Psychopathology

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Psychopathology

Psychopathology is the systematic study of abnormal experience, cognition and behavior – the study of the products of a disordered mind .

Descriptive psychopathology is the precise description,categorization and definition of abnormal experiences as recounted by the patient and observed in his behavior. It relies on the method of phenomenology by focusing on experienced phenomena in order to establish their universal character.

Motor Activity

Motor activity may be described as normal, slowed (bradykinesia), or agitated (hyperkinesia). This can give clues to diagnoses (e.g., depression vs. mania) as well as confounding neurological or medical issues. Gait, freedom of movement, any unusual or sustained postures, pacing, and hand wringing are described. The presence or absence of any tics should be noted, as should be jitteriness, tremor, apparent restlessness, lip- smacking, and tongue protrusions. These can be clues to adverse reactions or side effects of medications such as tardive dyskinesia, akathisia, or parkinsonian features from antipsychotic medications or suggestion of symptoms of illnesses such as attention-deficit/hyperactivity disorder.

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Disorders of motor activities

Induced movements

i)Automatic obedience - subject does whatever is asked of him or her, robotically obeying a command without question or concern.

ii)ambitendency - alternating cooperation and opposition; the patient makes a movement, but before completing it, starts the opposite movement

Disorders of motor activities

iv) Forced grasping - the offered hand is repeatedly grasped and shaken, despite requests not to do so

vi)Excitement - non goal-directed overactivity, sometimes repetitive or violent

- *seen in frontal lobe lesions*

Disorders of motor activities

Tics: Rapid irregular movements involving groups of facial or limb muscles

Mannerisms : Abnormal & occasional bizarre performance of goal-directed activity

Stereotypy : A negative & bizarre performance; Not goal-directed

Catalepsy: General term for an immobile position that is constantly maintained

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Disorders of motor activities

- Posturing :Assumption of various abnormal bodily positions for along time (*Psychological pillow)*

- *Negativism: Patient resists carrying out the examiners' instructions & his attempts to move or direct the limbs*

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Disorders of motor activities

- Echopraxia : Imitation of another persons movements
- Abulia: Reduced impulses to act or think; associated with indifferences about the consequences of action.The individual is unable to act or make decisions independently.
- Akinesia: Inability to move
- Akathisia: inability to sit/stand still

Catatonia

- a predominantly motor disorder thought to be related to affective disorder may be found as part of chronic schizophrenia and occasionally in organic cerebral disorders
- The core features are:
- posturing , stereotypy , waxy flexibility.
- other symptoms include: ambitendency ,echolalia, echopraxia, mannerism , excitement and negativism.

Clinical Implications

- **Excessive body movement (Agitation): Anxiety, mania, stimulant abuse**
- **Psychomotor retardation: Depression, organicity, catatonic , drug- induced stupor**
- **Tics/grimaces : S/E of Psychotropic Medications**
- **Repeated movements: OCD**
- **Picking up of dirt from clothes: Delirium, Drug-toxicities**

SPEECH AND LANGUAGE

- Fluency of speech
- rate
- Volume
- amount
- Tone
- Content of speech

SPEECH

Fluency can refer to whether the patient has full command of the English language as well as potentially more subtle fluency issues such as stuttering, word finding difficulties, or paraphasic errors.

The evaluation of the amount of speech refers to whether it is normal, increased, or decreased. Decreased amounts of speech may suggest several different things ranging from anxiety or disinterest to thought blocking or psychosis. Increased amounts of speech often (but not always) are suggestive of mania or hypomania. A related element is the speed or rate of speech. Is it slowed or rapid (pressured)? Finally, speech can be evaluated for its tone and volume.

Disorders of Speech

- **Pressure of speech : Rapid speech that is increased in amount, difficult to interpret and Interrupt**
- **Poverty of speech : Restriction in the amount of speech**
- **Dysprosody: Loss of normal speech melody**
- **Dysarthria: Difficulty in articulation**
- **Stuttering: Frequent repetition/ prolongation of a sound/syllable leading to markedly impaired speech fluency**
- ***Clang associations:* vague connections prompted by rhyme and sounds of words**
- ***Echolalia* : *words or phrases are imitated***
- ***logoclonia - perseveration of the last syllable of the last word . seen in organic disorders and occasionally in catatonia***
- ***palilalia - perseverated word is repeated with increasing frequency***

Clinical implications

- **Speech expressive problems : Brain involvement, developmental problems**
- **Pressure of speech : Mania**
- **Mutism/Alogia : Depressive Sx/Catatonic**

Mood and Affect

Mood

Mood is defined as the patient's internal and sustained emotional state. It’s experience is subjective, and hence it is best to use the patient's own words in describing his or her mood. Terms such as "sad," "angry," "guilty," or "anxious" are common descriptions of mood.

Range: depression – euthymic – euphoria. Inability to enjoy activities (anhedonia)
Inability to describe one’s emotion (alexithymia)
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Affect

Affect differs from mood in that it is the expression of mood or what the patient's mood appears to be to the clinician. Affect is often described with the following elements: quality, range, lability, appropriateness, and congruence.

Terms used to describe the quality of a patient's affect include dysphoric, happy, euthymic, irritable, angry, agitated, tearful, sobbing....

Range of Affect: normal, restricted, blunted and flat

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Affect

Appropriateness of affect refers to how the affect correlates to the setting. A patient who is laughing at a solemn moment of a funeral service is described as having inappropriate affect.

Affect can also be congruent or incongruent with the patient's described mood or thought content. A patient may report feeling depressed or describe a depressive theme but do so with laughter, smiling, and no suggestion of sadness.

Mood vs. Affect

Mood Subjective Pervasive & sustained emotion, it is not influenced by will, & is strongly related to values	Affect Objective (noted by the examiner) immediate experience associated to ideas or mental representations of objects
Sadness, aggression, Joyous etc	Classified as blunted, flattened, broad, labile, appropriate & congruent

Thought Content

Thought content is essentially what thoughts are occurring to the patient. This is inferred by what the patient spontaneously

expresses, as well as responses to specific questions aimed at eliciting particular pathology. Some patients may perseverate or ruminate on specific content or thoughts. They may focus on material that is considered obsessive or compulsive. Obsessional thoughts are unwelcome and repetitive thoughts that intrude into the patient's consciousness. They are generally ego dystonic and resisted by the patient. Compulsions are repetitive, ritualized behaviors that patients feel compelled to perform to avoid an increase in anxiety or some dreaded out come.

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Definitions

Ego-syntonic refers to instincts **or** ideas that are acceptable to the self; are compatible with one's values **and** ways of thinking

Ego-dystonic or ego alien refers to thoughts, impulses, **and** behaviors that are felt to be repugnant, distressing, unacceptable **or** inconsistent with one's self-concept.

Thought Content

1. Preoccupations
2. Delusions: Fixed false unshakable belief, which is out of keeping, not culturally determined or shared with a large group of people, divided into bizarre and non-bizarre .Questions that can be helpful include, "Do you ever feel like someone is following you or out to get you?" and "Do you feel like the TV or radio has a special message for you?"

3. Overvalued ideas: Ideas which are reasonable and understandable in themselves but which come to unreasonably dominate the patient's life.

4.Suicidal ideation

5. Homicidal Ideation

6. Phobias: an excessive fear of a specific object, circumstance, or situation with the development of intense anxiety, even to the point of panic, when exposed to the feared object.

7. Obsession (ego dystonic)

Types of Delusions

1. Delusions of persecution: being followed, harassed, threatened, or plotted against.

2. Delusions of grandeur: being influential and important, perhaps having occult powers, or actually being some powerful figure out of history (Napoleonic complex).

3. Delusions of reference: external events have personal significance, such as special messages or commands.

Types of Delusions

4-Delusions of love(Erotomania) characterized by the patient's conviction that another person is in love with him or her despite contrary evidence. The object of the affection is typically an older, inaccessible person with a higher social status who may have had little or no previous contact with the deluded person.

5- Delusions of guilt :A delusional belief that one has committed a crime or other reprehensible act. (*psychotic Depression)*

6- Delusions of control: The core feature is the delusional belief that one is no longer in sole control of one's own.

Types of Delusions

7-Hypochondriacal/somatic delusions founded on the conviction of having a serious disease.

8-Delusional jealousy:A delusional belief that one's partner is being unfaithful (Othello syndrome)

9-Delusional misidentification:A delusional belief that certain individuals are not who they externally appear to be.The delusion may be that familiar people have been replaced with outwardly identical strangers (*Capgras syndrome) or that strangers are (really) familiar people (Fraegoli syndrome)*.

Types of Delusions

10-Delusions of thought interference:. A group of delusions which are considered first- rank symptoms of schizophrenia. They are thought insertion, thought withdrawal, and thought broadcasting

11-Nihilistic delusion: A delusional belief that the patient has died or no longer exists or that the world has ended or is no longer real. Nothing matters any longer and continued effort is pointless. A feature of psychotic depressive illness

Thought Process

Thought process differs from thought content in that it does not describe what the person is thinking but rather how the thoughts are formulated, organized, and expressed. A patient can have normal thought process with significantly delusional thought content. Conversely, there may be generally normal thought content but significantly impaired thought process. Normal thought process is typically described as linear, organized, and goal directed.

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Thought Process

With flight of ideas, the patient rapidly moves from one thought to another, at a pace that is difficult for the listener to keep up with, but all of the ideas are logically connected. The circumstantial patient over includes details and material that is not directly relevant to the subject or an answer to the question but does eventually return to address the subject or answer the question. The tangential thoughts are seen as irrelevant and related in a minor, insignificant manner. Loose thoughts or associations differ from circumstantial and tangential thoughts in that with loose thoughts it is difficult or impossible to see the connections between the sequential content. Perseveration is the tendency to focus on a specific idea or content without the ability to move on to other topics. The perseverative patient will repeatedly come back to the same topic despite the interviewer's attempts to change the subject.

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Thought Process

Thought blocking refers to a disordered thought process in which the patient appears to be unable to complete a thought. The patient may stop midsentence or midthought and leave the interviewer wait ing for the completion. When asked about this, patients will often remark that they don't know what happened and may not remember what was being discussed.

Neologisms refer to a new word or condensed combination of several words that is not a true word and is not readily understandable, although some times the intended meaning or partial meaning may be apparent. Word salad is speech characterized by confused, and often repetitious, language with no apparent meaning or relationship attached to it.

Disorders of Thought process

1-Thought blocking: The patient experiences a sudden break in the chain of thought (*Schizophrenia)*.

2-Flight of ideas: A series of thoughts verbalized rapidly with abrupt shifts of subject matter with logical sequence. (Mania as well as in organic mental disorders), the logical connection between ideas is retained , associated with pressured speech always

3. Derailment: Thoughts slides on to a subsidiary content

4. Loosening of associations: A disorder of thinking & speech in which ideas shift from one subject to another with remote or no apparent reasons. Logical connection is lost.

5-. Perseveration: Repetitive behavior or repetitive expression of a particular word, phrase, or concept during the course of speech.

6- Circumstantiality: The determining tendency is maintained but the patient can reach the goal only after having exhaustively explored all unnecessary associations arising in his mind.

Disorders of Thought process

7-Tangentiality: expressions or responses characterized by a tendency to digress from an original topic of conversation, in which a common word connects two unrelated thoughts. Never reaching the point.

8- Echolalia : repeating the statements of the examiner, occurs in catatonia as well as certain neurological disorders

9- Neologism : The use of novel vocabulary, made up by the patient .

10- word salad: incoherent speech.

11- Clang associations:Thoughts are associated by the sound of words rather than by their meaning (e.g., through rhyming).

Clinical implications

- Circumstantiality: Defensiveness, paranoid thinking , Schizophrenia/ psychotic disorders
- Loosening of association : Schizophrenia/psychotic disorders
- Perseveration : Brain damage
- Word salad : Severe form of thought disintegration : Chronic psychotic illness

Perceptual Disturbances

Perceptual disturbances include hallucinations, illusions, depersonalization, and derealization.

Hallucinations are perceptions in the absence of stimuli to account for them. Auditory hallucinations are the hallucinations most frequently encountered in the psychiatric setting. Other hallucinations can include visual, tactile, olfactory, and gustatory (taste). non auditory hallucinations are often clues that there is a neurological, medical, or substance withdrawal issue rather than a primary psychiatric issue.

Perceptual Disturbances

In describing hallucinations the interviewer should include what the patient is experiencing, when it occurs, how often it occurs, and whether or not it is uncomfortable (ego dystonic). In the case of auditory hallucinations, it can be useful to learn if the patient hears words, commands, or conversations and whether the voice is recognizable to the patient.

Illusions : misperceptions of external stimuli. Ex: Hearing the wind rustle through the trees outside one's bedroom and thinking a name is being called is an illusion.

Depersonalization is defined as the persistent or recurrent feeling of detachment or estrangement from one's self. The individual may report feeling like watching himself or herself in a movie. Derealization is somewhat related and refers to feelings of unreality or of being detached from one's environment. The patient may describe his or her perception of the outside world as lacking lucidity and emotional coloring, as though dreaming or dead .

Misperceptions

- Illusions : misperceptions of external stimuli
- Hallucinations : sensory experience in the absence of a stimulus-various types : auditory (2nd, 3rd) visual gustatory, olfactory (organic, TLE), tactile (cocaine addiction, drug withdrawals)

  Pseudo-hallucinations

  Hypnopompic/hypnogogic hallucinations

  Functional/Reflex hallucinations

  Extracampine hallucination

Depresonalization/ Derealization

Hallucinations

- perceptions which arise in the absence of any external stimulus
- a false perception which is not in any way a distortion of a real perception but which springs up alongside it
- characteristics:

  1. Unwilled
  2. not subject to conscious manipulation has the same qualities of a real perception, i.e. vivid, solid
  3. perceived as being located in the external world

Auditory hallucinations

must be experienced as coming from outside the self

- *simple (sounds)*
- *complex (voices)*
- *musical - brain/ ear disease*

1.Audible thoughts-Thought Echo- (1st person) Hearing thought spoken aloud (thoughts are spoken just afterwards)

2. Second Person AH (addressing the pt. Directly = you)

person hears voices taking directly to them (can be persecutory, highly critical , complementary or command hallucinations) 2nd person hallucinations commonly found in psychotic depression

3. Third Person Hallucinations (Voices heard arguing)

a)the patient usually features in the third person in the content, referring to the pt. As he/she

b)Voices giving a commentary, may occur just before, during, or after the patient's actions

Visual Hallucinations

- strong correlation between presence of visual hallucinations and eye pathology
- can occur simultaneously with auditory hallucinations in temporal lobe epilepsy
- very uncommon in schizophrenia –

Visual Hallucinations

Visual

- *simple (flashes of light) - organic disease*
- *complex (objects, animals, people)*
- *Lilliputian•abnormal perception of objects shrunken in size, but normal in detail*

associations with:

•occipital lobe tumors

•loss of color vision

•homonymous hemianopia

• dyslexia

•cortical blindness•can occur in:

•post-concussional state•epileptic twilight states •hepatic failure

•Alzheimer's disease

•senile dementia

•multi-infarct dementia

•Pick's disease

•Huntington's chorea

Olfactory hallucinations

- *often associated with powerful emotions*
- *usually has a special or personal significance*

Gustatory hallucinations

- *occur in: 1• schizophrenia 2•temporal lobe epilepsy 3•lithium carbonate 4• disulfiram*

Tactile Hallucinations

Pseudohallucinations

- Not perceived by the actual sense organs, but experienced as emanating from within the mind
- they are a form of imagery
- characteristics:

although vivid, they lack the substantiality of normal perception

located in subjective, rather than objective space

unwilled, and not subject to conscious control or manipulation

retention of insight

not pathognomonic of any mental illness occur in

:• depression •obsessional states • hysteria •personality disorder •times of life crisis, e.g. bereavement - *hallucinations of widowhood; tend to be reassuring rather than frightening*

Other Types of Hallucinations

- **Autoscopic hallucination:** Experience of seeing ones own body projected in to external space, usually in front of oneself, for short periods
- ***Negative autoscopy*** *is the experience of looking into a mirror and seeing nothing at all*
- ***Reflex hallucination****: A stimulus in one sensory modality results in hallucination in another.....music-----visual hallucination –synesthesia-*
- ***Extracampine*** *(Concrete Awareness)*

  •hallucinations experienced outside of the normal sensory field, e.g. "he'sright behind me walking everywhere I go" •not of diagnostic importance

  •occur in:1 • schizophrenia 2• epilepsy 3•organic states 4•hypnagogic hallucinations in healthy people

Functional

  •hallucinations that are generated in the presence of an unrelated external stimulus of the same modality (usually auditory)

  •can occur in schizophrenia

Other Types of Hallucinations

Hypnogogic *(going to sleep) &* ***Hypnapompic*** *(on waking) hallucinations occur at either end of the sleep period*

- *can be visual or auditory*

- *associated with:*

1.healthy people 2. toxic states (e.g. fever, glue-sniffing) 3. post-infective depressive states 4. phobic anxiety neuroses 5. Narcolepsy

Clinical Implications

- **Any form of hallucinations: Schizophrenia (72% AH), affective disorders**
- **Visual hallucinations Suggestive of organic mental disorders**
- **Gustatory, olfactory, and tactile hallucinations: Strongly suggest organic mental disorders.**
- **Tactile hallucinations: Common in drug and alcohol withdrawal and intoxication states**

Cognition

The elements of cognitive functioning that should be assessed are alertness, orientation, concentration, memory (both short and long term), calculation, fund of knowledge, abstract reasoning, insight, and judgment.

Note should be made of the patient's level of alertness. The amount of detail in assessing cognitive function will depend on the purpose of the examination and also what has already been learned in the interview about the patient's level of functioning, performance at work, handling daily chores, balancing one's checkbook, among others. In addition the psychiatrist will have already elicited data concerning the patient's memory for both remote and recent past. A general sense of intellectual level and how much schooling the patient has had can help distinguish intelligence and educational issues versus cognitive impairment that might be seen in delirium or dementia.

Cognition

1 . Alertness (Observation)

2. Orientation: What is your name? Who am I? What place is this? Where is it located?What city are we in?

3. Concentration : Starting at 100, count backward by 7(serial 7 test). Name the months of the year backward starting with December.

4. Memory:
Immediate : Repeat these numbers after me: 1, 4, 9, 2, 5.

Recent: What did you have for breakfast? What were you doing before we started talking this morning? I want you to remember these three things: a yellow pencil, a tree, and a dog. After a few minutes I'll ask you to repeat them.

Long term: What was your address when you were in the third grade? Who was your teacher? What did you do during the summer between high school and college?

5. Calculations: If you buy something that costs $3.75 and you pay with a $5 bill, how much change should you get? What is the cost of three oranges if a dozen oranges cost $4.00?

6. Fund of knowledge

7. Abstract reasoning: Which one does not belong in this group: a pair of scissors, a hammer, and a spider? Why?. Proverb interpretation and similarity identification.

Abstract Reasoning

Abstract reasoning is the ability to shift back and forth between general concepts and specific examples. Having the patient identify similarities between like objects or concepts (apple and pear, bus and airplane, or a poem and a painting) as well as interpreting proverbs can be useful in assessing one's ability to abstract. Cultural and educational factors and limitations should be kept in mind when assessing the ability to abstract.

- Inability to abstract: concrete thinking

Cognition

- **G**eneral: Alertness and Co-operation
- **O**rientation: Time and Place
- **A**ttention: WORLD backwards and Serial Sevens
- **L**anguage: Naming and Repetition
- **C**alculation: Division and Subtraction
- **R**ight Hemisphere Function: Intersecting pentagons and Clock-face
- **A**bstraction: a conceptualization of ideas beyond the most obvious , concrete meaning of words. To make connections between words. (Proverbs and Similarities)
- **M**emory: Registration/ immediate recall, STM and Long- term memory
- **P**raxis:The ability to perform previously learned purposeful movements . Wave good-bye and Comb hair .

Insight

- **Insight § Patients awareness of his disability & need for help**

- **Awareness of disease:**
Do you consider that you are ill in any way?Why have you come into hospital? Do you have a physical or a mental illness? If you have a mental illness, what is it?

- **Correct labelling of abnormality:**
You described several symptoms.....namely....
What is your explanation of these experiences?

Insight

- ***Willingness to take treatment:***
- How do you feel about being in hospital…..? Coming to the clinic….? How do you feel about taking medication? Has the medication been helpful? Have any other treatments been helpful? Do you think that medication helps you to remain well?
- ***Hospitalization if needed***

- ***Side effects of medications***

Insight

The patient may have no insight, partial insight, or full insight

- **Clinical grading of Insight**

1. Completed denial of illness

2. Slight awareness of being sick & needing help but denying at the same time

3.Awareness of being sick, but attributed to external/ physical cause

4. Awareness of being sick due to something unknown in self

The amount of insight is not an indicator of the severity of the illness. A person with psychosis may have good insight, while a person with a mild anxiety disorder may have little or no insight.

Insight

Impaired in delirium, dementia, frontal lobe syndrome, psychosis, borderline intellectual functioning.

Judgement

Judgement refers to the person's capacity to make good decisions and act on them. The level of judgement may or may not correlate to the level of insight. A patient may have no insight into his or her illness but have good judgement. It has been traditional to use hypothetical examples to test judgement, for example, " What would you do if you found money on the sidewalk?" It is better to use real situations from the patient's own experience to test judgement. The important issues in assessing judgement include whether a patient is doing things that are dangerous or going to get him or her into trouble and whether the patient is able to effectively participate in his or her own care. Significantly impaired judgement can be cause for considering a higher level of care or more restrictive setting such as inpatient hospitalization.

Judgement

- Involves weighing and comparing the relative values of different aspects of an issue. By comparing pros and cons and then concluding the way a rational person would in such circumstances .

Judgement

Impaired in brain disease, schizophrenia, severe depression, intellectual disability, intoxication.

The End