

# A COMPANION TO FISH'S CLINICAL PSYCHOPATHOLOGY

**Dr. Shahul Ameen**

## CONTENTS

<b>Chapter</b>	<b>Page</b>
Disorders of Perception	2
Disorders of thought and speech	18
Disorders of memory	36
Disorders of emotion	42
Disorders of the experience of the self	51
Disorders of consciousness	54
Motor disorders	57



## Disorders of Perception

- Sensory Distortions
- Sensory Deceptions
- Disorders of the experience of time

### SENSORY DISTORTIONS

- Changes in intensity
  - Changes in quality
  - Changes in spatial form
- 
- Changes in intensity (Hyperaesthesia and hypoaesthesia):
    - Hyperaesthesia: increased intensity of sensations.
      - ✓ Intense emotions
      - ✓ Lowering of the physiological threshold
      - ✓ Hypochondriacal personalities
    - Some anxious and depressed personalities complain that voices of other people seem to come from a long way off.
    - A true hypoacusis occurs in delirium.
  
  - Changes in quality: are mainly visual distortions which colour all perceptions.
    - Xanthopsia: colouring of yellow; by santonin.
    - Chloropsia: colouring of green
    - Erythropsia: colouring of red; following preretinal and vitreous hemorrhage, snow blindness and blindness after electric shock.
  
  - Changes in spatial form (dysmegalopsia):

- ✓ Retinal disease
- ✓ Disorders of accommodation
- ✓ Disorders of convergence
- ✓ Temporal lobe lesions (mainly those affecting the posterior part)
- ✓ Delirium
- ✓ Poisoning with atropine or hyoscine

'Macropsia' and micropsia' have been used for changes in the perception of size in dreams and hallucinations.

- Micropsia: a visual disorder in which the pt. sees the object;
  - Smaller than they really are, or
  - Farther away than they really are; or
  - The experience of the retreat of objects into the distance, without any change in size (called porropsia by some authors)
    - ✓ Edema of the retina; since the visual elements are separated and the image falls on what is functionally a smaller part of retina than usual.
    - ✓ Partial paralysis of accommodation
    - ✓ Diseases affecting the nerves controlling accommodation; eg. chronic arachnoiditis affecting the optic chiasma.
- Macropsia:
  - ✓ Scarring of the retina with retraction (as the distortion produced by scarring is usually irregular, metamorphopsia is more likely to occur)
  - Accommodation and convergence can be dissociated with a haptoscope. If accommodation is normal but convergence is weakened, macropsia occurs and vice versa.
  - Although hypoxia and rapid acceleration of the body can affect accommodation and convergence, dysmegalopsia is rare among high-altitude pilots.

## SENSORY DECEPTIONS

- Illusions: misinterpretations of stimuli arising from an external object.
  - Hallucinations: perceptions without an adequate external stimulus.
- Illusions:
    - Stimuli from a perceived object are combined with a mental image to produce a false perception.
    - Derived from set and lack of perceptual clarity.
      - ✓ Delirium
      - ✓ Severe depression with delusions of guilt
      - ✓ Patients with delusions of self-reference.
      - Fantastic illusions: the pt. sees extraordinary modifications of his environment.
      - Pareidolia: vivid illusions occur without the pt. making any effort; are the result of excessive fantasy thinking and a vivid impressive visual imagery, thus differ from ordinary illusion.
- Illusions should be distinguished from:
- Intellectual misinterpretation: "the doctor is not really a doctor but the public prosecutor." The misinterpretation in acute schizophrenic shifts may be the result of an apophanous or delusional perception.
  - Functional hallucination: occurs in response to an environmental stimulus, but both the provoking stimulus and the hallucination are perceived by the pt.
- Hallucinations:
    - ❖ Definitions:
      - Esquirol: "a perception without an object."

- Does not quite cover the functional hallucination.
- Jaspers: "a false perception, which is not a sensory distortion or a misinterpretation, but which occurs at the same time as real perceptions".
- Excludes dreams.
- Hallucinations v/s perceptions: they come from 'within', although the subject reacts to them as if they were true perceptions coming from 'without'.
- Hallucinations v/s vivid mental images: images come from within but are recognized as such, but the distinction is not absolute.
- Hillers: hallucinations in schizophrenia are neither mental images nor true perceptions; the essential feature of a schizophrenic experience is 'the making of a relationship without adequate proof'.
- Gruhle: the schizophrenic experience is not perceptual, but the pt. is compelled to formulate some of his experiences in a perceptual form.
- Pseudo-hallucinations:
  - The name was given by Hagen.
  - 'Pale hallucinations': Griesinger.
  - 'Apperceptive hallucinations': Kahlbaum.
  - Jaspers:

True perceptions v/s mental images; former are

Substantial,

Appear in objective space,

Are clearly delineated,

Constant,

Independent of the will,

Their sensory elements are full and fresh;

while mental images are incomplete, not clearly delineated,

dependent on the will, inconstant, and have to be recreated.

Pseudohallucinations are a type of mental image which although clear and vivid lack the substantiality of perceptions: they are seen in full consciousness and are located in subjective space.

Gradual transition between the true and the pseudo-hallucination could occur.

- Some authors use 'pseudohallucinations' for hallucinations which are not considered to be real by the pt.
- Hare: the difference between real and pseudohallucinations depended on the absence or presence of insight.
- Sedman: since insight was often fluctuating and partial, it is more profitable to think in terms of degree of insight.
- Pseudohallucinations are sometimes experienced by hysterical and attention-seeking personalities.

❖ Causes of hallucinations:

- Intense emotions
  - Suggestion
  - Disorders of sense organs
  - Sensory deprivation
  - Disorders of CNS
- Emotion:
    - In very depressed patients with delusions of guilt; hallucinations tend to be disjointed, saying separate words or short phrases.
    - Occurrence of continuous persistent hallucinatory voices in severe depression should arouse the suspicion of schizophrenia or some intercurrent physical disease.
  - Suggestion:
    - Normal subjects can be suggested to hallucinate.

- Hypnotic hallucinations do not produce objective effects similar to those produced by ordinary perceptions, such as complimentary after-images and so on.  
Eg. visual hallucinations in 'hysterical psychoses'.
  - Disorders of sense organs:
    - Hallucinatory voices may occur in ear disease and visual hallucinations in eye disease, but usually there is a disorder of the CNS as well.
    - Peripheral lesions of sense organs may play a part in hallucinations in organic states.  
Eg. negative scotomata in delirium tremens.
  - Sensory deprivation:
    - Usually these are changing visual hallucinations and repetitive words and phrases.
    - 'Black-patch disease': delirium following cataract extraction in the aged; result of sensory deprivation and mild senile brain changes.
  - Disorders of the CNS:
    - Lesions of the diencephalons and the cortex can produce hallucinations which are usually visual, but can be auditory.
- Hypnagogic hallucinations:
- Occur when the subject is falling asleep, during drowsiness.
  - Are discontinuous.
  - Appears to force themselves on the subject.
  - Do not form part of an experience in which the subject participates, as he does in a dream.
  - Commonest hallucinations are auditory. One of the commonest is the subject hearing his own name being called. May also be animal noises, music or voices which may say a sentence or phrase which has no discoverable meaning.

- May be geometrical designs, abstract shapes, faces, figures or scenes from nature.
- EEG shows a loss of alpha rhythm at the time of the hallucination.
- In a sleep deprived subject a hypnagogic state may occur, in which there are auditory and visual hallucinations, ideas of persecution and no insight into the morbid phenomena. This condition usually disappears after a good sleep.

Hypnopompic hallucinations:

- Occur when the subject is waking up.
- The term should be retained for hallucinations persisting from sleep when the eyes are open.

❖ Hallucinations of individual senses:

- Hearing
- Vision
- Smell
- Taste
- Touch
- Pain and deep sensation
- Vestibular sensations
- The sense of presence

• Hearing:

- Elementary – noises; in organic states and schizophrenia.
- Partly organized – music
- Completely organized – hallucinatory voices
- Hallucinatory voices were called 'phonemes' by Wernicke.
- Imperative hallucination: voices giving instructions to patients, who may or may not feel obliged to carry them out.

- 'Thought echo' (Gedankenlautwerden, echo de pensees, thought sonorization): hearing one's own thoughts being spoken aloud; the voice may come from inside or outside the head.
- Running commentary hallucinations are usually abusive and often talk about sexual topics.
- In some patients occupation with a mental or physical task diminishes the hallucinations.
- Patients hearing voices have slight movements of the tongue, lips, and laryngeal muscles and there is an increase in the action potentials in the laryngeal muscles in these patients.
- Vision:
  - Elementary – flashes of light
  - Partly organized – patterns
  - Completely organized – visions of people, animals or objects
- Scenic hallucinations: hallucinations in which whole scenes are hallucinated like a cinema film; more common in psychiatric disorders associated with epilepsy. Chronic fantastic paraphrenics have scenic hallucinations in the form of mass hallucinations when they see and hear people being murdered, mutilated and tortured.
- Lilliputian hallucinations: micropsia affects the visual hallucinations, so the pt. sees tiny people. Unlike the usual organic visual hallucinations these are usually pleasurable.
- Visual hallucinations are more common in the acute organic states with clouding of consciousness than in the functional psychoses.
- Small animals are most often hallucinated in delirium.
- Visual hallucinations are extremely rare in schizophrenia.
- Visual hallucinations produced by the drugs of abuse typically consist of diffuse distortions of the existing visual world, which can often be seen with the eyes closed.
- Smell:

- ✓ Schizophrenia
- ✓ Organic states, like temporal lobe epilepsy.
- ✓ Depression (uncommon)
- Taste:
  - ✓ Schizophrenia
  - ✓ Acute organic states
- Touch:
  - 'Formication': a feeling that animals are crawling over the body; not uncommon in acute organic states.
  - 'Cocaine bug': formication occurring with delusions of persecution; in cocaine psychosis.
  - Sexual hallucinations occur in acute and chronic schizophrenics.
- Pain and deep sensation:
  - Twisting and tearing pains may be complained of by chronic schizophrenics.
  - 'External delusional zoopathy': a variety of somatic hallucinosis which may take the form of delusional infestation when the pt. is convinced that there is an animal crawling about on his body.
    - ✓ Organicity
    - ✓ Schizophrenia
  - 'Internal delusional zoopathy': belief that there is an animal inside his body.
- Vestibular sensations:
  - Eg. Sensations of flying through the air or sinking through the bed.
    - ✓ Acute organic states, most commonly delirium tremens.
- The sense of presence:
  - ✓ Organic states
  - ✓ Schizophrenia
  - ✓ Hysteria

- ❖ Special kinds of hallucinations:
  - Functional hallucinations: a stimulus causes the hallucination, but it is experienced as well as the hallucination.
    - ✓ Chronic schizophrenia
  - Reflex hallucinations: a stimulus in one sensory field produces a hallucination in another. This is a morbid variety of synaesthesia, in which an image based on one sensory modality is associated with an image based on another.
  - Extracampine hallucinations: a hallucination which is outside the limits of the sensory field. Have no diagnostic significance; can be hypnagogic, organic or schizophrenic.
  - Autoscopy (phantom mirror image): the pt. sees himself and knows that it is he. It is not just a visual hallucination, because kinaesthetic and somatic sensation must also be present to give the subject the impression that the hallucination is he.
    - ✓ Normal subjects when they are depressed or emotionally disturbed and also tired and exhausted.
    - ✓ Hysteria
    - ✓ Schizophrenia
    - ✓ Acute and subacute delirious states
    - ✓ Epilepsy
    - ✓ Focal lesions in parieto-occipital region
    - ✓ Toxic infective states whose effect is greatest in the basal regions of the brain
    - ✓ Drug addiction
    - ✓ Chronic alcoholism
    - 'Negative autoscopy': the pt. looks in the mirror and sees no image; in organic states.
    - Internal autoscopy: the subject sees his own internal organs.

- ❖ The features of organic hallucinations:
  - Depend on:
    - The general condition of the brain
    - Recent experiences
    - Psychodynamic factors
    - The effect of the local lesion
  - Hallucinations produced by focal lesions are associated with a generalized change in the activity of the brain, which is shown clinically by a mild or moderate disorder of consciousness.
  - Much of work on hallucinations in focal disorders comes from the investigation of epileptics by Penfield and his group who studied spontaneous hallucinations and hallucinations produced by brain stimulation during operative investigation of temporal lobe epileptics. He called hallucinations produced by epilepsy 'experiential hallucinations' and those produced by cortical stimulation 'experiential responses'; because these hallucinations were recognized by the subject as being past experiences. He also found that temporal lobe epileptics had interpretative signals of illusions, which were produced spontaneously or by stimulation, and divided these into auditory and visual illusions (which are sensory distortions); illusions of recognition (changes in familiarity of perception) and illusional emotions (ictal emotions).

#### Visual hallucinations:

- Stimulation of the visual projection area in the walls of the calcarine fissure causes the perception of flashes of light as does stimulation or irritation of the optic radiation.

- Lesions of the optic tract and the lateral geniculate bodies rarely cause hallucinations.
- Spontaneous visual hallucinations are often associated with a sensory defect.
- It is rare for hallucinations to occur in a non-hemianopic field.
- Penfield found that stimulation of Brodmann's areas 17, 18, and 19 gave rise to colored moving lights, stars, triangles and zigzag lines reminiscent of scotomata in migraine. He also found that grey or black fog could be produced by the stimulation of these areas. Colored objects were more commonly seen the nearer the site stimulated was to the occipital pole. Scenic complex hallucinations occurred following stimulation of the posterior part of the temporal lobe.

#### Tactile hallucinations:

- These are almost exclusively the result of a lesion which produces a sensory defect.
- Disorders of the body image are most likely to occur in lesions of the parietal cortex or the adjacent subcortical areas. Stimulation of the parietal cortex causes paresthesias and unpleasant sensations or the splitting off of the relevant region of the body. Parietal lesions can distort the body image without causing any disturbance of sensation.
- The phantom limb:
  - The most common organic somatic hallucination.
  - Occur in about 95 percent of all amputations after the age of 6 years.
  - The pt. feels that he has a limb, from which in fact he is not receiving any sensations, either because the limb has been amputated or because the sensory pathways from it have been destroyed.
  - In most phantom limbs the phenomenon is produced by peripheral and central disorders.

- Occasionally a phantom limb develops after a lesion of the peripheral nerve or the medulla or spinal cord.
- In rare cases patients with thalamoparietal lesions have a phantom third arm or leg.
- The phantom limb does not necessarily correspond to the previous image of the limb.
- If there is some clouding of consciousness the patient may be convinced that the phantom limb is real.
- Some patients have very painful phantom limbs which can be difficult to treat.

#### Auditory hallucinations:

- Whistling, buzzing, drumming and even bells can be heard by patients with middle or internal ear disease and also in the very rare cases of midbrain deafness.
- Hallucinations do not result from lesions between the medial corpora quadrigemina and the auditory cortex.
- Lesions of the thalamic projection to the auditory cortex can lead to sense distortions in the form of macracusia or acoustic quick motion.
- Auditory hallucinations can be caused by epileptic foci and space-occupying lesions in the temporal lobes.
- Penfield produced auditory hallucinations by stimulating the first temporal convolution in areas 41 and 42 of Brodmann. The points were deep in the posterior third of the Sylvian fissure and were limited anteriorly by the central sulcus. The hallucinations which occurred were noises like the rushing of the wind, motor-cars and railway trains. They were heard in the contralateral half of space or in both halves at the same time. Organized hallucinatory voices occurred on stimulation of the lateral surface of the first temporal convolution on both sides.

Hallucinations of taste:

- Occur most often in temporal lobe epilepsy, when they are associated with salivation and chewing and sniffing movements.
- Penfield produced hallucinations of taste by stimulating the depths of the Sylvian fissure around the transverse temporal gyri.

Olfactory hallucinations:

- Are typical auras of temporal lobe epilepsy.

Temporal lobe hallucinations:

- These are multisensory hallucinations, but they do not include somatic sensations, which is to be expected because the somatic sensory area is separated from the temporal lobe by the Sylvian fissure.
- Penfield found that combined visual and auditory hallucinations occurred when the first temporal convolutions on both sides were stimulated, while visual hallucinations alone occurred on stimulation of wide area of the lateral surface of the temporal lobe on the non-dominant side.

HALLUCINATORY SYNDROMES (Schroder):

1) Confusional hallucinosis:

- Consciousness is clouded
- Visual hallucinations are prominent.
- Auditory hallucinations are mainly music, noises or odd words, but connected sentences are occasionally heard.

2) Self-reference hallucinosis:

The pt. hears voices talking about him. He can usually give only a rough idea of what the voices are saying and is unable to reproduce them word for word. The patient is convinced that the voices come from people in his

environment and it may be difficult to decide if the patient is really experiencing hallucinations or is mishearing real conversations.

### 3) Verbal hallucinosis:

The pt. hears clear voices, which talk about him, and he can reproduce their content accurately. The voices may be attributed to real or imaginary people or to machines.

### 4) Fantastic hallucinosis:

- Here hallucinations of all kinds seem to occur.
- The patient describes fantastic experiences which are based on auditory, bodily and visual hallucinations.
- It is impossible to disentangle delusions and hallucinations.
- Sometimes it appears that the patient is describing dream experiences as if they were real.
- These patients usually have mass hallucinations.

## DISORDERS OF THE EXPERIENCE OF TIME

- Can be looked upon as distortions of perception.
- From the psychopathological point of view, there are 2 varieties of time;
  - Physical; determined by physical events.
  - Personal; personal judgment of the passage of time.
- Mania: time passes quickly.
- Depression: time passes very slowly;
  - If depression is severe pt. may feel that time stands still.
  - Is often very dramatically expressed by pts. with nihilistic delusions.
  - Is characteristic of psychotic depression and does not occur in reactive depressive mood states.
- Acute schizophrenia: personal time seems to go by fits and starts.
  - Sometimes is the expression of lack of continuity of the self.
  - Non-paranoid schizophrenics tend to underestimate the interview more than paranoid schizophrenics.

- Acute organic states: temporal disorientation.
- Pts. with mild acute organic states without temporal disorganization may overestimate the progress of time.
- Post-encephalitic states: time may be experienced as passing quickly or slowly during an oculogyric crisis.
- Temporal lobe lesions: time may be experienced as going too rapidly or too slowly.
- Second Estimation Point (SEP) was found to be lower in schizophrenics and depressives than in normals and to be higher than normals in manics.



## DISORDERS OF THOUGHT AND SPEECH

## INTELLIGENCE

- The ability to think and act rationally and logically.
- Does not continue to develop after age of 15 years.
- Age at which intellectual growth ceases depends on the test used.
- A slow decline in intelligence can be detected for the first time at about 35 years of age.
- $IQ = 100 \times MA/CA$
- Mental age = Score achieved by the average child of the corresponding chronological age.
- For individuals > 15 years of age, IQ is obtained by using 15 as an arbitrary divisor.
- Most intelligence tests are designed to give a mean IQ of the population of 100 with a std. deviation of 15.
- Two groups of individuals with MR:
  - 1) 'Subcultural mental defect': A quantitative deviation from the normal.
  - 2) The childhood psychiatric organic states.
- Amentia: was a synonym for 'mental subnormality'.
- Dementia: A loss of intelligence resulting from coarse brain disease.
- Schizophrenic deterioration: The loss of chronic schizophrenics' ability to think logically (previously called 'schizophrenic dementia').

## THINKING

- 1) Undirected fantasy thinking: 'autistic' or 'derealistic' thinking.
  - 2) Imaginative thinking: This does not go beyond the rational and the possible.
  - 3) Rational (conceptual) thinking: This attempts to solve a problem.
- The boundaries between these are not sharp.

Autistic thinking:

- Is quite normal
- Some quiet shy people may compensate for the disappointments in life by indulging in excessive autistic thinking.
- Bleuler: schizoid individual became schizophrenic when his autistic thinking became uncontrollable. The excessive autistic thinking in schizophrenia is partly the result of FTD.
  - This does not apply to all varieties of schizophrenia.

Classification of disorders of thinking:

- Disorders of the stream of thought
- Disorders of the possession of thought
- Disorders of the content of thinking
- Disorders of the form of thinking

The division is arbitrary.

#### DISORDERS OF THE STREAM OF THOUGHT

- Disorders of tempo
  - Flight of ideas
  - Inhibition or retardation of thinking
  - Circumstantiality
- Disorders of the continuity of thinking
  - Perseveration
  - Thought blocking

Flight of ideas

- The thoughts follow each other rapidly.
- There is no general direction of thinking.

- The connections between successive thoughts appear to be due to chance factors which, however, can usually be understood.
  - ✓ Mania (typical)
  - ✓ excited schizophrenics (occasional)
  - ✓ Organicity; especially lesions of hypothalamus
  - ✓ Mixed affective states (flight of ideas without pressure of speech)

#### Prolivity (ordered flight of ideas)

- In hypomania
- Despite many irrelevances, the patient is able to return to the task in hand.
- Clang and verbal associations are not so marked.
- The speed of emergence of thoughts is not as fast.
  - Prolivity: a lively embellishment
  - Circumstantiality: a tedious elaboration of details.

#### Inhibition or retardation of thinking

- The train of thought is slowed down and the no. of ideas and mental images which present themselves is decreased.
- Experienced as difficulty in making decisions, lack of concentration, a loss of clarity of thinking, and a strange indescribable sensation in the head.
- Diminution of active attention.
- Complaints of loss of memory, overvalued or delusional idea that he is going out of his mind.
  - ✓ Retarded depression
  - ✓ Manic stupor

#### Circumstantiality

- Thinking proceeds slowly with many unnecessary details but the point is finally reached.

- The goal of thought is never completely lost and thinking proceeds toward it by an intricate and devious path.
- Explained as the result of a weakness of judgment and egocentricity.
  - ✓ Epileptic personality change
  - ✓ Dullards who are trying to be impressive
  - ✓ Pedantic obsessional personalities

Perseveration (discussed in page 65)

Thought blocking

- A sudden arrest of the train of thought, leaving a blank.
- An entirely new thought may then begin.
  - ✓ Almost diagnostic of schizophrenia
  - ✓ Exhausted and anxious patients may easily lose the thread of the conversation and may appear to block
- Disorders of the possession of thought:
  - Obsessions and compulsions
  - Thought alienation

Obsessions

- "An obsession occurs when someone cannot get rid of a content of consciousness, although when it occurs he realizes that it is senseless or at least that it is dominating and persisting without cause" (Schneider).
- Commonest forms : concerned with fears of doing harm.
- Commonest themes : dirt and contamination and aggression
- Least common : religious and sexual
- Types: mental images, ideas, fears, impulses.
  - ✓ Obsessional states
  - ✓ Depression

- ✓ Schizophrenia
  - ✓ Occasionally in organic states; particularly post-encephalitic states
- Contrast thinking: a type of obsessional thinking in which the patient is compelled to think the opposite of what is said.

### Thought alienation

The patient has the experience that his thoughts are under the control of an outside agency or that others are participating in his thinking.

- Thought insertion
- Thought deprivation (the subjective experience of thought blocking and 'omission')
- Thought broadcasting (as he is thinking, everyone else is thinking in unison with him)

### DISORDERS OF THE CONTENT OF THINKING

"A delusion is a false unshakeable belief, which is out of keeping with the patient's social and cultural background"

- 1) True delusions are the result of primary delusional experience which cannot be deduced from any other morbid phenomenon.
  - ✓ Diagnostic of schizophrenia
  - ✓ Occasionally in organic states; especially in epileptic psychoses.
- 2) Delusion-like idea is secondary and can be understandably derived from some other morbid psychological phenomenon.
  - ✓ Psychoses
  - ✓ Psychogenic reactions

### Overvalued idea

A thought which, because of the associated feeling tone, takes precedence over all other ideas and maintains this precedence permanently or for a long period of time.

Primary delusions:

- Delusional mood
  - Delusional perception
  - Sudden delusional idea (Schneider)
- The essence of primary delusional experience is that a new meaning arises in connection with some other psychological event.
  - Conrad suggested that the term 'apophany' would be better than 'primary delusional experience'.
- Delusional mood: the patient has the knowledge that there is something going on around him which concerns him, but he does not know what it is. The meaning of the delusional mood usually becomes obvious when a sudden delusional idea or delusional perception occurs.
  - Delusional perception (apophanous perception): The attribution of a new meaning, usually in the sense of self-reference, to a normally perceived object. The new meaning cannot be understood as arising from the patient's affective state or previous attitudes.

Schneider:

- Delusional perception is diagnostic of schizophrenia.
- The important feature of this symptom is its 'two memberedness' – there is a link from the perceived object to the subject's perception of this object and a second link to the new significance of this perception.

Matussek:

There are 2 kinds of Delusional perception.

- Verbal: There is verbal indication of a delusional meaning.
  - Perceptual: The new meaning seems to be embedded in the perception itself. The essential properties of the perceived object come into prominence as a result of the loosening of the coherence of perception. This liberated essential property gives rise to the delusional meaning.
- Sudden delusional idea (autochthonous delusion): A delusion appears fully formed in the patient's mind.
    - Sudden ideas or 'brain-waves' occur in normal and abnormal personalities.
    - In depressive patients or in grossly abnormal personalities sudden ideas of the nature of delusion-like ideas or overvalued ideas can occur.
    - If a patient has a very grandiose or bizarre sudden idea it is likely that he is suffering from schizophrenia.
    - Delusional misinterpretation: Eg. A patient with delusions of persecution hears the stairs creak and knows that this is a detective spying on him.
    - Primary delusional experiences occur in acute schizophrenic shifts and are not seen in chronic schizophrenia.

#### Secondary delusions:

Can be understood as arising from some other morbid experience.

- 1) Projection: but as projection occurs in the non-psychotic some other explanation is necessary to account for the excessive projection which occurs in delusions, particularly those of persecution.
- 2) Latent homosexuality (Freud): the different ways in which this is denied gave rise to delusions of persecution, erotomania, jealousy and grandeur.
- 3) Depressive moods
- 4) Hallucinations

- 5) Psychogenic reactions in abnormally suspicious personalities
- 6) Sensitive personalities

#### Systematization:

- Delusional work: the elaboration of delusions and their integration into some sort of system that occurs in schizophrenia.
- Delusions are divided into systematized and nonsystematized.
- In the completely systematized delusions there is one basic delusion and the remainder of the system is logically built on this error.
- Completely systematized delusions are extremely rare.
- Systematization is not a question of all or nothing, but of more or less.
- Systematization appears to be related to the retention of integrity of the personality.
- Incoherent and unintegrated delusions are common in young schizophrenics, while in older schizophrenics the delusions are customarily systematized more or less.

#### The content of delusions

- Is naturally dependent on the social and cultural background.
- Have changed with time.
- Classification:
  - Delusions of persecution
  - Delusions of jealousy
  - Delusions of love
  - Grandiose delusions
  - Delusions of ill health
  - Delusions of guilt
  - Nihilistic delusions
  - Delusions of poverty

Delusions of persecution:

- Result of apophanous experiences, auditory hallucinations, bodily hallucinations and experiences of passivity.
- Can take many forms:
  - Delusions of reference: Pt. knows that people are talking about him, slandering him or spying on him.
    - ✓ Schizophrenia
    - ✓ Depressive illnesses
    - ✓ Psychogenic reactions
  - Belief that they or their loved ones are about to be killed.
  - Being robbed or deprived of their just inheritance.
  - Have special knowledge which the persecutors want to take.
  - Being poisoned – these are often explanatory delusions or based on hallucinations of smell and taste.
  - Delusions of influence: are logical results of experiences of passivity.
- Correct meaning of the word 'paranoid' is 'delusional'.

Delusions of jealousy:

- The term is a misnomer
- Often the pt. has been suspicious, sensitive and mildly jealous before the onset of the illness or psychogenic reaction.
- The severity of the condition fluctuates in the course of time, so that sometimes it seems to be a series of psychogenic reactions.
  - ✓ Alcohol addiction
  - ✓ Schizophrenia
  - ✓ Affective psychoses

Delusions of love ('fantasy lover', 'erotomania')

- ✓ Schizophrenia

- ✓ Abnormal personality developments

Grandiose delusions:

- ✓ Schizophrenia
  - ✓ Drug dependence
  - ✓ Organic brain syndromes
  - ✓ General paresis
  - ✓ Happiness psychosis
- Expansive delusions: may be supported by hallucinatory voices or by confabulations.
  - Manic patients do not usually have well held expansive delusions.

Delusions of ill health (Hypochondriacal delusions):

- ✓ Depressive illnesses
  - ✓ Schizophrenia
  - ✓ Abnormal personality developments
- Depressive delusions are the result of an uncovering of the patient's basic worries – of health, finances, moral worth, and relationships with others.
  - May also involve patient's spouse and children.
  - Many depressed puerperal women fear or believe that the newborn child is mentally subnormal.
  - Might include the overvalued ideas and delusions of incurable insanity seen in moderately depressed patients.
  - In the early stages of schizophrenia hypochondriacal delusions are usually the result of depression and explanations of general psychological and physical insufficiency, while in chronic schizophrenia they are usually the result of somatic hallucinations.
- Chronic hypochondriasis :
    - May be the result of a personality development.

- Could be;                      Overvalued idea  
   Obsessional  
   Delusional preoccupation with appearance  
   Delusion of ill health

Delusions of guilt:

- Reactive depression: no ideas of guilt
- Mild depression: Pt. may be somewhat self reproachful and self critical
- Severe depression: delusions of guilt
- Very severe depression: delusions take on a somewhat grandiose character; these extravagant delusions of guilt are often associated with nihilistic ones.

Nihilistic delusions (delusions of negation):

- ✓ Very severe agitated depressions, especially 'involitional melancholia'.
- ✓ Subacute delirious states
- ✓ Schizophrenia
- Sometimes associated with delusions of enormity; belief that one can produce a catastrophe by some action.

Reality of delusions:

- Attack or assault on alleged persecutors in acute schizophrenia is not common.
- Delusions or overvalued ideas of jealousy seem to be the most dangerous kind of delusion and overvalued idea.
- Action is more likely to be taken on the basis of delusion-like or overvalued ideas than on the basis of true delusions.

DISORDERS OF THE FORM OF THINKING

- 'Formal thought disorder': a synonym for the disorders of conceptual or abstract thinking which occur in schizophrenia and coarse brain disease.
- Schizophrenic FTD can be divided into 2 subgroups:
  - Negative FTD: the pt. has lost his previous ability to think, but does not produce any unusual concepts.
  - Positive FTD: The pt. produces false concepts by blending together incongruous elements.
- Bleuler: the outstanding feature of schizophrenic FTD is the lack of connection between associations, which gave rise to changeable and unusual concepts.

The incompleteness of ideas is the result of:

- Condensation: 2 ideas with something in common are blended into a false concept.
  - Displacement: one idea is used for an associated idea.
  - Misuse of symbols: using the concrete aspects of the symbol instead of the symbolic meaning.
- These concepts were borrowed from Freud, who pointed out that these mechanisms are characteristic of thinking in dreams.
  - Cameron: grouped the symptoms of disorganization resulting from functional or organic psychiatric states into:
    - 1) Inco-ordination
    - 2) Interpenetration: The speech contains elements which belong to the task in hand interspersed with a stream of fantasy which the pt. cannot stop.
    - 3) Fragmentation
    - 4) Overinclusion: An inability to maintain the boundaries of the problem and to restrict operations within their correct limits.
  - Asyndesis: the lack of adequate connections between successive thoughts.
  - Metonyms: the imprecise approximations in which pt. uses some substitute term or phrase instead of a more exact one.

- Goldstein: in schizophrenia and in coarse brain disease there is a loss of abstract attitude so that thinking becomes concrete – in the former the pt. does not lose his fund of words.
- Payne: tests of concrete thinking which are performed badly by schizophrenics with FTD are in fact tests of overinclusion. Schizophrenics who showed overinclusion showed marked psychomotor slowness.
- Chapman: the schizophrenic cannot free himself from the major meaning of a word.
- Schneider: isolated 5 features of FTD.
  - 1) Derailment: the thought slides on to a subsidiary thought.
  - 2) Substitution: a major thought is substituted by a subsidiary one.
  - 3) Omission: the senseless omission of a thought or part of it.
  - 4) Fusion: heterogeneous elements of thought are interwoven with each other.
  - 5) Drivelling: there is a disordered intermixture of constituent parts of one complex thought.

3 features of healthy thinking:

- 1) Constancy: the characteristic persistence of a completed thought whether or not it is simple or complicated in its content.
- 2) Organization: the contents of the thoughts are related to each other in consciousness and do not blend with each other, but are separated in an organized way.
- 3) Continuity: even the most heterogeneous thoughts, sudden ideas or observations which emerge are arranged in order in the whole content of the consciousness.

There are 3 corresponding varieties of objective thought disorder:

- 1) Transitory thinking: derailments, substitutions and omissions occur. Both grammatical and syntactical structures are disturbed.
- 2) Drivelling thinking: the pt. has a preliminary outline of a complicated thought with all its necessary particulars, but he loses his preliminary

organization of the thought, so that all the constituent parts get muddled together. The pt. has a critical attitude towards the thoughts.

- 3) Desultory thinking: speech is grammatically and syntactically correct, but sudden ideas force their way in from time to time.
- Desultoriness: the continuity is loosened,
  - Omission: the intention itself is interrupted and there is a gap.

There are 3 symptom groups in schizophrenia which could occur separately or in combinations.

1) Desultory group:

- Affective blunting
- Lack of drive
- Somatic hallucinations
- Desultory thinking
  - ✓ Hebephrenic schizophrenia
  - ✓ Paranoid schizophrenia
  - ✓ Catatonic schizophrenia

2) Thought withdrawal group

- Transitory thinking
- Thought withdrawal
- Delusional inspiration
- Experience of passivity
- Religious and cosmic experiences
- Perplexity
  - ✓ Paranoid schizophrenia with  
Projection symptoms

3) Drivelling group

- Primary delusional experiences

- Loss of interest in things and values
- Inadequate affective responses
- Drivelling thinking.
  - ✓ Paranoid schizophrenia with systematized delusions.

## SPEECH DISORDERS

- Kleist et al compared speech disorders in schizophrenia with aphasias.
- Critchley: there are considerable linguistic differences between the verbal productions of aphasics and schizophrenics.
- Classification:
  - 1) speech disorders which are mainly functional:
    - stammering and stuttering
    - mutism
    - talking past the point
    - neologisms
    - speech confusion
  - 2) Aphasia
    - Receptive aphasias
    - Intermediate aphasias
    - Expressive aphasias

### Stammering:

- The normal flow of speech is interrupted by pauses or by the repetition of fragments of the word.
- Often associated with grimacing and tic-like movements of the body.
- Usually begins about the age of 4
- Much more common in boys.
- Often improves with time and only becomes noticeable when the patient is anxious for any reason.

- Occasionally occurs during a severe adolescent crisis or at the onset of an acute schizophrenia – probably the result of severe anxiety bringing to light a childhood stammer which has been successfully overcome.

#### Mutism:

- The complete loss of speech.
  - ✓ Disturbed children
  - ✓ Hysteria
  - ✓ Depression
  - ✓ Schizophrenia
  - ✓ Coarse brain disease
  - ✓ Catatonic stupor
- Elective mutism: in children, who refuse to speak to certain people.
- Pure word dumbness: the pt. is mute, but he can read and write.
- Akinetic mutism: mutism, a lowering of the level of consciousness, anterograde amnesia, preserved awareness of the environment.
  - ✓ Lesions at the base of the brain, especially space occupying lesions affecting the third ventricle, the thalamus and the midbrain.
- Commonest hysterical disorder of speech is aphonia.

#### Talking past the point (vorbeireden, "pseudo-pseudo-dementia"):

The content of the patient's replies to questions shows that he understands what has been asked and is deliberately talking about an associated topic.

- ✓ hysterical pseudodementia
- ✓ acute schizophrenia (usually in adolescents)
- ✓ chronic catatonia (particularly on asking personal questions)

#### 'Ganser syndrome' (Ganserism):

- When pseudodementia is really malingering.

- Described by Ganser in criminals awaiting trial for serious offences.
- Ganser used the word Vorbeigehen
- Accompanied by lack of insight, fluctuating 'twilight' diminution of consciousness of short duration, hysterical analgesia, and hyperaesthesia.

## Neologisms

4 types:

- 1) A completely new word whose derivation cannot be understood.
- 2) A word which has been incorrectly constructed by the faulty use of the accepted rules of word formation.
- 3) A distortion of another word.
- 4) An ordinary word used in a special way.

Origins of neologisms:

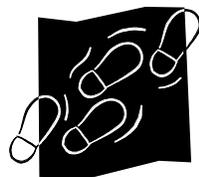
- 1) Neologisms in catatonics may be mannerisms or stereotypies
  - 2) Some schizophrenic neologisms could be regarded as the result of paraphasia (Kleist)
  - 3) A result of severe positive FTD.
  - 4) Result of a derailment (relativity – relationship).
  - 5) An attempt to find a word for an experience which is completely outside the realms of normal (technical neologism)
  - 6) Pt. may be using neologisms used by the hallucinatory voices.
  - 7) Used in order to placate the 'voices' or to protect himself from them.
- Paraphasias: wrong words, newly invented words, or words with distorted phonetic structure used by patients with aphasia, particularly those with motor aphasia – superficially resembles neologisms.
  - Malapropisms: ludicrously misused words that may be used by bewildered dullards – may be mistaken for neologisms.

Speech confusion (word salad):

- Utterly confused speech, talking utter nonsense.

- There is gross thought disorder, but the pt. speaks in a normal way with change of intonation and so on.
- Seen in some chronic schizophrenics, Bleuler called this type of schizophrenia 'schizophasia'.

(The section on aphasias is excluded, since it is referring mainly to a book published in 1966)



DISORDERS OF

## MEMORY

Seven stages in memory (Welford):

- 1) Adequate perception, comprehension and response to the material to be learned.
- 2) Short-term storage
- 3) Formation of a durable trace
- 4) Consolidation
- 5) Recognition that certain material needs to be recalled
- 6) Isolation of the relevant memory
- 7) Using the recalled material

### THE AMNESIAS

- Psychogenic amnesias:
  - Anxiety amnesia
    - ✓ Psychogenic reactions
    - ✓ Morbid anxiety; particularly in depressive illnesses.
  - Kathymic amnesia – a set of ideas which are disturbing when conscious are repressed in an attempt to avoid the affect which they would otherwise produce.
    - ✓ Hysteria
    - ✓ Normal persons
  - Hysterical (dissociative amnesia) – there is a complete loss of memory and loss of identity, but the pt. can carry out complicated patterns of behaviour and is able to look after himself. Is often associated with a fugue or wandering state.
- Organic amnesias:
  - ❖ Acute coarse brain disease:

- Poor memory is due to disorders of perception and attention and the failure to make a permanent trace.
- Retrograde amnesia: amnesia which embraces the events just before the injury; is the result of disturbance of the short-term memory.
- Post-traumatic amnesia: the period between loss of consciousness and the appearance of full awareness and memory; duration is directly related to the severity of the head injury.
- Anterograde amnesia: the pt. is apparently fully conscious, but has no memory for the events which occur; is the result of a failure to make permanent traces.
  - ✓ Alcoholic 'blackout'
  - ✓ Delirium
  - ✓ Twilight state due to epilepsy
  - ✓ Pathological drunkenness
- Transient global amnesia:
  - A sudden onset of retrograde amnesia covering a period of a few days upto several years.
  - Perception and personal identity remain normal
  - An anterograde amnesia continues until recovery (upto several hours)
  - The amnesia subsequently shrinks to a period of half to five hours.
  - In some pts. there is evidence of ischemia in the territory of the posterior cerebral circulation.
  - The immediate cause is probably from bilateral temporal or thalamic lesions.
  
- ❖ Subacute coarse brain disease:

- The pt. may have a retrograde amnesia which stretches back over a no. of years before the onset of the disease; is due to destruction of memory traces.
- The amnestic state:
  - There are 3 faults: difficulty in forming permanent traces, difficulty in recall and thought disorder.
  - There is disorientation for place and time, euphoria and confabulation.
  - Is related to damage to the floor and walls of the third ventricle and those parts of the brain, eg. temporal lobes, closely linked to them.
  - In some pts. there is a complete loss of 'impressibility' (registration of new memories).
  - The disorder of thinking is an inability to change set, called tram-line thinking. Once thought is proceeding in a given direction it continues in that direction for an unnecessarily long time, and instead of being corrected by the incoming information it distorts the information that is getting registered and makes recall difficult.
- ❖ Chronic coarse brain disease:
  - The amnesia extends over many years.
  - Ribot's law of memory regression: in dementing illnesses the memory for recent events is lost before the memory for remote events.

#### DISTORTION OF MEMORIES

- Disorders of recall (paramnesias)
- Distortions of recognition
- Disorders of recall:
  - Retrospective falsification
  - Retrospective delusions

- Delusional memories
- Confabulations
  
- ❖ Retrospective falsification: the subject modifies his memories in terms of his general attitudes.
  - ✓ Normal people (degree of retrospective falsification is inversely related to the degree of insight and self-criticism of the individual)
  - ✓ Hysterical personality
  - ✓ Depressive illness
  - ✓ Agitated depression
  - ✓ Mania
  
- ❖ Retrospective delusions:
  - The pt. dates back his delusions.
  - Could be regarded as delusional retrospective falsification.
    - ✓ Schizophrenia
  
- ❖ Confabulations:
  - A false description of an event, which is alleged to have occurred in the past.
  - Could be influenced by the examiner.
  - Could be explained as a result of 'tram-line' thinking.
  - Some amnestic pts. will construct completely false explanations of TAT cards based on one false interpretation of a detail.
    - ✓ Organic states
    - ✓ Hysterical psychopaths
    - ✓ Amnestic syndrome
    - ✓ Chronic schizophrenia
  - Some chronic schizophrenics confabulate, producing detailed descriptions of fantastic events which have never happened. Leonhard suggests that these

pts. have a special form of FTD which he calls 'pictorial thinking'. Bleuler preferred to call them 'memory hallucinations', since the memories are false and unchangeable. But the 'hallucinatory flashbacks' which occur in temporal lobe epilepsy may better merit the designation 'memory hallucinations'.

- Disorders of recognition:
  - Déjà vu and déjà vecu
  - Misidentification
  
- ❖ Déjà vu:
  - The subject has the experience that he has seen or experienced the current situation before.
  - The sense of recognition is never absolute.
    - ✓ Normal people
    - ✓ Temporal lobe lesions
  
- ❖ Misidentification:
  - Positive misidentification
  - Negative misidentification
  
- Positive misidentification:
  - The pt. recognizes strangers as his friends and relatives.
  - Some pts. assert that all of the people whom they meet are doubles of real people.
    - ✓ Confusional states
    - ✓ Acute schizophrenia (can be based on a delusional perception)
    - ✓ Chronic schizophrenia (false identity to every fresh person met)
  - Capgras syndrome: pt. insists that a particular person (or persons), usually somebody with whom the pt. is emotionally linked, is not the person

he claims to be but is really a double; is often accompanied by depersonalization and occurs in a paranoid setting.

- ✓ Schizophrenia (commonest cause)
- ✓ Involutional depression
- ✓ Very hysterical women
- 'Amphitryon illusion': pts. believe that their spouses are doubles.
- 'Sosias illusion': pt. believes that other people as well as the spouse are doubles.
- Syndrome of Fregoli: the pt. identifies a familiar person (usually his persecutor) in various strangers, who are therefore fundamentally the same individual.
- Negative misidentification:
  - The pt. denies that his friends and relatives are people whom they say they are and insists that they are strangers in disguise.
  - Could result from an excessive concretization of memory images.



Disorders of

## emotion

### Definitions:

- Feeling: a positive or negative reaction to some experience
  - The subjective experience of emotion.
- Emotion: a stirred up state due to physiological changes which occurs as a response to some event and which tends to maintain or abolish the causative event.
  - The emotion is designated by the content of consciousness which has evoked the physiological changes.
- Affects: waves of emotion in which there is a sudden exacerbation of emotion usually as a response to some event.
  - Sthenic affects: anger, rage, hate and joy.
  - Asthenic affects: anxiety, horror, shame, grief and sadness.
- Affectivity: the total emotional life of the individual
- Mood: the emotional state prevailing at any given time.
  - "The dominant hedonic tone of the moment": Deese.
- Mood state: a lasting disposition, either reactive or endogenous, to react to events with a certain kind of emotion.

### Classification of emotional disorders:

- 1) Abnormal emotional predispositions
- 2) Abnormal emotional reactions
- 3) Abnormal expressions of emotion
- 4) Morbid disorders of emotion
- 5) Morbid disorders of the expression of emotion
  - 'Abnormal': excessive responses of a normal kind.

- 'Morbid': those phenomena which appear to be the result of a morbid process within the nervous system.
  
- ❖ Abnormal emotional predisposition:
  - Hyperthymic personality: the person is overcheerful and is not touched by the minor irritations of life.
  - Dysthymic personality: the person always looks on the sad side of life and is miserable.
  - The hyperthymic, dysthymic, cyclothymic and irritable temperaments, which are often found in pts. with manic depressive illness, may be genetically caused.
  - Other predispositions to emotional disorders are probably partly, if not wholly, determined by childhood experiences.
    - increased emotional responsiveness (highly suggestible individuals who are prone to disinhibited behaviour)
    - emotionally cold personality (maternal deprivation may give rise to affectionless individuals; there is some constitutional predispositions as well)
  - In children and adolescents there is normally a lack of constancy in emotional feeling and instinctual life, which is associated with a lack of persistence, a tendency to egotism, cruelty, outbursts of emotion and overvalued thinking.
  
- ❖ Abnormal emotional reactions:
  - Anxiety:
    - an unpleasant affective state with the expectation, but not the certainty of something untoward happening.
    - 'a fear for no adequate reason'

- 'Acute anxiety states': exaggerated states of normal fear.
- 'Anxious disposition': a low threshold for the development of anxiety.
  
- Phobias:
  - Fears restricted to a specific object, situation or idea.
  - Agoraphobia is not a true phobia.
  
- Reactive depression:
  - pts. usually not self-reproachful but tend to blame others for their illness.
  - Morbid thinking is not present.
  - Threats of suicide are not infrequent, even suicidal attempts are made.
  - Often anger and resentment are ill-controlled.
  - They enjoy sympathy.
  - Loss of weight, loss of interest and loss of libido are not common.
  - Sleep is almost invariably disturbed.
  
- Verstimmung ('ill-humored mood state'):
  - Irritable, angry depressive states.
  - Pts. are not only unhappy themselves, but make others unhappy as a result of their unpleasant, aggressive behaviour.
  - The borderline between reactive depression and Verstimmung is not well marked.
    - ✓ Disturbed adolescents
    - ✓ Abnormal personalities, particularly 'psychopaths'.
    - ✓ Morbid depression (often the expression of an abnormal personality, occasionally result of a mixed affective state)
    - ✓ Schizophrenia
    - ✓ Organic states
    - ✓ Mania (pt. is irritable, querulous and awkward)

- ✓ Epilepsy (may occur when there have been no fits for sometime and often improve after the pt. has a fit)
  
- Euphoria:
  - Undue cheerfulness and elation.
  - The hyperthymic individual is usually euphoric.
  
- ❖ Abnormal expressions of emotion:
  - Means persons who show emotional expression and behaviour very different from the average normal reaction, but not different in kind.
  - May be the result of learning or may be subsumed under the term 'emotional lability'.
  
- Dissociation of affect:
  - A lack of manifestation of anxiety or fear under conditions where this would be expected.
  - Is said to be an unconscious defense reaction against anxiety.
  - The term covers a no. of different forms of behaviour;
    - o Plain denial of anxiety.
    - o Belle indifference: seen in hysteria – the pt. has gross symptoms and severe disabilities but is undisturbed by his suffering.
  - dissociation of affect should not be applied to
    - o Emotional indifference: often found in violent criminals who are usually able to discuss their unpleasant crimes without any emotion.
    - o Apathy: a loss of feeling; emotional indifference and a lack of activity, often associated with a lack of activity, often associated with a sense of futility.
      - ✓ Traumatic depersonalization
      - ✓ Situations of hopelessness, like prisons
      - ✓ Malnutrition

- Perplexity: a state of puzzled bewilderment.
  - ✓ Anxiety
  - ✓ Mild clouding of consciousness
  - ✓ Acute schizophrenia
  
- ❖ Morbid disorders of emotion:
  - Depressed mood state:
    - 'Vital hypochondriacal' depression (Schneider): the type of depression in which 'precordial anxiety' (a sense of oppression in the chest associated with anxiety) occurs.
  - Morbid anxiety often occurs in association with morbid depression and gives rise to the clinical picture of agitated depression.
  - Organic neurasthenia: mild anxiety mixed with depression and irritability, occurring in mild acute and chronic coarse brain disease.
  - Anxiety or fear seen in schizophrenia is difficult to be regarded as morbid, since it can be understood as a natural reaction to the delusions and hallucinations.
  
- Irritability:
  - A liability to outbursts
  - A state of poor control over aggressive impulses directed towards others, most frequently to those nearest and dearest.
  - May be a trait of personality (the explosive personality) and it occurs in morbid states.
  - Is very commonly a manifestation of the tension accompanying anxiety.
  - Appears episodically in women as part of the premenstrual syndrome.
  - May occur in any organic state, but is rarely seen in the amnesic syndrome.

- Ictal moods in temporal lobe epilepsy are most commonly of depression and anxiety, and less commonly of euphoria or extremely unpleasant feelings.
- Apathy:
  - 'apathetic hebephrenia' (Leonhard): chronic schizophrenia in which pt. describes his frightful experiences with an indifferent air, have no drive, no interest in anything, is difficult to employ and hangs about the hospital completely indifferent to his lot.
  - The anergic state seen in depression is not apathy because the pt. is not completely indifferent; it is rather that he is too preoccupied with his miseries.
  - Chronic organic states, particularly those in which the frontal lobes are affected, may be associated with apathy.
- Morbid euphoria and elation:
 

<ul style="list-style-type: none"> <li>✓ Mania</li> <li>✓ Organic states</li> <li>✓ Schizophrenia (occasional)</li> </ul>		<p>there is a silly cheerfulness and flight of ideas is rarely present.</p>
---	--	---

  - The manic, in contrast with the general paretic, does not have well-held grandiose delusions.
  - Lesions of the hypothalamus may produce clinical pictures resembling mania with flight of ideas.
  - Euphoria classically occurs in disseminated sclerosis.
  - Euphoria and a general passive attitude are characteristic features of the amnesic syndrome.
  - Moria (Witzelsucht): silly euphoria with lack of foresight and general indifference; found in frontal lobe lesions, particularly when the orbital surface is damaged.

- Ecstasy:
  - A sense of extreme well-being associated with a feeling of rapture, bliss and grace.
  - Not associated with overactivity and flight of ideas.
  - Visions of religious themes and voices of Higher Beings may be seen and heard.
  - In milder ecstatic states the pt. may preach or lecture in a high-flown way.
    - ✓ Happiness psychosis
    - ✓ Schizophrenia
    - ✓ Epilepsy
    - ✓ Abnormal personalities with the appropriate religious training
  
- ❖ Morbid disorders of emotional expression:
  - Parathymia (inadequacy or blunting of affect):
    - In its mildest forms, shows itself as a (recently acquired) insensitivity to the subtleties of social intercourse.
    - A complete loss of all emotional life so that the pt. is indifferent to his own well-being and that of others.
  
  - Incongruity of affect:
    - A loss of the direction of emotions, so that an indifferent event may produce a severe affective outburst, but an event which is emotionally charged to the examiner has no effect on the pt.'s emotional expression.
    - Is not necessarily a primary disorder of affect; FTD would lead to a distortion of the schizophrenic's comprehension of his environment, so that although the affect expressed might appear incongruous to the outsider, it might be congruous with the pt.'s thoughts.
    - Dissociation of affect, the affectionless personality and the effects of anxiety may lead to difficulties in diagnosis.

- Stiffening of affect:
  - The emotional expression is congruous at first, but it does not change as the situation changes.
    - ✓ Schizophrenia
  
- In chronic hebephrenia the abnormality of emotional expression may occur against a background of an enduring mood state, such as silly euphoria, careless indifference, querulous ill-humor and autistic depression.
- Some chronic paranoid schizophrenics discuss their delusions with elation, depression or irritability; but outside their delusions they show some emotional blunting.
  
- 'Smiling depression':
  - Unless they are overwhelmed by their miseries or suffering from psychomotor retardation, depressives can produce the communicatory smile.
  - These pts. smile with their lips, but not with their eyes.
  - They are particularly sensitive about ideas of guilt and are often extremely disturbed by commiseration, so that they become obviously depressed or even burst into tears when the examiner sympathizes with them.
  
- Compulsive (forced) affect:
  - The expression of emotion in the absence of any adequate cause.
  - Lability of affect: the pt. has difficulty in controlling his emotions.
    - ✓ Abnormal personalities, like appreciation-needing and irresolute psychopaths.
    - ✓ Some normal subjects.
    - ✓ Organic states; like organic neurasthenia.
    - ✓ Morbid depression
    - ✓ Mania

- Affective incontinence: there is complete loss of control over emotions. In mild cases, pt. breaks into tears when a very slightly emotionally charged topic is mentioned, when the symptom is marked he breaks into tears when spoken to and has no feelings of sadness.
  - ✓ Organic states; like cerebral arteriosclerosis, disseminated sclerosis.
  - ✓ Attacks of forced laughing occur most commonly in disseminated sclerosis.



## DISORDERS OF THE EXPERIENCE OF THE SELF

- Ichbewusstsein = ego consciousness
- Weitbrecht suggested the term 'self experience'
- 4 aspects of self-experience (Jaspers):
  - The awareness of existence and activity of the self.
  - The awareness of being a unity at any given point of time
  - The awareness of continuity over a period of time
  - The awareness of being separate from the environment or, in other words, awareness of ego boundaries.
- All events which can be brought into consciousness are associated with a sense of personal possession although this is not usually in the forefront of consciousness. This 'I' quality has been called 'Personalization' by Jaspers.
- 2 aspects of the sense of self-activity:
  - The sense of existence.
  - The awareness of the performance of one's actions.

Disturbance of awareness of self activity:

- Depersonalization
- Loss of emotional resonance

Depersonalization:

- Should be distinguished from:
  - o Preoccupation
  - o Loss of interest
  - o Nihilistic delusions

- There are 3 different types of depersonalization which are qualitatively different.
- Clinically, is more in females.
- High anxiety scores correlated with depersonalization experiences in women but not in men.
  - ✓ Emotional crisis or threat to life.
  - ✓ Anxiety states with phobias
  - ✓ Depression
  - ✓ Schizophrenia | when there is a depressive mood and
  - ✓ Organic states | a premorbid insecure personality.
  - ✓ Epilepsy – psychomotor epilepsy, multiple types of attacks, depressive states during the attacks, depression apart from the attacks.
- Depressed mood does not appear to account for the depersonalization found in schizophrenia and organic states.

#### Loss of emotional resonance:

- In depression, most marked when the depressive encounters his loved ones.
- In morbid depression, complaints of depersonalization and derealization arise from the loss of emotional resonance, while in schizophrenia depersonalization results from the subjective experience of the breakdown of the boundaries of the self.

#### Disturbances of the immediate awareness of self-unity:

- ✓ Psychogenic and depressive depersonalization
- ✓ Naïve or appreciation-needing personalities
- ✓ Demoniac possession
- ✓ Schizophrenia

Disturbance of the continuity of self:

- ✓ Fantastic paraphrenics
- ✓ Religious conversion

Disturbance of the boundaries of the self:

- ✓ Organic conditions, like anosognosia.
- ✓ Hypnagogic states
- ✓ Schizophrenia
- ✓ Obsessions and compulsions
- Knowledge of what is body and what is not is based on the link between information from the extero- and the proprioceptors.
- 'Made experiences' is also used for apophanous experiences when the pt. knows that all the events around him are being made for his benefit.
- Another aspect of loss of boundary with the environment is seen when the pt. knows that his actions and thoughts have an excessive effect on the world around him.



## DISORDERS OF CONSCIOUSNESS

- Consciousness: a state of awareness of the self and the environment.
  - Active consciousness: when the subject focuses his attention on some internal or external event
  - Passive consciousness: when the same events attract the subject's attention without any conscious effort on his part.
  
- Distractibility: the pt. is diverted by almost all new stimuli and habituation to new stimuli takes longer than usual.
  - ✓ Fatigue
  - ✓ Anxiety (due to anxious preoccupations)
  - ✓ Severe depression
  - ✓ Mania
  - ✓ Schizophrenia (may be due to paranoid set or FTD)
  - ✓ Organic states (may be due to paranoid set)
  
- In the amnesic syndrome, the pt's thinking and observation are dominated by rigid sets, so that perception and comprehension are affected by selective attention.
- Disorders of consciousness are associated with disorders of perception, attention, attitudes, thinking, registration and orientation.
- If a pt. is disoriented, there is a *prima facie* case that he has an organic state; the major exception to this rule is the chronic hospitalized schizophrenic.

- Consciousness can be changed in three ways:
  - 1) Dream-like changes of consciousness
  - 2) Lowering of consciousness
  - 3) Restriction of consciousness
  
- ❖ Dream-like changes of consciousness:
  - There is some lowering of the level of consciousness which is the subjective experience of a rise in the threshold for all incoming stimuli.
  - The pt. disoriented for time and place, but not for person.
  - Clinical features:
    - Visual hallucinations – usually of small animals, associated with fear or even terror; or Lilliputian hallucinations which may be associated with pleasure.
    - Disordered thinking as it is in dreams, showing excessive displacement, condensation and misuse of symbols.
    - Auditory hallucinations – commonly elementary, rarely continuous voices, organized auditory hallucinations take the form of odd disconnected words or phrases.
    - Other hallucinations of touch, pain, electric feelings, muscle sense and vestibular sensations often occur.
    - When the underlying physical illness is severe, insomnia is marked.
  - ‘Occupational delirium’: when the pt. is restless and carries out the actions of his trade.
  - ‘subacute delirious state’ (toxic confusional state): milder degrees of delirium, where pt. may have a general lowering of the consciousness during the day and be incoherent and confused, while at night delirium occurs with visual hallucinations and restlessness. There may also be some restriction of consciousness so that the mind is dominated by few ideas, attitudes, and hallucinations.

- ❖ Lowering of consciousness (torpor):
  - Pt. is apathetic, generally slowed down, unable to express himself clearly and may perseverate.
  - After some weeks there is a remarkable partial recovery and the pt. is left with a mild organic defect.
    - ✓ Severe infections, like typhoid and typhus.
    - ✓ Arteriosclerotic disease, following a cerebrovascular accident.
  
- ❖ Restriction of consciousness:
  - There is some lowering of the level of consciousness, and the awareness is narrowed down to a few ideas and attitudes which dominate the pt's mind.
  - 'twilight state' (Westphal): there is a -
    - a restriction of the morbidly changed consciousness
    - a break in the continuity of consciousness
    - relatively well ordered behaviour
  - Commonest twilight state is the result of epilepsy.
  - Simple, hallucinatory, orientated, perplexed, psychomotor, excited and expansive twilight states have been described.
  - 'Hysterical twilight state': the restriction of consciousness resulting from unconscious motives.
    - ✓ Severe anxiety
  
  - 'fugues': wandering states with some loss of memory
    - ✓ depression
    - ✓ Hysterical fugue: more common in subjects who have previously had a head injury with concussion.



## MOTOR DISORDERS

- 2 approaches to motor disorders:
  - As neurological disorders – Kahlbaum, Wernicke, Kleist.
  - As a result of the patient's conscious or unconscious attitudes.
- Motor disorders may be subjective or objective
  - Abnormal Subjective experiences of motor behaviour (alienation of motor acts):
    - Obsessions and compulsions
    - Experience of passivity: the pt. merely assert that his behaviour is controlled from without and be unable to give any further explanation.
    - Delusion of passivity: development of secondary delusions to explain the foreign control.

Classification of motor disorders:

Disorders of adaptive movements:

- Disorders of expressive movements
- Disorders of reactive movements
- Disorders of goal – directed movements

Nonadaptive movements:

- Spontaneous movements
- Abnormal induced movements

Motor speech disturbances in mental disorders:

- Attitude to conversation
- The flow of speech
- Mannerisms and stereotypies

- Perseveration
- Echolalia

Disorders of posture:

- Distorted normal postures
- Manneristic postures
- Abnormal postures
- Stereotyped postures

Abnormal complex patterns of behaviour:

- Non-goal-directed patterns of behaviour
- Goal-directed abnormal patterns of behaviour

Disorders of expressive movements:

- Range of emotional expression is very different in different cultures and may be markedly different in different individuals in the same culture.
- In depression the main fold in upper lid is angulated upwards and backwards at the junction of the inner third with the middle third of the fold (Veraguth).
- Omega sign (Athanassio): the occurrence of a fold like the Greek letter omega in the forehead above the root of the nose produced by the excessive action of the corrugator muscle; seen in depression.
- In retarded depression all bodily movements, including gestures, are diminished or absent.
- In agitated or anxious depression, pt. is usually restless and apprehensive.
- In schizophrenia, especially in catatonia, expressive movements are often disordered.
- Schnauzkrampf ('snout spasm'): In catatonia the rounded lips are sometimes thrust forward in a tubular manner so that they resemble an animal's snout – it is best considered as a stereotyped posture.
- In mania, expressive movements are exaggerated.

- 'Emotional lability': transient depression lasting for a few seconds interrupting the manic overactivity from time to time.
- In ecstasy or exaltation, the pt. has a rapt intense look and is not restless and interfering like the manic.
- The flat, full, expressionless face with a greasy appearance ('ointment face') occurs in post-encephalitic Parkinsonism, while the face in Parkinson's disease is mask-like, but not greasy.

#### Disorders of reactive movements:

- Reactive movements are immediate automatic adjustments to new stimuli.
- Marked anxiety: there may be a great increase in the 'startle reflex'.
- Motility psychosis: Reactive movements are lost in the inhibited phase, although voluntary movements are carried out in a graceful way.
- Catatonia: Reactive movements are usually affected by obstruction.
- Neurological disorders, including Parkinsonism may lead to a loss of reactive movements.

#### Disorders of goal-directed movements:

- Psychomotor retardation
- Obstruction
- Mannerisms
- Goal directed movements reflect the personality of the subject and his current mood state.
- The agitated depressive is easily distracted so that he may have difficulty in initiating a voluntary movement and be unable to carry through a complicated pattern of voluntary movements.
- The manic carries out individual actions swiftly, but his general pattern of behaviour is not consistent.

- ❖ Psychomotor retardation:
  - Occurs in depressive illness, and slows down all psychic and motor acts.
  - Experienced subjectively as a feeling that all actions have become much more difficult to initiate and carry out.
  - Mildest degrees: a lack of expression with furrowed eyebrows, the gaze directed downwards and the eyes unfocussed.
  - More severe degrees: movements become slow and dragging.
  
- ❖ Obstruction (Sperrung, blocking):
  - Occurs in catatonia.
  - Gives rise to an irregular hindrance to psychic or motor activity.
  - May affect habitual or reactive movements.
  - The pt. may be unable to begin an action at one time and a little later be able to carry it out with no difficulty.
  - At times a voluntary action seems to break through the obstruction and is carried out rather quickly.
  - The muscle tension may be normal, increased or decreased.
  - The effort needed to overcome obstruction is not dependent on peripheral factors, but appears to be a difficulty in carrying out the act itself.
  - A characteristic feature of the obstruction is 'the reaction at the last moment' (Kleist).
  - Mild obstruction: motor activity appears stiff and awkward.
  - More severe obstruction: akinesia
  - Very marked obstruction: stupor
  
- ❖ Mannerisms (bizarries):
  - "Unusual repeated performances of a goal-directed motor action or the maintenance of an unusual modification of an adaptive posture".

- The strange use of words, high-flown expressions and movements and postures which are out of keeping with the total situation can be regarded as mannerisms.
  - ✓ Relatively normal subjects; when the subject has the need to be noticed, but has not the capacity to be intellectually outstanding or original.
  - ✓ Abnormal personalities; may be the result of a lack of control over motor behaviour, which is often associated with a lack of self-confidence.
  - ✓ Schizophrenia; may result from delusional ideas, but best regarded as an expression of the catatonic motor disorder.
  - ✓ Neurological disorders; result of a lack of co-ordination of pyramidal and extra-pyramidal systems.

#### Spontaneous movements:

- Tics
- Static tremor
- Spasmodic torticollis
- Chorea
- Athetosis
- Stereotypies
- Animals prevented from carrying out a normal pattern of behaviour which is usually released by a certain compound stimulus may perform another pattern of movement, which is nonadaptive. This is known as displacement activity.
- Most normal subjects have motor habits which are not goal-directed and which tend to become more frequent during anxiety (Eg. scratching of the head, clearing the throat, etc). These actions have obviously been goal-directed at some time, but have since become spontaneous and not

directed towards any goal. These could be regarded as displacement activities.

❖ Tics:

- Sudden involuntary twitchings of small groups of muscles.
- Usually reminiscent of expressive movements or defensive reflexes.
- As a rule the face is affected (Eg. blinking, distortions of the forehead, nose or mouth, etc.), but clearing of the throat and twitching of the shoulders may also be tics.
- ? Psychogenically determined motor habits
- ? Brought to light by emotional tension in a pt. with constitutional predisposition
- May have a clear physical basis, as in Gilles de la Tourette's syndrome, in onset of torsion dystonia or Huntington's chorea, or after encephalitis.

❖ Static tremor:

- Occurs in the hands, head and upper trunk when the subject is at rest.
- Is sometimes familial.
- Also occurs in Parkinsonism, alcoholism, and thyrotoxicosis.
- Tends to worsen as the pt. grows older.
- Patients are usually able to carry out voluntary movements accurately.
- Organic tremors are made worse by emotional disturbances.

❖ Spasmodic torticollis:

- A spasm of the neck muscles, especially the sternomastoid, which pulls the head towards the same side, and twists the face in the opposite direction.
- ? some cases are hysterical
- ? Is basically neurological, although it may be aggravated by psychogenic factors.

## ❖ Chorea:

- Abrupt jerky movements which resemble fragments of expressive or reactive movements.
- Huntington's chorea: the face, upper trunk and the arms are most affected. Snorting and sniffing are often also present.
- Sydenham's chorea: the movements are less jerky and somewhat slower. The arms and face are affected and respiration is often affected. There is usually widespread hypotonia, sometimes hyporeflexia and not infrequently a prolongation of the muscular contraction evoked during a tendon reflex (Gordon's phenomenon).

## ❖ Athetosis:

- The movements are slow, twisting and writhing.
- Brings about strange postures of the body, especially of the hands.
- Choreic and athetotic movements can occur in catatonia.

## ❖ Stereotypies:

- Repetitive non-goal directed actions carried out in a uniform way.
- May be a simple movement or a stereotyped or recurrent utterance.
- Verbal stereotypies are words or phrases which are repeated. They may be produced spontaneously or be set off by a question.
- Verbal stereotypies are found in expressive aphasia.
- Bostroem defined grotesque distorted movements and postures in which no aim or goal can be seen, as bizzarries.

## Parakinetic catatonia:

- 'clown-like' behaviour: pt. has general overactivity, frequent grimaces, and smile like a clown.
- Pt. is usually able to answer simple questions and may be capable of simple routine work.

- Some continually intertwine their fingers.

Abnormal induced movements:

❖ Automatic obedience:

- The pt. carries out every instruction regardless of the consequences.
  - ✓ Catatonia
  - ✓ Dementing disorders

❖ Command automatism:

- Some authors use as synonym for automatic obedience.
- A syndrome characterized by automatic obedience, waxy flexibility, echolalia and echopraxia (Bumke).

❖ Echopraxia:

- Patients imitate simple actions which they see.
- Disorders of perception and difficulties in understanding speech in schizophrenia may account for echopraxia in that illness.
- Echopraxia usually happens when the pt. is trying to communicate with another person, and is more common when he finds it difficult to communicate verbally.
- Three types:
  - 1) Completely automatic echopraxia
  - 2) Echopraxia to memory images
  - 3) Voluntary echopraxia

These 3 types correspond to the 3 different stages of imitation in childhood which Piaget had described.

❖ Echolalia:

- The pt. echoes a part or the whole of what has been said to him, irrespective of whether he understands them or not.

- Could be the result of disinhibition of a childhood speech pattern.
  - Tends to occur in subjects who wish to communicate, but have permanent or transient receptive and expressive speech disorders.
  - Some non-psychotics, particularly nervous embarrassed women may echo the last words which have been said to them.
  - Organic echolalia results from a lesion of the left temporal lobe and the adjacent regions of the parietal lobe.
  - Echologia (Kleist): catatonic pt. replying to questions by echoing the content of the questions in different words.
  - Echo reactions occur in:
    - ✓ Transcortical aphasias and dementing conditions
    - ✓ Severe mental subnormality with incomplete development of speech
    - ✓ Epileptic personality deterioration
    - ✓ Clouded consciousness
    - ✓ Catatonia
    - ✓ The early stages of speech in childhood
    - ✓ Fatigue and inattentiveness in normal subjects
  - Common factors in conditions in which echo reactions occur are an impulse to speak, a tendency to repetition and a disorder of the comprehension and expression of speech.
- ❖ Perseveration:
- Is a senseless repetition of a goal-directed action which has already served its purpose.
  - Is more obvious when the speech is affected.
  - Perseveration is more likely to occur if the problem the pt. is dealing with is more difficult.
  - In the early stages the pt. can recognize his difficulty and tries to overcome it.
    - ✓ Catatonia

- ✓ Coarse brain disease
- Palilalia: the pt. repeats the perseverated word with increasing frequency.
- Logoclonia: the last syllable of the last word is repeated.

Both types occur in coarse brain disease, in particular in Alzheimer's disease.

- Compulsive repetition: the act is repeated unless the pt. receives another instruction – is more frequent in schizophrenics.
- Impairment of switching: the repetition continues after the pt. has been given a new task – more common among demented.
- Ideational perseveration: the pt. repeats words and phrases during his reply to a question – equally common in both groups.

- In some cases there is perseveration of theme rather than the actual words and this can be regarded as an impairment of switching.
- In other cases the set or attitude is perseverated.

❖ Forced grasping:

- Despite frequent instructions not to touch the examiner's hand, the pt. continues to shake it when offered to him.
- ✓ Chronic catatonia
- ✓ Dementias

❖ Grasp reflex:

- The pt. automatically grasps all objects placed in his hand, sometimes the reflex has to be produced by drawing an object across the palm.
- When unilateral in a fully conscious pt., indicates a frontal lobe lesion on the opposite side.

- When bilateral or occurs in clouded consciousness, merely indicates a widespread disorder of the cerebral cortex, which may or may not be reversible.
  
- ❖ Magnet reaction:
  - If the examiner rapidly touches the palm and steadily withdraws his finger the pt.'s hand follows the examiner's finger.
    - ✓ Catatonia
    - ✓ Coarse brain disease
  
- ❖ Co-operation (mitmachen):
  - The body can be put to any position without any resistance on the part of the pt.
    - ✓ Catatonia
    - ✓ Neurological disease affecting the brain
  
- ❖ Mitgehen:
  - The pt. moves his body in the direction of the slightest pressure on the part of the examiner.
  - Can be regarded as a very extreme form of co-operation.
  - In both mitmachen and mitgehen, once the examiner let go of the body the part which has been moved returns to the resting position. When examining, as in the elicitation of all types of abnormal compliance, the pt. must be made to understand that he is expected to resist the examiner's efforts to move him.
  
- ❖ Gegenhalten (opposition, reactive muscle tension):
  - Some catatonics oppose all passive movements with the same degree of force as that which is being applied by the examiner.

- May only appear when the examiner attempts to produce brusque, forceful, passive movements.
  
- ❖ Negativism:
  - Is an apparently motiveless resistance to all interference.
  - Can be regarded as an accentuation of opposition.
  - Some negativistic patients appear to be angry and irritated, while others are blunted and indifferent.
  - The emotional state in negativism is closely allied to anxiety or fright (Kleist).
  - There is the affective state of negativism and true catatonic or psychomotor negativism (Gross).
  - Negativism depends to some degree on the environment – fellow patients evoke the negativistic reactions much less easily than doctors and nurses.
    - ✓ Catatonia
    - ✓ Severely mentally subnormal
    - ✓ Dementias
      - Passive negativism: all interference is resisted and orders are not carried out.
      - Active (command) negativism: the pt. does the exact opposite of what he is asked to do, in a reflex way.
  
- ❖ Ambitendency:
  - The pt. makes a series of tentative movements which do not reach the intended goal when he is expected to carry out a voluntary action.
  - Is an expression of ambivalence of the will (Bleuler).
  - Can be regarded as a mild variety of negativism or as the result of obstruction.

- Ambitendency is often found in negativistic patients when they are approached carefully and every effort is made to win their confidence, as a result of a partial breakdown of the negativistic attitude.
- Patients with marked obstruction may make a series of tentative movements before the obstruction prevents all movement; this does not occur in ambitendency due to negativism.

#### Motor speech disorders in the psychoses:

- ❖ Attitude to conversation:
  - Negativism
  - Easy distractibility
  - Interference from hallucinatory voices
  - Continuous whispering to the voices; in some catatonics and paraphrenics
  - Staring at the examiner with expressionless face, not saying a word; in some catatonics
  - Turning towards examiner with a blank face and replying to every question, whether sensible or not and talking past the point; in some catatonics.
  - Looking in a puzzled bewildered way, having muteness or poverty of speech; in confusion psychosis.
- ❖ The flow of speech:
  - Muteness
  - Pressure of speech
  - Extreme volubility with very muddled speech; in fantastic paraphrenics
  - Slowing of speech; in psychomotor retardation
  - Strange and stilted; in catatonia
  - Odd intonation, talking in falsetto tone or having a staccato or nasal speech; in catatonia
  - Never speaking above a whisper

- Speaking in a strange strangled voice (Wurgstimme) – may be a mannerism or the result of delusions.

❖ Mannerisms and stereotypies:

- Mannerisms of stress, inflection, rhythm and pronunciation can occur.
- Verbigeration: one or several sentences or strings of fragmented words are repeated continuously.
  - Is not always spontaneous.
  - Sometimes in verbigeration the pt. produces strings of incomprehensible jargon in which stereotypies are embedded.
  - Usually the voice is monotonous.
- Schizophasia (discussed in page 35)

Disorders of posture:

- Abnormal postures occur in abnormal personalities who are seeking attention and appreciation; these may also result from nervous habits in disturbed adolescents and over-anxious personalities.
- Manneristic posture: an odd stilted posture which is an exaggeration of a normal posture, and is not rigidly preserved.
  - ✓ Schizophrenia (related to delusional attitudes, or catatonic)
- Stereotyped posture: an abnormal and nonadaptive posture which is rigidly maintained.
  - Eg. Psychological pillow: pt. lies with his head a few inches off the pillow, and maintains this posture for hours – due to contraction of sternomastoid muscles.
    - ✓ Catatonia
    - ✓ dementia
  - The exact point at which a postural mannerism becomes a stereotypy may be difficult to decide.

- Perseveration of posture: the pt. tends to maintain for long periods (at least one minute) postures which have arisen fortuitously or which have been imposed by the examiner.
  - Waxy flexibility (*flexibilitas cerea*) (Wernicke): there is a feeling of plastic resistance as the examiner moves the body, which resembles the bending of a soft wax rod, and when the passive movement stops the final posture is preserved.
    - ✓ Encephalitis, vascular disorders and neoplasms affecting the midbrain.
  - Catalepsy (preservation of posture): there is no resistance to passive movements, but as the examiner releases the body those muscles which fix the body in the abnormal position can be felt to contract.
  - If gentle passive movements fail to elicit catalepsy, it can sometimes be evoked by jerking the arm or leg rather brusquely into a strange position.
  - Catalepsy usually lasts for more than one minute and ends with the body slowly sinking back into the resting position.
  - Catalepsy is often very variable.
    - ✓ Mute stuporose catatonics
    - ✓ Mild states of akinesia
    - ✓ Encephalitis, vascular disorders and neoplasms affecting the midbrain.

Non-goal directed patterns of behaviour:

- Stupor
- Excitement

- ❖ Stupor:
  - A state of more or less complete loss of activity with no reaction to external stimuli (Bumke).
  - Completely stuporose patients are mute, but in sub-stuporose states patients may briefly reply to questions in muttered monosyllables.
    - ✓ Fright neuroses
    - ✓ Hysteria
    - ✓ Depression
    - ✓ Cycloid psychoses
    - ✓ Catatonia (commonest cause among functional psychoses)
    - ✓ Coarse brain disease
    - ✓ Inhibited confusion psychosis
    - ✓ Motility psychosis
  - Psychogenic stupor: the pt. appears as if 'paralyzed with fear' and is unable to retreat from danger – can be terminated by sedation and reassurance.
    - ✓ Severe fright neuroses
  - Hysterical stupor: the pt. retreats from his problem by becoming mute and motionless.
    - Not uncommon
    - Sometimes is the hysterical prolongation of a fright neurosis.
    - Is more likely to occur in primitive unsophisticated subjects or in grossly disturbed appreciation-needing personalities.
    - Reassurance coupled with Hypnosis or small doses of sodium amylobarbitone will usually lead to uncovering of the conflict and its disappearance.
  - Akinetic mutism (discussed in page 33)
  - Stupor may occur in epilepsy, when there is a continuous epileptic discharge in the EEG or repeated bursts of such discharges.

- 'Petit mal status': recurrent catatonic stupor in which EEG shows continuous spike and wave discharges – is a special variety of status epilepticus.
- Pts. with Gjessing's periodic catatonia have very slow waves in the EEG during the reaction phase.
  
- Catatonic stupor:
  - Increased or reactive muscle tension is most marked in the anterior neck muscles, the masseters, the muscles around the mouth and the proximal muscles of the limbs.
  - Very rarely, all muscles are flaccid with the exception of one group in which tension is markedly increased.
  - The face is usually stiff and without expression, giving rise to a 'dead-pan' expression, but often the eyes are lively.
  - Incontinence of urine is the rule, faecal incontinence may occur.
- Bewildered stupor is diagnostic of inhibited confusion psychosis; presence of primary delusional experiences in a bewildered pt. with a near-stuporose state is not diagnostic of schizophrenia.
- In motility psychosis the reactive and expressive movements are affected more than the voluntary ones.
- Patients with catatonic stupor may have slight stereotyped movements of the hands and fingers; this does not occur in stupor resulting from the cycloid psychoses.
- In depressive stupor, catalepsy, obstruction, stereotypies, change in muscle tone and incontinence of urine and faeces do not occur; in contrast to catatonic stupor.
- The possibility of a neurological disorder should never be overlooked in a rapidly developing stupor.

- ❖ Excitement:
  - In some cases can be understood as being secondary to some other psychological abnormality.
    - Paranoid schizophrenia: sudden increase in the intensity of hallucinatory voices.
    - Mania: natural consequence of the elevated mood.
    - Appreciation-needing personalities: desire for attention; to impose a solution of pt's problems on the environment.
  - Some excitements, such as those arising in catatonia and coarse brain disease cannot be understood as arising from some other psychological abnormality.
  - Psychogenic excitements:
    - Acute reactions
    - Goal-directed reactions

#### Acute reactions:

- Predisposed subjects may react to moderately stressful situations with senseless violence.
- Chaotic restlessness rather like a 'storm of movement' may occur in susceptible subjects during catastrophes, and in unsophisticated and mentally subnormal persons subject to mild stress.

#### Goal-directed reactions:

- Excitement is part of attention-seeking behaviour.
- Occur in adolescent and young adult women who have been unhappy since childhood.
- Even during severe excitement, it is usually possible to make contact with these pts. and interrupt the overactivity. They seem eager to be punished and enjoy a good fight.
- They often complain of visual hallucinations, particularly of men, but they do not show any clear schizophrenic symptoms.

- Excitement in depression:
  - Moderately severe agitated depression: takes a mechanical form; pts. wander about restlessly and bewail their fate monotonously.
  - Severe agitated depression: the pt., usually a woman, wrings her hands continuously, sits up in bed, rocks to and fro and laments; sometimes picking the hair, rubbing the face or pulling the hair; the total picture is one of abject misery.
  
- Excitement in motility psychosis:
  - The movements are graceful and no stereotypies occur.
  - Do not have the very angular stiff movements of catatonia.
  - If very severe, repetitive movements such as rocking to and fro may occur.
  
- Catatonic excitement:
  - Body movements are often stiff and stilted.
  - Violence is usually senseless and purposeless.
  
- Delirium:
  - Many pts. are extremely frightened
  - There may be ill-directed overactivity
  - Occupational delirium may occur.
  
- Epileptic furore: the pt. becomes senselessly violent and indiscriminately destructive during an epileptic confusional state.
  
- Pathological drunkenness:
  - There is an excitement with senseless violence after the pt. has drunk a small quantity of alcohol.
  - The episode lasts an hour or so.
  - The pt. has a complete amnesia for the episode.

- The pt. is not ataxic and does not have the usual signs of drunkenness.

Impulsive actions:

- Non-goal-directed complex patterns of behaviour
- Dynamic psychologists attribute these actions to unconscious motives.
  - ✓ Normal people
  - ✓ Abnormal personalities
  - ✓ Catatonia (actions usually of aggressive kind)

Goal directed abnormal patterns of behaviour:

- Compulsive rituals
  - Commonest are cleaning, avoiding, repeating and checking.
- Practical joking
  - Behaving in a childish spiteful way to other pts. and even to doctors and nurses.
  - Is really a special form of aggressive behaviour.
    - ✓ Schizophrenia; especially silly hebephrenia
    - ✓ Mania
    - ✓ Abnormal personalities
- Brutal and aggressive behaviour
  - Is often socially determined.
  - On the whole, aggression is not very common in chronic functional disorders.
  - Aggressiveness in chronic schizophrenics seems to be more common in those pts. who come from backgrounds in which violent behaviour is common.
  - Some schizophrenics with blunting of affect may become brutal and unnecessarily aggressive when thwarted or interfered with, although they are well behaved if left alone.
- Murder

- ✓ Organic states, particularly epilepsy
- ✓ Schizophrenia (murder alleged persecutors, obeying hallucinatory voices, doing 'sacrifices' in conformance with grandiose religious beliefs).
- ✓ Depression (usually with delusions)
  - 'Extended suicide': pt. with delusional depression murdering his children in the mistaken belief that they have incurable inherited insanity or some foul disease.
- Promiscuity
  - Disinhibition resulting from coarse brain disease, mania or schizophrenia may give rise to promiscuous behaviour.
  - In some schizophrenics the point of onset of the illness cannot be determined and there is a slow, steady, ethical and moral deterioration which finally becomes so marked that it becomes obvious that there has been a schizophrenic process at work.