Introduction

- Mental disorders are characterized by abnormalities in thoughts, perceptions, mood, and behavior that deviate from a socially defined norm enough to impair social functioning. So, psychopathology is the study of these deviations, the symptoms and signs of mental disorders, their etiology, and their pathogenesis.
- **Culture:** the enduring behaviors, ideas, attitudes, and traditions shared by a large group of people and transmitted from one generation to the next
- **Norm:** an understood rule for accepted and expected behavior

General issues - Symptoms of Psychiatric illness

- In general medicine, symptom refers to an abnormality reported by the patient, while sign refers to an abnormality detected by the doctor by observation or clinical examination. In psychiatry, the terms symptom and sign tend to be used synonymously because abnormalities of mental state can only be elicited by exploring, with the patient, their internal experiences.
- **Endogenous vs. reactive:** These terms have been largely made outmoded by developments in understanding of mental disorders, but are still seen occasionally. It was formerly thought that some conditions arose in response to external events (e.g. depression arising after job loss) (reactive), while others arose spontaneously from within (endogenous).
- **Psychotic vs. neurotic:** in present classifications these terms are used purely descriptively to describe two common types of symptoms that may occur in a variety of mental disorders. Previously, they were used to distinguish those disorders characterized by impairment of insight, abnormal beliefs, and abnormal perceptual experiences from those where there was preserved insight but abnormal affect.
- **Structural vs. functional:** A distinction formerly made between those brain disorders with observable structural abnormalities on post-mortem (e.g. Alzheimer's disease) and those without (e.g. schizophrenia). This usage has diminished since the discovery of definite observable brain changes in those disorders formerly called (functional psychoses). Nowadays, the term is more often used in neurology/neuropsychiatry to distinguish syndromes which generally have abnormal investigation findings (e.g. multiple sclerosis) from those without (e.g. conversion paralysis).

Cultural Variations in Psychopathology

- Symptoms are similar in their form in widely different cultures. However there are cultural differences in the symptoms which revealed to doctors; depression in eastern countries report more somatic complaints than western people as they report more mood symptoms. In some countries the effects of psychiatric disorders are ascribed to witchcraft and ghosts while in more civilized countries are not.
- In some cultures mental disorders are stigmatized and make patients burden more.

Disturbances of Mood & Affect

**Mood**

- The subjective experience of feeling or emotion as described by the patient in the history. Mood is a pervasive and sustained emotion, is not influenced by will, and is strongly related to values. It is distinct from **Affect** (which is a feeling state noted by the examiner during the mental status examination).
- The principal but not the only domain of symptoms in mood disorders is the extent and type of mood deviation. Although there are no sharp boundaries between the normal variations and pathological states of mood, the severe states are clearly abnormal and difficult to empathize. Mood can be abnormal in several ways:
- **Euthymic**: normal range of mood.
- **Dysphonic**: unpleasant mood.
- **Depression**: psychopathological feeling of sadness.
- **Anhedonia**: loss of interest in, and withdrawal from all pleasurable activities, often associated with depression.
- **Alexithymia**: inability to, or difficulty in, describing or being aware of emotions or mood.
- **Expansive**: a person’s expression of feelings without restraint.
- **Irritable**: a state a person is easily annoyed and provoked to anger.
- **Labile**: oscillation between euphoria and depression.
- **Elevated**: air of confidence and enjoyment, mood more cheerful than normal.
- **Euphoria**: intense elation with felling of grandeur.
- **Elation**: felling of joy, euphoria, triumph, intense self-satisfaction and optimism.
- **Hypomania**
- **Mania**: mood state characterized by elation, agitation, hyperactivity, hypersexuality, and accelerated thinking and speaking.
- **La belle indifference**: in appropriate attitude of calm or lack of concern about one’s disability.
- **Emotional incontinence**: extreme variation in emotion

### Disturbances of Affect

1. Appropriate
2. Inappropriate
3. Restricted
4. Flat
5. Blunted
6. Labile

### Disturbances of Perception

Perception is a complex process which is not restricted to the screening of physical signals by sense organs but implies the processing of these data to represent reality.

**Imagery**: is the awareness of a percept that has been generated within the mind. Imagery can be called up and terminated by an effort of will (voluntary).

**Illusion**

- Illusions are misperceptions of external stimuli or a type of false perception in which the perception of a real world object is combined with internal imagery to produce a false internal percept.
- They occur when the general level of sensory stimulation is reduced and when attention is not focused on the relevant sensory modality.
- Also occur in anxiety and delirium.

**Hallucination**

- A false sensory perception of something that is not there i.e. in the absence of external real stimuli.
- An Illusion differs in being a perceptual distortion of something that is there.
- A true hallucination will be perceived as in external space, distinct from imagined images, outside conscious control, and as possessing relative permanence. A pseudo-hallucination will lack one or all of these characteristics.
- A hallucination is not always a sign of psychosis.
Hallucinations are sub-divided according to their modality of sensation and may be:

1. **Auditory hallucinations**: false perceptions of sounds (voices, music, buzzing, motor noises, murmuring). (second person, third person)
2. **Gustatory hallucinations**: false perceptions of taste.
3. **Olfactory hallucinations**: false perceptions of smell.
4. **Visual hallucinations**: false visual perceptions with eyes open in a lighted environment. (Visual images with the eyes closed are not true hallucinations.
5. **Tactile hallucinations**: false sensations of touch. (usu. assoc. w/ a delusion consistent w/ the sensation.)
   - **Formication**: a particular type of tactile hallucination, is the sensation of bugs crawling on or under skin.
   - **Hypnagogic and hypnopompic** hallucinations—images experienced during the “twilight” stages while falling asleep and waking up, respectively—are not true hallucinations.
   - All of the above hallucinations can occur in schizophrenia, affective disorders, & organic mental disorders. Visual hallucinations are suggestive of organic mental disorders but are seen in functional disorders. Gustatory, olfactory, and tactile hallucinations strongly suggest organic mental disorders. Tactile hallucinations are common in drug and alcohol withdrawal and intoxication states.
   - **Autoscopic hallucination**: is the experience of seeing one’s own body projected in to external space, usually in front of oneself, for short periods…..near death experience???
   - **Reflex hallucination**: a stimulus in one sensory modality results in hallucination in another…..music-----visual hallucination.

**Disturbances of Thought**

Thinking is goal directed flow of ideas, symbols, and associations initiated by a problem or task and leading toward a reality-oriented conclusion.

**Types of thinking:**

1. **Fantasy thinking** (also called autistic thinking) produces ideas which have no external reality. This process can be completely non-goal-directed, even if the subject is to some extent aware of the mood, affect, or drive which motivates it.
2. **Rational** (conceptual) thinking attempts to resolve a problem through the use of logic, excluding fantasy. The accuracy of this endeavour depends on the person's intelligence, which can be affected by various disturbances of the different components involved in understanding and reasoning.
3. **Imaginative** thinking can be located between the fantasy thinking and rational thinking. It is a process of forming a representation of an object or a situation using fantasy but w/o going beyond rational & possible.

**Disturbances in form of thought**

1. **Neologism**: new words created by a patient.
2. **Word salad**: incoherent mixture of words and phrases.
3. **Circumstantiality**: indirect speech that is delayed in reaching the point but eventually gets from original point to desired goal.
4. **Tangentiality**: in ability to have goal-directed associations of thought; never gets from point to desire goal.
5. **Perseveration**: persisting response to a previous stimulus after a new stimulus have been presented.
6. **Verbigeration**: meaningless repetition of words or phrases.
7. **Echolalia**: psychopathological repetition of words or phrases of one person by another person.
8. **Irrelevant answer
9. **Loosening of association**: flow of thought in which ideas shift from one subject to another in a completely unrelated way.
10. **Flight of ideas**: rapid, continuous verbalizations or plays on words produce constant shifting from idea to another, ideas tend to be connected.
11. **Clang association**: association of words similar in sound but not in meaning.
12. **Blocking**
13. **Glossolalia**: private spoken language.
Disturbances in content of thinking

1. **Poverty**: A form of abnormal belief. These are ideas which are reasonable and understandable in themselves but which come to unreasonably dominate the patient's life.

2. **Overvalued ideas**: An abnormal belief which is held with absolute subjective certainty, which requires no external proof, which may be held in the face of contradictory evidence, and which has personal significance and importance to the individual concerned. Excluded are those beliefs which can be understood as part of the subject's cultural or religious background. While the content is usually demonstrably false and bizarre in nature, this is not invariably so. Types of delusions (contents):
   - **Delusions of persecution**, i.e., being followed, harassed, threatened, or plotted against.
   - **Delusions of grandeur**, i.e., being influential and important, perhaps having occult powers, or actually being some powerful figure out of history (Napoleonic complex).
   - **Delusions of reference**, i.e., external events or “portents” have personal significance, such as special messages or commands. A person with delusions of reference believes that strangers on the street are talking about him or her, the television commentator is sending coded messages, etc.
   - **Delusions of love**: characterized by the pt's conviction that another person is in love w/ him or her.
   - **Delusions of guilt**: A delusional belief that one has committed a crime or other reprehensible act. A feature of psychotic depressive illness.
   - **Delusions of control**: The core feature is the delusional belief that one is no longer in sole control of one's own body. The individual delusions are that one is being forced by some external agent to feel emotions, to desire to do things, to perform actions, or to experience bodily sensations. (types: withdrawal, insertion, broad casting)
   - **Hypochondriacal delusions**: founded on the conviction of having a serious disease.
   - **Delusional jealousy**: A delusional belief that one's partner is being unfaithful (Othello syndrome)
   - **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). A rare symptom of schizophrenia or of other psychotic illnesses.
   - **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.
   - **Folie à deux (“madness for two”)**: A disorder characterized by the sharing of delusional (usually persecutory) ideas by two or more (folie à plusieurs) individuals living in close association, usually in a family relationship. One member of the pair (or group) seems always to influence and dominate the other(s). The delusional ideas may lead to strange types of behavior such as preparing for the end of the world
   - **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
   - **Pseudologica fantastica**: a type of lying in which a person appears to believe in the reality of his fantasies and act on them.

3. **Obsession**: Recurring ideas, images, or wishes that dominate thought. The content may be unacceptable and actively resisted but intrudes into consciousness again and again. A feature of obsessive-compulsive disorder and some cases of schizophrenia.

5. **Compulsion**: A behavior or action which is recognised by the patient as unnecessary and purposeless but which he cannot resist performing repeatedly (e.g. hand washing).

6. **Phobia**: A particular stimulus, event, or situation which arouses anxiety in an individual and is therefore associated with avoidance.

7. **Hypochondriasis**: The belief that one has a particular illness despite evidence to the contrary. Its form may be that of a primary delusion, an overvalued idea, a rumination, or a mood congruent feature of depressive illness.
Motor Symptoms & Signs

Motor symptoms and signs may be due to a neurological disorder causing organic brain syndrome, such as rigidity in Parkinson's disease, or may be related to emotional states such as restlessness or tremor in anxiety. However, there is a further group of symptoms which affect voluntary movements and often occur in functional psychoses. These symptoms are neither unequivocally neurological nor clearly psychogenic in origin and are termed motility disorder by some authors.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
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<tbody>
<tr>
<td>Tics</td>
<td>are rapid irregular movements involving groups of facial or limb muscles.</td>
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<tr>
<td>Mannerism</td>
<td>abnormal and occasionally bizarre performance of a voluntary, goal-directed activity (e.g. a conspicuously dramatic manner of walking).</td>
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<td>Stereotypy</td>
<td>a repetitive and bizarre movement which is not goal directed (in contrast to mannerism). The action may have delusional significance to the patient. Seen in schizophrenia.</td>
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<tr>
<td>Catatonia</td>
<td>a syndrome characterized by cataleptic posturing, stereotypy, mutism, stupor, negativism, automatic obedience, echolalia, and echopraxia. There are two subtypes: excited and retarded. The excited subtype is characterized by dramatic increases in motor behavior, occasionally to the point of physical collapse; the retarded subtype is characterized by slowed motor behavior, occasionally to the point of immobility.</td>
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<tr>
<td>Catalepsy</td>
<td>a rare motor symptom of schizophrenia. Describes a situation in which the patient's limbs can be passively moved to any posture which will then be held for a prolonged period of time. Also known as waxy flexibility or flexibilitas cerea. (psychological). pillow.</td>
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<td>Posturing</td>
<td>the assumption of various abnormal bodily positions, often a feature of catatonia.</td>
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<td>Negativism</td>
<td>a motor symptom of schizophrenia where the patient resists carrying out the examiners' instructions and his attempts to move or direct the limbs.</td>
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<td>Echopraxia</td>
<td>Imitation of another person's movements. (Echolalia and echopraxia are seen in pervasive developmental disorders, organic mental disorders, catatonia, and other psychotic disorders.)</td>
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<tr>
<td>Ambitendency</td>
<td>series or uncertain, incomplete movements carried out when a voluntary action is anticipated.</td>
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Disorders of Memory

- Memory may be differentiated into short-term or recent memory and long-term or remote memory. Furthermore, ultra-short-term memory may be distinguished from short-term memory. Ultra-short-term memory encompasses immediate registration within the span of attention. Short-term memory reflects new learning. Long-term memory is usually associated with earlier data or other information that has been stored for months or years.

- **Amnesia:** is a period of time which can’t be recalled & it may be global or partial. w/ regard to time it may be:
  1. **Retrograde amnesia:** an expression derived from the idea that one is looking backwards from an event (e.g.: brain trauma or electroconvulsive therapy) to find period before the event to be deleted.
  2. **Anterograde amnesia:** means a period of deleted memory after an event. Although it is difficult to distinguish between types of amnesia, focal lesions in the hippocampus seem to affect remote memory less than recent memory, whereas diffuse brain disease often affects both. In psychogenic amnesia it is sometimes possible to recognize specific personal meaning in the events which cannot be recalled.

- Some patients are aware of memory disorder and complain about it; others tend to neglect their memory deficits and manifest secondary signs such as confabulations. **Confabulations** are inventions which substitute for missing contents in gaps of memory; the patient is not aware that they are not true memories.

- **Déjà vu:** a sense that events being experienced for the first time have been experienced before. An everyday experience but also a non-specific symptom of a number of disorders including temporal lobe epilepsy, schizophrenia, and anxiety disorders.

- **Jamais vu:** the sensation that events or situations are unfamiliar, although they have been experienced before. An everyday experience but also a non-specific symptom of a number of disorders including temporal lobe epilepsy, schizophrenia, and anxiety disorders.

Disorders of Consciousness

- **Consciousness:** is awareness of self and environment.
- **Coma:** is the most extreme form of impaired consciousness, the patient show no external evidence of mental activity and little motor activity other than breathing.
- **Clouding of consciousness:** conscious level between full consciousness and coma. Covers a range of increasingly severe loss of function with drowsiness and impairment of concentration and perception.
- **Stupor:** a condition where a person is immobile, mute, and unresponsive, but appears to be fully conscious because the eyes are open and follow the movement of external objects.
- **Confusion:** The core symptom of delirium or acute confusional state. There is disorientation, clouding of consciousness & deterioration in ability to think rationally, lay down new memories, & to understand sensory input.
- **Twilight state:** is a well-defined interruption of the continuity of consciousness. Consciousness is clouded and sometimes narrowed. Despite the disorder of consciousness the patient is able to perform certain actions, such as dressing, driving, or walking around. Subsequently, there is amnesia for this state. Twilight states may occur in epilepsy, alcoholism, brain trauma, general paresis, and dissociative disorder.
- **Oneiroid state:** the patient experiences narrowing of consciousness together with multiple scenic hallucinations. Oneiroid states may occur in schizophrenia, but are also observed in patients under intensive care who have to be totally passive and dependent on others. The atmosphere is perceived as strange and dreamlike. Accordingly patients may be aloof and behave like dreamers. Unlike twilight states, the contents of oneiroid states are often remembered.

- Finally, it should be noted that subconscious of psychoanalytical theory is not open to direct clinical exam.

Insight

- The clinical assessment of a patient's capacity to understand the nature, significance, and severity of his or her own illness has been called insight. Insight is composed of three overlapping dimensions: the ability to relabel unusual mental events as pathological, the recognition that one has mental illness, and compliance with treatment.