chapter 12) and perinatal psychiatry (Chapter 13) are then covered. The book ends with a group of topics that are common to all disorders: suicide (Chapter 15), cultural and international psychiatry (Chapter 17), psychiatry in general practice (Chapter 18), psychiatry in the general hospital (Chapter 19) and finally mental health services (Chapter 20).

This is a substantial book, and reading it cover to cover would appear to be a daunting prospect for any trainee starting out in psychiatry. However, there is no need to digest its contents in the first month of the first placement, and it is intended that the greater bulk of it can be read well into the second year of the three-year core training programme and beyond. We hope it can also be used by anyone else interested in the subject. We would recommend that those new to psychiatry and mental health services focus first on understanding the organising principles of assessment (Chapter 2) and the core common conditions of depression (Chapter 3.1), bipolar disorder (Chapter 4.1), schizophrenia and its clinical features (Chapter 5.1) and their respective drug treatments (Chapters 3.3 and 5.3). The development of a therapeutic alliance is at the core of psychiatric practice, and the complexities sometimes encountered are discussed in chapters on personality disorder, body distress disorder and neuropsychiatric disorders. Other chapters deal with commonly encountered conditions as well as those less-often seen. Learning in psychiatry, as in medicine more widely, is based on the blend of clinical experience and the acquisition of theoretical knowledge, supervised by experienced clinicians. A consistent and reliable assessment technique can only be acquired by practice. Learning from the individual patient by reading the theoretical background to their problems brings an increase in understanding and meaning to the individual case. It enriches the knowledge base with which the clinician then approaches each new clinical encounter. We learn psychiatry from our individual patients and not from a book – but a book can provide a framework to organise this learning. As such, we hope that reading the whole book, sometime in the 2nd or 3rd year of a three-year training programme, will provide a feel for the breadth and depth of psychiatry as well as provide a summary of the current known facts of our discipline.

Psychiatry is however far more than a body of facts to be memorised. It is a skill, a mode of healing and an empathic profession that include a variety of differing capabilities. Defining these more diffuse qualities needed to practise successfully has proved a challenge, but the Royal College of Psychiatrists in the United Kingdom has drawn up a syllabus to form the basis of the necessary values and skills required to practise. The new curriculum has guided the selection of content included in this book, and further details are given in Appendix I.1.

We are extremely grateful to the authors who have either fully updated or provided completely new chapters for this edition. These chapters are erudite, concise and readable. Each contain a wealth of information drawn from the considerable expertise of these leaders in their field, providing evidence and practical guidance which, we're sure, will be of great value to readers in their clinical practice – and for their exams.

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Appendix I.1: Broad Themes for Psychiatry within the Revised Curricula

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The Purpose of a Curriculum in Psychiatry

'The purpose of the core and higher psychiatry curricula is to train medical doctors to specialise in the assessment, diagnosis, treatment, management of patients with mental disorders in a wide range of clinical settings in collaboration with the patient, other health professionals and relevant others including families and carers of all ages.'[1]

One of the great strengths that psychiatry brings to the diagnosis, care and treatment of patients is the fact that psychiatrists come from an extended, holistic training background that takes into account the psychological, biological, social, cultural, spiritual and gender context in which all these issues are embedded. 'This holistic person-centred care approach underpins the speciality of psychiatry and the key role of psychiatrists in multi-disciplinary teams.'[1] Psychiatrists also work with capacity and risk issues and address prevention, advocacy and the reduction of stigma.

A person-centred and recovery-oriented approach to clinical practice is now an explicit part of health service policy in the UK: 'Person-centred care focuses on the patient as a person, with 'personhood' being its superordinate principle'.[2] This forms the key message of *Person-Centred Care: Implications for Training in Psychiatry* (CR215) and reminds us that the language we use in clinical practice is of crucial importance.[2,3] Person-centred care is now a central feature of the revised curricula, comprising a number of different but related components.

Generic Professional Capabilities and Specific Speciality Curricula

Good Medical Practice[4] and *Core Values for Psychiatrists* (CR204)[5] are the foundation documents for the revised curricula. There is a new curricula structure that aligns to the General Medical Council (GMC) frameworks *Excellence by Design*[6] and *Generic Professional Capabilities*[7] and in line with the principles of the *Shape of Training Review* [8] with implementation in autumn 2022.

There are nine **Generic Professional Capability** domains:

1. Professional values and behaviours
2. Professional skills
3. Professional knowledge
4. Health promotion and illness prevention
5. Leadership and team-working
6. Patient safety and quality improvement (QI)
7. Safeguarding vulnerable groups
8. Education and training
9. Research and scholarship

Each domain is shaped by a 'why, what, how' model – higher learning outcomes (HLO) provide the 'why', key capabilities (KC) provide the 'what', and illustrations provide the 'how'. The domains are supported by a separate updated illustrations document. The new curriculum framework aims to provide a flexible and adaptable approach to training, and the broad capabilities will ensure that trainees draw on a breadth of experience to achieve them. The curricula continue to be outcome based and capability focused.

Implementation of the Curricula in Psychiatry

Training in psychiatry, as in all areas of medicine, is explicitly experiential, learning through doing. Supervised 'workplace based' learning is the keystone to developing safe practice, and this is blended with the expectation that psychiatrists develop a wide and deep theoretical knowledge base from a range of perspectives. Doctors progressing through psychiatric training progress through a blend of completing work in real workplace settings, undertaking workplace-based assessments with experienced supervisors, developing a portfolio demonstrating their working practice – including feedback from others – and testing their theoretical knowledge via examinations.

Since the second edition of *Seminars in General Adult Psychiatry,* the health, wellbeing and service delivery

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landscapes in the UK have evolved significantly. This is reflected in the revised curricula by some existing themes becoming more prominent and the introduction of some new themes into the training and assessment programmes for core and higher trainees. Going forward, the following themes are fundamental to the practice of modern psychiatry; they will enhance the delivery of person-centred care and treatment for patients of all ages:

- A values-based and evidence-based clinical approach
- Multi-disciplinary model of person-centred care
- Shared responsibility and shared decision-making
- Integration of social psychology developments and interventions, with biological advances and interventions, particularly in neuroscience
- Integrating approaches to addressing the physical and mental health needs of patients
- Ensuring safe, effective prescribing of medicines and other interventions
- Developing sustainable approaches to health and health care
- Developing a sophisticated understanding of their duties as a doctor and a psychiatrist and the rights and duties of the people with whom they work
- Developing a sophisticated understanding of how medicine and psychiatry impact on and interact with society and how systems impact on individuals, including psychiatrists
- The need to develop psychiatrists and others, including people who use services, to adapt and shape developments in the service and future legal landscapes

Two themes in particular merit highlighting as they have significant implications for future training and will impact positively on the delivery of person-centred care in clinical practice.

The core values and principles that are outlined in *Core Values for Psychiatrists* (CR204)[5] underpin the therapeutic relationship between the patient and the doctor, which in turn influences the quality of recovery. This key thread is embedded into the revised curricula and training, ensuring the balance of a values-based and evidence-based approach to clinical practice. Domain 1 (HLO 1)[1]: 'Demonstrate the professional values and behaviours required of a medical doctor in Psychiatry, with reference to *Good Medical Practice*[4] and *Core Values for Psychiatrist* (CR204)'.[5]

Shared decision-making is a model of consent mandated by the *Montgomery* ruling[8] and is clarified in the updated GMC guidance *Decision Making and Consent*[9]. Shared decision-making and consent is a collaborative process, based on the evidence and values through which a doctor supports a person to reach a decision about their treatment. In person-centred care, alongside the relevant evidence, this process requires advanced communication skills to support a dialogue with the patient and to identify and manage any values conflicts that may arise. The dialogue should include explaining the outcome of the assessment and discussing the patient's ideas, values, concerns and expectations as well as informing the patient of the material risks and benefits of available treatment options. Domain 2 (HLO 1)[1]: 'Consistently use active listening skills and empathic language which respects the individual, removes barriers and inequalities, ensures partnership and shared decision-making and is clear, concise, non-discriminatory and non-judgemental'.

How Does This New Edition of *Seminars* Fit with the Continued Development of Training in Psychiatry?

This edition of *Seminars in General Adult Psychiatry* aims to describe some of the practical aspects of general adult psychiatry blended with the theoretical background for the main conditions found in its practice, particularly within a UK context. In the spirit of quality improvement, it is intended as a 'work in progress'. It seeks to synthesise the knowledge of experienced academics with the practical experience of people with the lived experience of the conditions described and people with experience in delivering and developing services. As such, we hope it will provide a readable and helpful manual to aid the present and coming cohorts on their journey.

Person-centred care is the principle at the heart of good medicine and psychiatry; this is demonstrated through the professional values and behaviours shown by practitioners. Like all crafts, experience and skill are gained over time. The blend of supervised broad practical experience, theoretical knowledge across the domains and personal reflection enables psychiatrists to acquire the necessary values, behaviours, knowledge and skills through their training. The process of learning, however, never reaches an end point as psychiatrists are dealing with complexity and uncertainty. They are always in a state of 'incomplete knowledge', and good psychiatry requires the humility to recognise this. With the right support and training, psychiatry provides an unequalled opportunity for a career in which the holistic person-centred approach to the care of people with mental illness can bring the greatest of rewards.

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