Chapter 9: Psychopathology and Phenomenology

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Introduction

This chapter aims to provide an account of the psychopathology and phenomenology of the psychiatric disorders that you are most likely to encounter as a medical student. It contains both essential knowledge for your training as a doctor and that which you may need once you have qualified. In other words, it is more comprehensive than what you require for your psychiatry attachment, but it will be useful, beyond this time, in your clinical practice as a physician. The chapter comprises several sections that address different themes. Within these sections, important terms are given primacy and others are usually listed alphabetically for ease of reference.

The essence of psychiatry is the exploration of the subjective experiences of individuals with mental disorders. An appreciation of what people are thinking and how they are feeling enables a more nuanced empathetic understanding of

distress and its diverse manifestations. Other chapters in this book discuss psychiatric history-taking (anamnesis), mental state examination (MSE) and formulation with a view to developing a management plan. To achieve this, the first step is to elicit the signs and symptoms that contribute to a diagnosis of a psychiatric disorder. This requires phenomenological knowledge and the ability to identify psychopathology.

Psychopathology refers to deviations in mental states, processes, and experiences, and it entails the systematic study of abnormal experiences, thoughts and behaviours. In other words, it is the study of the 'products' of the disordered mind (Sims, 1995: Page 1.). Psychopathology can be examined from three perspectives: *experimental* (biological aspects), *experiential* (phenomenological aspects), and *explanatory* (psychological factors), however in practice, it is useful to regard it as having two main components:

1. The empathic appraisal of subjective experience and,
2. The observation of behaviour.

The latter requires careful attention and involves more than merely counting symptoms. It also necessitates objectivity.

To assess the subjective experience of an individual the clinician needs to make use of ***empathy***. However, it is important not to confuse this with ***sympathy***, which is the relational resonance we have with someone else's experience. In contrast, empathy is a concept within descriptive psychopathology that is used to gain insight and assess another person's internal mental state. It draws on the observer's capacity for cognition and emotional experiences, and these are used as a comparative measure. Typically, it involves the psychiatrist questioning the patient until they are able to create a sense of the patient's subjective internal experience. This is then relayed to the patient and through successive iteration the experience is accurately captured.

Psychopathology is a broad term that encompasses all abnormal experiences, and within this, ***descriptive psychopathology*** specifically characterises and categorises those experiences that are described by the patient and observed in their behaviour.

Karl Jaspers (1883-1969) is widely regarded as the father of descriptive psychopathology, even though he was inspired in much of his thinking by the philosopher Edmund Husserl. Jaspers was a psychiatrist as well as being a philosopher. Both he and Husserl believed that the direct investigation of mental phenomena and their atheoretical description, without aetiological exploration, provided deep understanding. Therefore, in keeping with this approach, the signs

and symptoms of mental disorders should be defined purely on the basis of description. In other words, in the absence of any assumptions about aetiology and potential consequences.

Phenomenology is the study of the framework of consciousness – specifically, as it is experienced from the first-person perspective. Notably, it involves *precise description* and nothing more; it does not entail explanation.

German Berrios provides four meanings for phenomenology (Berrios, 1993) and, of these, it is the usage employed by Karl Jaspers, that involves the description of mental states in an empathic and theoretically neutral manner, that is used here (Jaspers, 1963).

It is vital to note that it is not possible to learn the empathic method of eliciting symptoms from a book. As well as being equipped with the necessary knowledge of what to look for, it is essential to see patients and interview them and assess their mental state with the aim of understanding their subjective experience. Therefore, eliciting symptoms in a clinical context is critical to gaining a true appreciation of psychiatric phenomena. In addition, written and sometimes video examples can also be useful and for detailed explanations we recommend Sim's *Symptoms in the mind: an introduction to descriptive psychopathology* (see the recommended readings at the end of this chapter for full details). For video materials it is worthwhile searching online for particular phenomena of interest, or specific disorders within which they manifest.

Mental State Examination (MSE)

The MSE is discussed in Chapter 5, and this should be read in conjunction with this chapter on psychopathology and phenomenology. A template for the format of the MSE is provided in Chapter 5, and we have adhered to this framework to a large extent. There are however a few variations, which reflects the fact that there is no absolute standard for reporting the mental state examination. This is because the MSE, like all medical examinations, is not limited to a particular part of the interaction with a patient. For example, when observing a patient at the bedside who is perspiring profusely, and complaining of a feeling that they are "burning up", it is immediately apparent that the patient is likely to have a raised body temperature. However, this can only be confirmed by taking the patient's temperature using a thermometer. In other words, while what can be elicited upon examination was evident from history-taking and a preliminary interaction, a formal assessment was still needed to confirm the change. Similarly, in psychiatry, important aspects of the mental state of an individual will necessarily become apparent during history-taking, for example whether the person maintains eye contact, is restless and unable to sit

still, or is easily distracted, as well as how they communicate and to what extent they understand the questions being put to them. An impression on these matters will already have been formed to some extent by the time a formal MSE is conducted.

Further, even within the MSE, global assessments such as whether the person has insight, how they behave and interact, and whether they have decision-making capacity are best decided towards the end of the examination, once more specific aspects have been elicited. The structure of the MSE and when and where to position various components can be confusing.

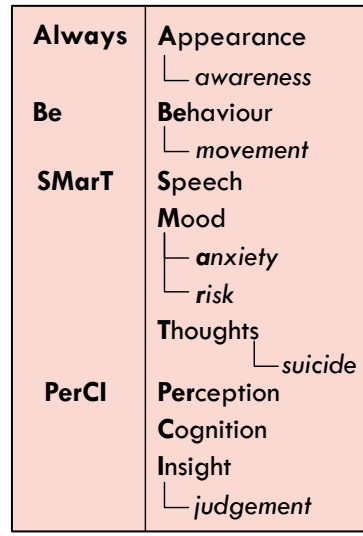

Figure 9.1. Outline for noting and presenting psychopathology and phenomenology as part of the mental state examination. Note, suicide is an idea and therefore belongs within *thoughts*. However, suicidal thinking and ideation are features of depression and therefore, asking about suicidal ideation in the context of mood is both logical and clinically more practical. Hence why *risk* has been inserted within mood - although risk is a broader term, and it includes harm to self and others.

Therefore, it is important to remember that the MSE is a snapshot of how the person is *now*, and if they are being assessed in hospital, their mental state is likely to have changed considerably from the time they were first admitted. For example, a person who presented agitated and with suicidal ideation some days ago may now be calm and no longer thinking about harming themselves. If assessing them now, then it is the latter (an absence of suicidal thinking) that is reported in the MSE. Hence, there is some fluidity as regards when various aspects of the MSE are assessed, and in which order the assessment is conducted. The format, however,

applies to reporting the findings in the medical notes and summarising these as part of a formal presentation.

The psychopathology and phenomenology in this chapter has been grouped according to seven of the components of the MSE: appearance and behaviour, speech, mood – which includes the assessment of anxiety and risk, thoughts – which again includes the assessment of suicidal thinking, perception, cognition and insight. These headings and the order in which they may be noted can be committed to memory and recalled using the following: Always Be SMarT PerCI (see Figure 9.1).

Appearance and Behaviour

It goes without saying that while noting a person's appearance and behaviour, a record should be made regarding their level of consciousness, for example whether their awareness is compromised or if they seem unusually vigilant or alert. **Awareness** and **consciousness** are related but distinct concepts. Awareness refers to the recognition and perception of information, while consciousness encompasses a wider range of experiences (see Cognition).

In terms of **appearance**, this has a practical purpose in that it allows individuals to be identified in hospital settings, but otherwise it also provides a general indication of whether an individual is taking care of themselves, for example, with adequate grooming and taking an interest in how they appear.

As with appearance, **behaviour** should be documented briefly but may require detailed observation and noting if it reflects the individual's mental state. For example, eye contact, facial expression and general attitude towards others are good indicators of how the person is regarding others. A note should be made of how the patient relates to others and the degree of rapport that is established in the interview.

It is here under appearance and behaviour that any notes regarding **movement** should be made. A general comment about the amount of movement, especially if excessive or limited, is helpful in addition to specific abnormalities of movement. Consideration should be given, however, to the fact that patients may be nervous about being interviewed and therefore, some agitation is to be expected, especially at the outset. However, an excess of motor activity wherein the person is restless, fidgeting, and even perhaps getting up and pacing is unusual, as is a noticeable reduction of activity and slowness of movement. Occasionally, the person may be completely immobile and say nothing (mute).

The abnormalities of movement can be considered under two broad headings: ***adaptive*** and ***non-adaptive*** movements. Adaptive movements

encompass ***expressive movements*** involving the upper body – face, hands, arms and trunk. Expressive movements are often altered in disorders such as depression and schizophrenia – for example, in severe depression (melancholia) the person may exhibit psychomotor retardation in which, along with slowing of thought, the person has reduced and slowed gestures and bodily movements. ***Reactive movements*** are also adaptive and refer to the automatic and immediate adjustments a person makes in response to a stimulus. For example, flinching when startled by a loud sound. This can also reflect heightened anxiety. Conversely reactivity may be diminished in catatonia and Parkinson's disease. Disorders of ***goal-directed movements*** are also adaptive movements and may or may not indicate mental illness. For example, mannerisms are not necessarily pathological.

Non-adaptive movements include ***spontaneous movements*** and ***abnormal induced movements***. Spontaneous movements include face touching or scratching, stroking the face or touching or pulling the nose. At one time these actions were goal-directed but have gradually lost purpose and have become spontaneous. They are akin to displacement activity seen in animals and usually triggered by frustration and anxiety. They include tremors, tics and stereotypies. ***Abnormal induced movements*** are thought to be either a reaction to the environment or a consequence of excessive obedience. Many of these occur in catatonia, which can be categorised according to whether the motor symptoms feature automatic phenomena e.g., automatic obedience; repetitive phenomena e.g., perseveration; withdrawal phenomena e.g., mutism, posturing; and agitated phenomena e.g., impulsivity.

In addition to the two major headings (adaptive/non-adaptive), the individual's ***posture*** should be assessed and noted whether it is abnormal. Further, in psychiatric patients it is also important to examine for ***treatment associated movement disorders***. These most often occur with antipsychotic (neuroleptic) medications.

Beyond these relatively straightforward patterns of abnormal behaviour there are many ***complex patterns of abnormal behaviour*** that can occur in psychiatric disorders. These can also be divided into goal-directed abnormal patterns of behaviour, such as aggressive and disruptive behaviour that sometimes occurs in psychotic and organic brain disorders, and non-goal-directed abnormal patterns of behaviour that include excitement and stupor, which are sometimes seen in catatonia and extremes of mood (mania and depression) as well as delirium.

Disorders of movement are important as they can often provide useful insights as regards a person's mental state. If for instance a person is especially fidgety, appears somewhat agitated, and is finding it hard to sit still, it suggests that

they may be feeling anxious and restless. Disorders of movement can be noted at the outset of the MSE especially if they have pertinence to the examination as a whole e.g., "the person was difficult to assess as they could not sit for long and were having to pace from time-to-time throughout the interview". They can also be noted under cognition especially if describing the level of consciousness e.g., drowsy or alert.

Key terms describing movement phenomena are listed in Table 9.2 at the conclusion of this chapter. This table includes descriptions of various kinds of tremor, which can be broadly divided into: ***action*** and ***resting tremors***, based on whether they are brought about by voluntary contraction of muscles (action) or not.

Speech

Speech is the most sophisticated and immediate means through which we not only express ourselves but also gain insights into the minds of others. Therefore, our current understanding of disordered thoughts derives primarily from the speech-related impairments they cause. However, the terminology used to describe disordered thoughts often revolves around abnormalities in speech, and this can sometimes lead to imprecision.

Further, while speech provides valuable insights into the inner workings of the mind, a comprehensive understanding of a person's thoughts requires consideration of additional factors such as the individual's cognitive processes, emotional experiences, and social context. By adopting an integrated approach, psychiatrists endeavour to construct a more precise and nuanced understanding of disordered thinking.

- When engaging a patient, it is necessary to first determine whether they are able to speak.
    - Occasionally a person does not speak at all, even though they have the ability to do so (***mutism***). More commonly, they may be impaired in their ability to vocalise speech (***dysphonia***) or articulate speech (***dysarthria***) or comprehend or express language (***dysphasia***).
    - If English is not their first language this should be noted even if they have a good command of it.
- Note the **form, amount, rate, volume** and **tone** of speech (see Figure 9.2). Both the amount and rate of speech can be increased or decreased. These are termed ***logorrhoea***, and ***poverty of speech*** with respect to amount, and ***pressure of speech*** and ***speech retardation*** with respect to rate.

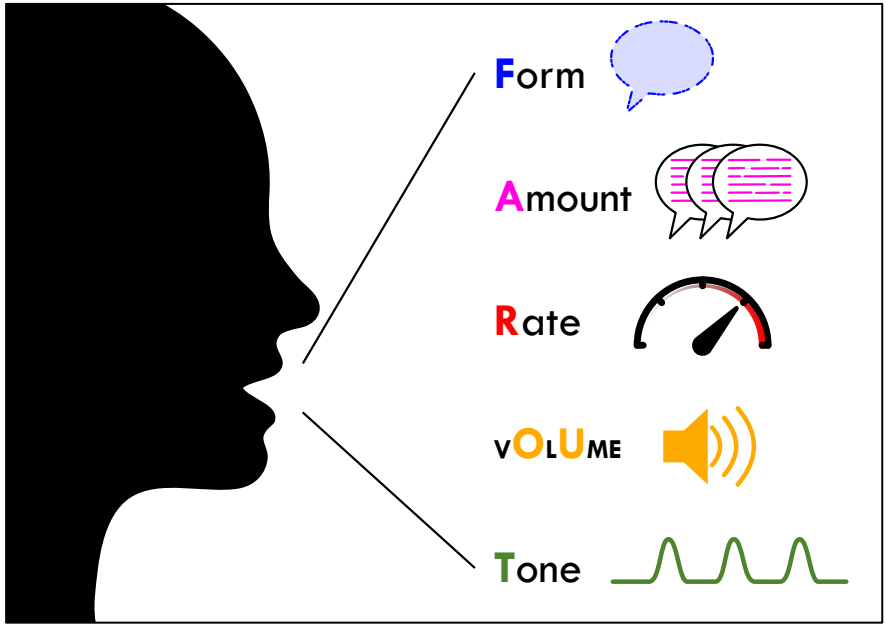

Figure 9.2. The illustration shows a person stating "FAR-OUT" which colloquially refers to something that is exceptional or outstanding. More specifically, it means something is unorthodox or unconventional and this is exactly what needs to be determined when assessing a person's speech. The aspects of speech that need to be noted can be committed to memory and recalled using 'FAR-OUT' as a mnemonic for **F**orm, **A**mount, **R**ate, v**O**l**U**me and **T**one of speech.

Form

Thoughts are necessarily expressed in speech, and some thoughts produce characteristic patterns of speech. It is important to note in these instances that the disorder is that of thought but that it is reflected in speech. This can cause confusion and so below we have provided two common examples of speech patterns (tangential and circumstantial) that are in fact abnormalities of thought form.

Agrammatism: The syntax of speech is lost and as such it becomes meaningless. The person experiences difficulty or an inability to use grammatically correct speech, and often omits conjunctions and neglects tense and word order. Agrammatic speech is often telegraphic and effortful, and while individual words or phrases may still be understandable, the overall meaning of what is being said is lost or is hard to comprehend. In **paragrammatism** speech may still contain well-constructed sentences. Further, while agrammatism usually affects propositions, articles and conjunctions within speech, paragrammatism usually involves

substitution errors in pronouns and verb tense, suggesting that it impacts a later stage in the process of sentence formation.

Clang association: the association of words based on the common sound of syllables rather than meaning. It usually results in nonsensical rhyming speech patterns.

Echolalia: The immediate, automatic (involuntary) and pointless repetition of words or phrases of another person's speech. Note, **echologia** is similar in that the person repeats what has been said but without using the exact same words.

Linguistic stereotypy: a tendency to employ a specific word or phrase repeatedly in everyday speech, despite it being unnecessary or simply to excess. It is noteworthy that such usage can be considered normal within the realm of colloquialisms or specific dialects.

Metonym: an existing word with a new meaning or one that is used in an idiosyncratic manner that does not conform to language norms.

Neologism: a totally new word that has been constructed by the individual or the abstraction of words to create a new word.

Perseverative speech: the persistent and involuntary repetition of a particular word or phrase, beyond the point that it is relevant or appropriate. It differs from verbal stereotypy in which the same word or phrase is used excessively irrespective of context.

Schizophasia (word salad or confused speech): Individuals produce a jumble of unrelated words, phrases, and nonsensical language that produces incoherent and fragmented speech that is difficult to understand. There is a loss of association between words.

Overlapping phenomena:

Tangentiality and **circumstantiality** are patterns of speech that are indicative of formal thought disorder. These are described in more detail under Thoughts, specifically under Form of Thoughts.

Amount

Alogia: This is also referred to as **poverty of speech**. It can be severely (and noticeably) limited to the extent that the person uses only single words to

respond. It is important to note that it is a functional, non-organic inability to speak, and that less severe cases may be referred to as dyslogia. Note, in some individuals the amount of speech is not necessarily reduced, it may simply require greater prompting.

Logorrhoea: increased quantity of speech, often described as voluble and garrulous. It often lacks meaningful content or coherence and is difficult to understand. Note, there is no increase in the *rate* of speech.
Poverty of content refers to instances where the quantity of speech is adequate, but the content is vague and lacks substance. Poverty of speech may be seen in schizophrenia and severe depression.

Rate

Rapid and slow speech: the rate of speech can be increased or decreased. In rapid speech the rate of speaking is markedly increased, and the quantity of speech may be noticeably greater. This is seen in mania where the person is talking rapidly and is difficult to interrupt. The opposite can also occur where speech is slowed. This is common in depression and seen in **psychomotor retardation.** It can be referred to more specifically as **speech retardation.**

Pressured speech is separate from rapid speech. When speech is pressured the pauses that normally occur in speech are lost and speech essentially becomes continuous. In other words, there is no break or pause and the person is difficult to interrupt. Speech when pressured may also be faster than usual but this is not necessary. Pressured speech is often seen in mania but may sometimes occur in psychosis and extreme agitation or anxiety.

Mutism: the complete loss and absence of speech despite being fully conscious. It can occur in adults in a wide variety of psychiatric disorders such as depression and schizophrenia. In children it can occur if they choose to refuse to speak in certain situations, or to particular people, and this is termed **selective mutism**.

Psychomotor retardation: a slowing down of psychological and physical processes that can be both subjectively and objectively perceived, which results in reduced cognition, speech, and movement, with particular difficulty in initiating action. It is typically a feature of melancholia.

Volume

It is important to note whether the person speaks loudly or softly and whether this in accordance with the environment. It may be appropriate for example for someone to be speaking loudly if in a noisy emergency department, or softy if imparting particularly sensitive information.

Tone

This usually applies where a person's tone conveys additional meaning. For example, they may be upset and angry and have an 'aggressive tone'. The intonation of speech may also reflect the person's mood and how they are feeling: speaking excitedly for example when elated and having a monotonous tone without inflexion when depressed. These emotional characteristics of speech are valuable and should be used alongside the formal appraisal of mood itself (see below).

Mood, Anxiety, Risk

Our emotions involve a complex interplay of cognitive, physiological, and subjective elements, and colloquially they are referred to as feelings. Emotions comprise elements of mood, affect and temperament that are distinct psychological concepts. Each of these relates to different aspects of an individual's emotional experience and behaviour (see recommended readings).

The emotional predisposition of an individual, refers broadly to their emotional temperament and their mood in general. It can be described as normal (*euthymia*), predominantly depressive (*dysphoria*) or predominantly euphoric (*hyperthymia*). Other changes in mood can be regarded as *emotional reactions* and these include *irritability, anxiety* and *apathy* as well as *anhedonia* and indeed, *depression* and *mania*. How emotions are expressed by an individual usually provides additional information and therefore, when noting affect, it should be specified whether it is *blunted,* or whether there is a *dissociation* such that the affect is inappropriate with respect to thought content and/or it is incongruous such that the individual's affect does not accord with the magnitude of events. Note, marked dissociation or incongruity of affect is suggestive of psychosis and warrants further exploration.

Emotions and Feelings

Emotions are colloquially referred to as one's feelings. Emotions are composites of a number of states that have different characteristics and so it is important to separate these when appraising how someone is feeling. The three main emotional components are mood, affect and temperament (MAT) (See Figure 9.3).

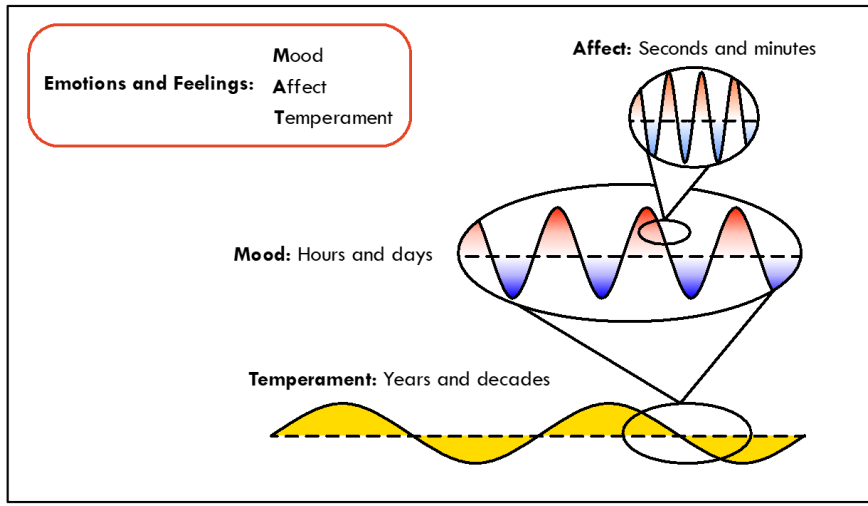

Figure 9.3. The relationship between mood, affect and temperament. Emotions (feelings) comprise mood, affect and temperament. Mood reflects a prolonged emotional state, affect pertains to outward emotional expression, and temperament refers to an individual's inherent and stable behavioural tendencies.

Mood is a sustained emotional state that influences a person's overall outlook and perception of the world. A particular mood state typically lasts for hours and sometime days.

When examining mood, in addition to recording the current mood, its severity should also be rated. If an abnormality of mood is suspected, then after suitable exploration, both one's impression of the patient's mood (objective mood) as well as the report provided by the patient (subjective mood), should be recorded.

Anhedonia: the subjective inability (or reduced ability) to gain pleasure or experience joy from thoughts and activities that the person would usually find enjoyable and rewarding. It is important to note that this symptom refers to the sensation of experiencing emotion (c.f. affect) and it is best elicited by asking specifically about the experiences the person normally finds pleasurable such as watching their favourite sporting team or spending time playing with their children/grandchildren. Questions therefore need to be tailored accordingly.

***Apathy*:** a lack or complete loss of interest, enthusiasm, or motivation towards activities, goals, or life in general. Individuals experiencing apathy have a diminished experience of the sensation of emotion and may exhibit reduced emotional responsiveness and a diminished sense of purpose or engagement. Clinically, the impact of apathy is typically more pervasive than anhedonia.

***Dysphoria*:** an unpleasant mood state characterised by discomfort, dissatisfaction, or unease. It occurs in depression and anxiety and is the opposite of euphoria.

Elation: an elevation of affect or mood.

***Euphoria*:** a happy and pleasant mood when occurring within normal limits. In pathological states is used to signify an extreme change with excessive feelings of happiness and well-being. The latter is also sometimes referred to as **ecstasy**. Excessive and sustained euphoria that does not reflect the reality of one's situation is a feature of mania.

Euthymia: normal contented mood that is neither elevated nor depressed. The term is often used in bipolar disorder to refer to mood status where there are no symptoms of depression or mania.

Lability of mood: the tendency of mood to fluctuate rapidly and unpredictably. Described colloquially as "mood swings". When the changes in mood are extreme and lead to a complete loss of emotional control, this can be described as **emotional incontinence** and suggests an organic aetiology. More commonly, oscillations and variations in mood indicate the possibility of a bipolar illness (See Chapter 17).

Affect is the observable emotional expression and responsiveness that an individual displays in their demeanour, facial expressions, voice tone, and body language. It is subject to variation over short periods of time (minutes and seconds) and denotes the outward manifestation of a person's emotional state. Clinically, a distinction should also be drawn between mood and affect and the latter if not normal can be further specified as inappropriate, incongruent, flat, blunted or expansive. Dissonance between a person's mood (i.e. their subjective appraisal of their mood) and their affect (i.e. their observable emotional state) is referred to as ***incongruity of affect/mood***.[It is important to note that in some psychology texts and publications the term affect has a broader meaning and is used interchangeably with emotion, as this can cause confusion].

It is important to assess emotional responsivity, as it can be diminished, resulting in a reduction in the range and intensity of emotional expression. Individuals may appear emotionally dulled such that their facial expressions, tone of voice, and overall demeanour lack the usual variations of emotion. Terms such as "emotional numbing" are sometimes used, and affect can also be described as being constricted. The main difference is that of degree. ***Restricted affect*** is the mildest

change. The person is less expressive than usual and experiences a reduction in their emotional responsivity. It is sometimes referred to as ***constricted affect***. ***Blunted affect*** is significantly compromised in their ability to express emotion, more so than someone with restricted affect but less than that which occurs in flattening of affect. A ***flat affect*** refers to a complete or nearly complete lack of emotional expression and responsivity. Note these are all terms applied to affect; decrements in mood – the experience of emotion, are described using terms such as apathy and anhedonia.

Temperament refers to elements of personality, and it reflects an individual's innate and enduring predisposition or style of behaviour, emotional response, and interaction with the environment. It is thought to be biologically anchored and therefore tends to be consistent over time. Aspects of temperament have emotional components and can contribute to feelings of *irritability* and perhaps also the inability to experience emotion altogether (alexithymia).

Aptly, ***alexithymia*** is sometimes described as ***emotional blindness*** as it refers to an inability to identify and comprehend one's own emotions and express them verbally. It has been described as 'having no words for one's emotions' and there is both scientific and taxonomic uncertainty as to whether it is symptom of mood for example, or whether it is a facet of personality and whether it should be regarded as pathological.

Similarly, the classification of ***irritability*** is in question. Clinically, it is a transdiagnostic phenomenon. It is technically conceptualised as a heightened sensitivity to stimuli, coupled with a lowered threshold for responding with anger and aggression to typically less vexing stimuli. It manifests within a wide range of disorders, is present across the lifespan, and is the only phenomenon that spans both poles of mood (see further readings).

Anxiety

Anxiety is a normal but unpleasant affective state. Colloquially, it is often referred to as stress. It is an emotional state of unease, worry, apprehension or intense inner tension and fear that is occasionally accompanied by physiological symptoms (increased heart rate, muscle tension, rapid breathing, dry mouth, and restlessness). It usually occurs because of an anticipated threat, which induces fear without adequate reason. Experientially it is separate and quite distinct from mood but it often cooccurs. Therefore, when assessing mood, it is customary to assess ***anxiety***. This is logical, as anxiety is also often a prelude to the emergence of mood symptoms. Further, many of the treatments for mood disorders, both psychological and pharmacological, are also effective in relieving anxiety. If upon inquiry the person reports they are feeling anxious then both the psychological and physical

symptoms of anxiety should be explored further (see Chapter 18 on anxiety disorders, for greater detail).

Risk

A final but important component of assessing mood is to appraise the level of ***risk***. This is because thoughts of suicide occur most commonly in mood disorders. These need to be explored sensitively but thoroughly. It is sometimes helpful to link questions about suicide, to symptoms of mood and anxiety. For example,
"You mentioned that your mood is especially low in the morning, is it ever so low that you sometimes wish you had not woken up?".
Alternatively, *"do you ever feel so anxious or low that the thought of ending your life crosses your mind?".*
These questions are difficult and ideally, they should only be put to the patient once sufficient rapport has been established. When noting the psychopathology of emotion, it is useful to have the following subheadings - predispositions, reactions and expressions.

Thoughts

Thoughts have both form and content. The proper terms to describe disorders pertaining to these two facets are: ***formal thought disorder*** (FTD), which refers specifically to the formation of an individual's thoughts and ***content thought disorder***, which refers specifically to what the individual is thinking – their 'thought content'. Problems regarding the formation of thoughts (FTD) impact the process of thinking, and manifest in the individual's pattern of speech. In contrast, problems regarding thought content are not discernible by examination of speech patterns and therefore a necessary distinction is drawn (See Table 9.1).

In addition to separating thought from speech it is important to understand the different aspects of problems concerning thinking. This requires an appreciation of the nature of thoughts, which as yet, is not fully known. Therefore, thoughts have to be conceptualised, and one example is to liken the process of thinking to that of a ***stream*** of flowing ideas. The ideas and the stream emanate from our thought processes within the mind, and they flow according to rules that govern our thinking processes. The rate at which thoughts occur is the rate at which the stream is flowing. The substance of the stream and its function is determined by its ***content*** e.g., the nature and the purpose of our ideas. The structure of the stream depends on the relationship between various ideas and this gives it shape – in other words, it is the ***form*** of our thoughts.

Table 9.1. Framework for assessing phenomenology of thoughts.

	Thought	Speech
Formal Thought Disorder (FTD)	Process *(how the person thinks)*	Pattern *(how the person speaks)*
Content Thought Disorder	Content *(what the person thinks)*	Subject Matter *(what the person says)*

When disrupted by disorders, thoughts may not be forthcoming or may be interrupted or slowed; they may be completely lacking or hindered significantly; or alternatively, they may be fast flowing and uncontrollable. These are disorders of the ***stream of thought***. In addition, the thoughts themselves (the ideas) may be unusual or abnormal, and cause for concern, and this may include all manner of variations – for example fears, odd ideas and made-up beliefs. However, in all of these cases, it is ***thought content*** that makes the thoughts abnormal. Further, the thoughts themselves may not be linked in a way that makes sense – having lost their cohesion, their connections and associations, and therefore presenting with odd patterns of thought that are difficult to follow and comprehend. These are aberrations of ***thought form*** and although the patterns appear in speech, they are primarily disorders of thought. Figure 9.4 illustrates these three properties of thoughts. Each of them should be assessed and noted separately.

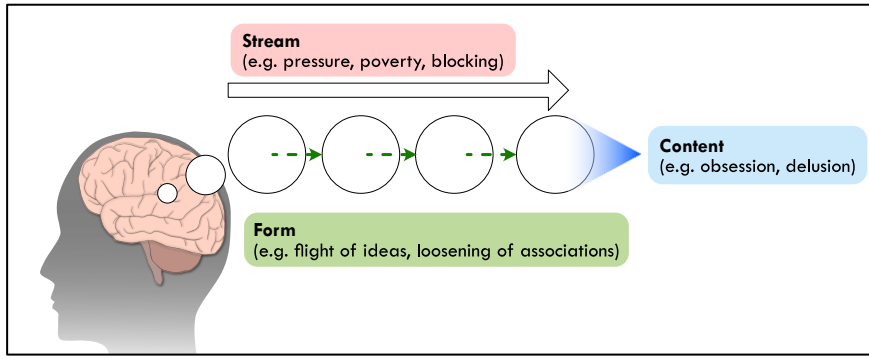

Figure 9.4. Schematic illustrating the components of the psychopathology of thoughts. Thought ***stream*** (red) reflects the flow of thoughts e.g., phenomena such as pressured speech, poverty of thought and thought blocking. Thought ***form*** (green) denotes the process of thinking and how thoughts are linked together. Formal thought disorder (FTD), where these processes begin to breakdown, may manifest as loosening of associations. Thought ***content*** (blue) refers to what the individual is thinking. It is the substance of thought – in terms of its meaning. Therefore, disorders of thought content include over-valued ideas, obsessions and delusions.

Stream of Thoughts

When the stream of thought comes to an abrupt stop – sometimes mid-sentence and the person themselves feels that they have not only lost their train of thought, but their mind has gone completely blank and become devoid of thoughts altogether, this kind of disruption is referred to as ***thought block*** (or thought blocking, *entgleiten*). The person often experiences and describes a 'mental block' during which time they felt unable to continue speaking, despite wanting to do so. The pause may be brief (a few seconds) but can be much longer and the phenomenon is also sometimes referred to as ***thought obstruction***. Usually, when they resume thinking /speaking they do so with a totally new train of thought. It is a symptom of schizophrenia but can also occur in severe anxiety.

Disruptions to the flow of thought may also manifest with too few or too many thoughts. In other words, changes to the amount or quantity of thoughts. The term ***poverty of thought*** is used to describe the phenomenon of having too few thoughts and it manifests as poverty of speech (e.g., alogia, see earlier under speech). The opposite of this phenomenon is having the experience of too many thoughts – termed '***pressure of thought***', which then presents as pressured speech (see earlier under Speech).

Form of Thoughts

Problems with the formation of thought are called ***formal thought disorder (FTD)***. The term should *not* be abbreviated to 'thought disorder' as this lacks specificity and encompasses disorders of thought content. Further, it should be noted that FTD is not synonymous with the descriptor 'psychotic'. This is important nowadays in clinical practice where patients experiencing a psychotic episode are often wrongly assumed to have FTD when in fact they do not. In other words, it is possible to have severe psychosis and not have FTD. Usually, FTD occurs in schizophrenia and organic brain disorders, and it should only be used to describe disorders of the *form of thinking*.

According to Bleuler, the key problem in schizophrenia is that the associations linking thoughts become disordered and this leads to features such as ***displacement***, ***condensation*** and ***misuse of symbols(Jerónimo et al., 2018)***. In displacement, one idea displaces another that is loosely associated. In condensation two associated ideas are melded into one idea that is false. In misuse of symbols, there is concrete thinking, such that the person fails to grasp the symbolic meaning. The loosening of associations between thoughts is a central feature. Cameron describes this as ***asyndesis*** - pointing to a disintegration of connections between thoughts(Jerónimo et al., 2018). In addition, he noted ***over-inclusiveness*** in

patients with schizophrenia in which the person is unable to maintain conceptual boundaries and also often uses imprecise terms (*metonyms*).

Schneider defined five features of FTD: fusion, omission, derailment, substitution and drivelling(Jerónimo et al., 2018). ***Fusion*** (*verschmelzung*) is akin to condensation except that the elements of thought that are conjoined are not necessarily linked. ***Omission*** is straightforward and involves simply leaving out some part of a thought or a whole thought altogether. ***Derailment*** (*entgleisen*) refers to the shifting of thought 'off its tracks' to another subsidiary theme, and ***substitution*** is a loose variant of this which involves the complete replacement of a major thought with a more subsidiary one. ***Drivelling*** is the incomprehensible intermingling of the various parts of a complex thought.

Schneider also proposed three key features of healthy thoughts namely, *constancy*, *organisation*, and *continuity* and suggested that in schizophrenia each of these is impaired and that this results in a transitoriness of thinking (***transitory thinking***), an absence of normal thought organisation (***drivelling thinking***) and an interruption to the continuity of thought with sudden ideas forcing their way into the normal thoughts of the individual (***desultory thinking***).

Normally, as part of our existence we act on the world – in other words, we do things to the world and to ourselves and others - we have a sensation of intentionality that is innate to our existence and subjective experience. However, with thought insertion and withdrawal the individual feels that something other than themselves is in control and doing things to them. This displaced locus of control in which the person believes they are being controlled is also the basis of passivity phenomena involving desires, feelings, and actions. Regarding thoughts, passivity phenomena may manifest as thought insertion, withdrawal and broadcasting.

Thought insertion is the subjective experience of thoughts or ideas being "placed" in one's mind. The thoughts are inserted without the person's consent and are not under their control. ***Thought withdrawal*** is the subjective experience of one's thoughts being removed by an external force. The person experiences the 'sensation' of the process of removal of the thought and is left with a sense of loss of control over their thinking. ***Thought broadcasting*** is also called '*thought diffusion*' and sometimes more informally referred to as '*thought leakage*'. The person feels that their thoughts are accessible to people around them, and that somehow, they are passively escaping their mind and therefore effectively being broadcast. They may even feel that this is taking place via means of various technologies such as radio, television or the internet. The feelings this induces are usually negative and typically the phenomenon is accompanied by great concern as the person fears others will come to know their thoughts, which may be of an aggressive or embarrassing nature.

Other Terms for Disorders of Thought Form

Dereistic thinking refers to idiosyncratic thoughts that are not in keeping with reality but are also not being falsified by reality per se. For example, daydreaming.

Tangential thoughts are apparent in a corresponding pattern of speech that constantly pursues irrelevant topics and fails to arrive at the main point. Verbal responses are oblique and only glance at the gist.

Circumstantial thoughts are apparent in a corresponding pattern of speech wherein the conversation meanders, delving into unnecessary details as it progresses towards its ultimate goal. Importantly, the point that the person intends to make is finally reached although in the process they have usually incorporated many irrelevancies and focused on unnecessary details. It can occur in schizophrenia and those with a learning disability and is associated with obsessional personality traits. Ultimately, their account often includes many trivial details that are largely irrelevant. However, in contrast to **tangentiality**, a person being circumstantial eventually arrives at their main point (their intended destination).

In ***loosening of associations***, thoughts shift from one idea to another but lack connection. The person experiences this as their speech being illogical and their thoughts being confused.

Flight of ideas is best thought of as a combination of either tangential thinking or loosening of associations with pressure of speech. It is important to note that the latter is not simply rapid speech (see earlier).

Thought Content

Ruminations: These consume the individual's thought processes and disrupt normal thinking. They are persistent, repetitive thoughts that often centre on past events (as opposed to future events, which usually characterise worry) hence they often occur in anxiety, depression and obsessive-compulsive disorders.

Phobias: an irrational and persistent fear of an object, activity, or situation that goes beyond normal bounds and is difficult to control. It leads to conscious avoidance of the feared entity.

Pseudologia fantastica (mythomania): the person lies fluently and plausibly, hence often referred to as 'pathological lying'.

Obsessions: these are persistent and intrusive thoughts, images, or impulses, that usually causes distress in the form of anxiety and sometimes guilt. The obsessional thoughts themselves are seen as senseless but cannot be controlled by the individual. Indeed, they seem to occur against the person's will and cannot be resisted. Hence, moods and hallucinations are not described as obsessional, whereas thoughts, ideas, impulses and fears as well as mental images can all be described as obsessions. Obsessions differ from normal worries in that they persist beyond the point of relevance or usefulness and seem to occur without purpose. Their content is often repugnant to the individual. For example, religious individuals may be tormented by blasphemous thoughts and those that are shy may experience ruminations of a sexual nature. Other common examples include fears of contamination, the need for order, and aggressive thoughts. ***Compulsions*** are often regarded as separate from obsessions but in essence, compulsions are simply obsessional motor acts. They can be driven directly by obsessional thinking or occur in response to an obsessional thought or image. Usually, compulsions involve a behavioural or mental activity that is undertaken to alleviate anxiety or distress associated with an obsession. Typically, compulsions provide no pleasure or gratification, but offer temporary relief to the individual from the anxiety and/or distress associated with an obsessional thought. Common examples of compulsions include behaviours such as hand washing or checking, and mental activities such as counting, praying or repeating words or phrases to oneself in one's mind.

Ideas of reference: a belief that neutral events or stimuli in the environment have a special and personal significance directed towards oneself. Individuals experiencing ideas of reference may interpret ordinary occurrences or unrelated actions of others as being specifically related to them. This manifests as a feeling that external incidents and causal events have reference to oneself. If this feeling transmutes to a fixed idea or belief, then it may be referred to as a ***delusion of reference*** (see below).

Overvalued idea: A preoccupation that is held intensely by an individual, and while they believe it to be justified, it remains open to counterargument or evidence. In other words, the idea itself is acceptable and comprehensible but is problematic because it dominates the person's thoughts and behaviour. Further, the idea is not commonly shared by others with similar backgrounds. Notably, an overvalued idea differs from an obsessional thought as it is not regarded as being senseless and it differs from a delusion because the belief is not fixed.

Delusion: a fixed, and indeed, unshakeable, false belief that persists despite evidence to the contrary. Delusions are irrational and not in line with cultural, religious, or societal norms. Note, delusions are not always and necessarily

false, but they arise through a process that is illogical and often bizarre. Delusions can be primary or secondary. A ***primary delusion***, also termed an autochthonous delusion, or delusional intuition, is one that is psychologically irreducible. It is not in any way linked to previous ideas or events and it appears fully formed. A ***secondary delusion*** is understandable in the context of previous events or ideas and arises from such prior events or ideas. Delusions have many themes (see below) and typically develop gradually through various stages (see Figure 9.5).

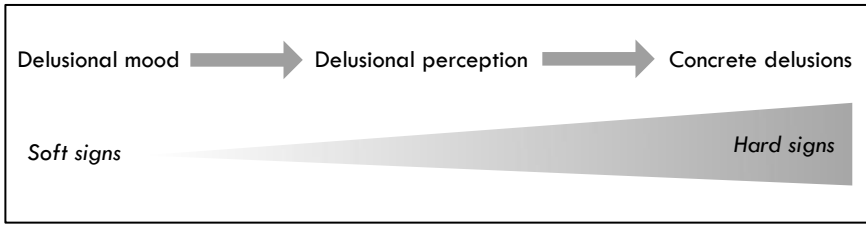

Figure 9.5. Schematic illustrating the typical development and progression of delusions. Delusions commonly occur as part of **psychosis**, a process that is usually marked by 'hard signs', which also include hallucinations and formal thought disorder. Typically, the **hard signs** of psychosis do not appear abruptly. Instead, they usually emerge gradually indeed often insidiously, beginning with 'soft signs'. The first step is the emergence of a **delusional mood** (Wahnstimmung) in which the individual begins to sense (feel) that something, that they can't put their finger on, is not quite right. Sights and sounds might become more intense, and the environment appears more vivid and clearer to them than ever before. Certain matters take on a special significance and the individual generally feels unsettled and has a sense of foreboding. Over time, delusional mood gives way to **delusional perception** in which the percept is normal, but its interpretation is abnormal. In other words, delusional significance is attributed to normal percepts. Finally, delusional perception and delusional mood are superseded by **concrete delusional ideation**. Now the person 'knows' for sure what they are thinking is true – and their beliefs become fixed.

Delusional Themes

Jealousy: A mistaken conviction that one's spouse or partner is being unfaithful. The person remains vigilant for signs supporting this belief, fabricates proof if none is present, and dismisses contradictory evidence. This condition is also referred to as **morbid jealousy**, or **pathological jealousy** and is sometimes described as ***Othello syndrome.***

Being controlled (passivity phenomena): a false belief that external forces, such as machines or other people, are controlling one's thoughts, feelings, or actions. Delusions of control are of various types:

- Passivity of affect, desire, or action
- Somatic passivity
- Thought broadcast
- Thought insertion
- Thought withdrawal

Grandeur: A false belief in one's exceptional ability, knowledge, worth, identity, prestige, power, importance, or achievements far beyond reality. This belief is also referred to as a **grandiose delusion**.

Persecution: a false and persistent belief that one is being targeted, harmed, or threatened by others. Individuals experiencing this delusion interpret neutral or benign actions as evidence of malicious intent to harm them.

Reference: the belief that neutral or unrelated events, objects, or actions hold special significance that is specifically directed toward oneself. Individuals experiencing this delusion may interpret everyday occurrences as having hidden messages or meanings intended for them (see also ***ideas of reference***).

Somatic: a false belief concerning one's body or physical health. Individuals experiencing somatic delusions believe they have a medical condition, deformity, or infestation, despite evidence to the contrary. These delusions often centre around bodily functions or appearance.

Hypochondriacal: a fear or a preoccupation with the belief that one has a serious physical illness or abnormality based on an incorrect interpretation of bodily symptoms. The person cannot be reassured and repeatedly seeks help.

Nihilistic: the irrational belief that oneself, others, or the world as a whole do not exist, and that these things lack meaning or significance. Individuals experiencing this delusion may feel detached from reality and may deny the existence of essential aspects of life. In severe psychotic depression a nihilistic delusion may occur in combination with a somatic delusion in which the individual believes they don't exist or are dead. This is called Cotard's syndrome (*le délire de negation*) after Jules Cotard.

Querulent: a persistent and unwarranted belief that one is being unjustly persecuted, harassed, or conspired against by others. Individuals with querulent delusions may obsessively pursue legal action or make repeated complaints to authorities, even when evidence contradicts their claims.

Perception

Perception is the process by which sensory information is received, organised, and interpreted by the brain to create a meaningful understanding of the external world. It involves the integration of sensory inputs, such as sight, hearing, touch, taste, and smell, along with cognitive processes, emotions, and past experiences, to construct a coherent and subjective representation of one's surroundings.

The phenomenology of perception refers to the subjective experience and interpretation of sensory information by an individual. It explores how sensory stimuli are processed, organised, and given meaning, influencing one's perception of the world and interactions within it.

Changes in perception that occur because of a change in the quality or intensity of a stimulus, or its spatial form are termed ***sensory distortions***. These include changes in the threshold for sensations such that, for example, normal sounds may seem louder to the point they are distressing (*hyperacusis*), or alternatively, they may be noticeably dampened as can happen in depression with the dulling of taste and colour. The colours of objects may be altered altogether – although this is usually a consequence of drug-taking or the toxic effects of medications. In such instances, the spatial form of objects may be distorted with things seeming much larger or smaller. Mood and anxiety can also distort our experience of time (personal judgement of time passing). When low in mood for example, most people complain of time passing slowly whereas when happy time seems to pass quickly. Sensory distortions are interesting and noteworthy, but it is sensory deceptions that are the mainstay of perceptual psychiatric phenomena.

Sensory Deceptions

Generally, there are two distinct kinds of sensory deceptions: illusions and hallucinations.

Illusions

Illusions are misperceptions of real external stimuli. They occur when sensory inputs are correctly perceived but are interpreted by the brain inaccurately. Illusions can involve any of the sensory modalities (e.g., vision, hearing, touch) and are specified accordingly. Visual illusions are the most common and although they do not usually indicate psychopathology they can occur in delirium and in psychiatric disorders. Therefore, it is important to differentiate them from hallucinations (see below), in particular functional hallucinations where the hallucination and stimulus

are perceived simultaneously. In the latter instance the two remain differentiated whereas in an illusion the stimulus becomes part of the new perception.

In addition to subtyping illusions according to sensory modality, they can also be defined based on the mechanisms involved. Three types of illusions have been described.

Affect illusions arise in the context of specific mood states, for example, in melancholia, severely depressed individuals are more prone to misperceive negatively things that are said to them.

Completion illusions involve completing an incomplete percept, such as reading a word that is missing a letter as if it were complete. This usually arises because of inattention.

Pareidolia are illusions that arise without effort. They are usually vivid and occur within poorly defined stimuli such as a fire or the clouds in the sky resulting in images and shapes.

Hallucinations

Hallucinations are perceptual distortions within any sensory channel without any corresponding external stimuli or trigger. They can therefore involve seeing, hearing, feeling, tasting, or smelling things that are not actually present. Typically, hallucinations are described and categorised based on the sensory modality involved, and in psychiatry auditory hallucinations are the most common type.

The definition of hallucinations is important. Put succinctly they are false perceptions or a perception without an object. A more detailed definition is that a hallucination is a percept that seems real and is therefore experienced as emerging from the sensory organs and not from *within* the mind. The key is that there is no real external object, and the hallucination is being generated internally. Hallucinations can be confused with vivid mental images, which can appear to be real and exist externally. However, these are recognised as not being real by the person perceiving the mental image. In contrast, a person experiencing a hallucination fails to make this distinction and regards it as real.

Auditory Hallucinations

Auditory hallucinations are described as follows:

Auditory Hallucinations: Hearing distinct words, phrases, or sentences spoken by voices or entities, often directed towards the individual.

These can be categorised into three perspectives:

- *First Person* ('I'): The individual hears voices referring to themselves using "I." Voices make statements, give instructions, or converse as if speaking from their own perspective.
- *Second Person* ('you' or direct address): Hallucinatory voices directly address the individual using "you" or their name. They command, criticise, or comment on the person's thoughts, actions, or behaviour.
- *Third Person* ('he/she' or 'him/her'): Voices refer to the individual in the third person, using pronouns like 'he/she' or 'him/her.' Multiple speakers may engage in conversations, discussing the person's actions and behaviour.

Non-Verbal Auditory Hallucinations: Perceiving sounds, noises, or music without distinct verbal content. These may include buzzing, ringing, footsteps, or other auditory sensations.

Command Hallucinations: Voices instructing the individual to perform specific actions, often with varying degrees of urgency or authority.

Conversational Hallucinations: Hearing voices engage in dialogue with each other or with the person experiencing the hallucination.

Commentary Hallucinations: Voices providing a running commentary on the person's thoughts, actions, or surroundings.

Somatic Auditory Hallucinations: Hearing internal bodily sounds, such as one's heartbeat or digestive noises, as if they were originating externally.

Thought Sonorisation subsumes two slightly different phenomena.

Gedankenlautwerden is a composite German word that means 'thoughts becoming audible'. It refers to the experience of hearing one's own thoughts spoken out loud while having the thoughts. The two occur simultaneously. In contrast, in ***echo de la pensée*** the person hears their thoughts *after* they have been produced. Therefore, ***thought echo*** is a specific type of auditory hallucination in which an individual hears their own thoughts being spoken aloud, often as if echoed by another voice.

Thought echo can be further specified as **direct**, where the person hears their thoughts repeated exactly as they occur in their mind, resembling an immediate echo. And **indirect** where the person hears their thoughts being spoken aloud, but with variations or additions that may change the original content.

Visual Hallucinations

Visual hallucinations are perceptual distortions in which an individual sees objects, images, or scenes that are not actually present in their external environment. These hallucinations involve the sense of sight and can vary from simple shapes to complex and detailed visual experiences. Types:

Simple Visual Hallucination: Basic, unformed visual perception, such as flash of light, geometric shapes, or colours.

Complex Visual Hallucination: Detailed and elaborate visual experience involving recognisable objects, scenes, or people.

Lilliputian Hallucination: Visual hallucination where objects or people are perceived as smaller than they should be.

Autoscopic Hallucination: involves perceiving images of one's own body or face projected into the surrounding environment.

Negative Autoscopy: the individual feels as though their own presence or body is missing, leading to a sense of disembodiment. Interestingly, the person reports they cannot see an image of themselves in a mirror.

Tactile Hallucination: false or disordered perception of touch or physical contact that may involve sensations felt on the skin such as animals or insects crawling (formication), or the feeling of being touched by a person who is not present. The hallucination may also involve the sensation of organs moving within the body, or the skin being stretched or pulled.

Gustatory Hallucination: false or distorted perception of taste and flavour that can vary from pleasant to unpleasant sensations.

Olfactory Hallucination: perceptual distortions in which an individual perceives smells or odours in their environment.

Somatic Hallucination: perceptual distortions involving false sensations experienced in the body, such as touch, pressure, movement, or internal bodily functions. May vary from subtle sensations to intense and distressing experiences. ***Phantom limb sensation*** is a somatic hallucination where an individual continues to feel sensations, such as pain or movement, in a limb that is no longer present (e.g. amputated). This phenomenon occurs due to the brain's continued representation of the missing limb, leading to perceptions within the brain even though the limb is absent.

Specific kinds of hallucination

Some hallucinations occur in relation to sleep. ***Hypnagogic Hallucinations*** occur immediately before falling asleep (gogic – going to bed). Common themes include sensations of falling, floating or seeing geometric shapes

or patterns. ***Hypnopompic Hallucinations*** occur immediately before wakening (pompic – popping awake). Often these include a sense that another person is in the room, or sensations of weightlessness or flying.

A ***pseudo-hallucination*** is a perceptual experience that has sensory qualities similar to a hallucination but *is recognised by the individual* as not originating from external stimuli. It occurs within the mind's eye or mental imagery, often lacking the sense of reality present in true hallucinations.

A ***functional hallucination*** is triggered by an environmental stimulus from within the *same* sensory modality. For example, an auditory hallucination that is triggered by the sound of a particular piece music. In contrast, a ***reflex hallucination*** is triggered by a stimulus in a *different* sensory modality.

Depersonalisation and ***derealisation*** are considered disturbances in the subjective experience of reality rather than psychotic symptoms, although they sometimes occur in psychotic states. Hence, they are considered here. These symptoms can also occur in the context of emotional states, organic brain disease and substance misuse. Usually, ***depersonalisation*** involves a subjective sense of detachment from oneself, leading to a feeling of unreality regarding one's thoughts, sensations, body awareness, and perception of time. Despite this change, individuals still experience and recognise low mood and/or anxiety, which often accompanies this phenomenon, and it is this associated distress that prompts them to seek assistance. The phenomenon is often accompanied by ***derealisation*** in which the individual perceives their external environment, including other people, as unreal, distant, or distorted. It involves a sense of detachment from the surroundings as if the world around them has taken on a dream-like or surreal quality.

Cognition

A comprehensive and formal assessment of cognition (see definition below) requires sophisticated testing that takes considerable time (hours) and requires specialist expertise. Bedside, the appraisal of cognition involves assessing the level of consciousness and awareness and then conducting simple tests to assess *orientation*, *attention* and *concentration*, *memory* and *general mental abilities*. More details about cognition and cognitive testing are provided in Chapter 6 but in essence orientation to time, place and person should be noted along with the results of a straightforward test of attention/concentration such as serial sevens. This involves subtracting 7 from 100 and then repeating this for as long as possible (e.g., 100, 93, 86, 79, …). The time taken and any errors are noted. Short-term memory is assessed as well as recent and remote memory before evaluating the grasp the person has on current affairs. Only if the person struggles with these tests is a more comprehensive assessment indicated.

In addition to the formal appraisal of ***cognition*** – *the mental process of gaining knowledge through experience and thought to achieve understanding* – it is important to be familiar with terms that define the general awareness of an individual. These are less specific to psychiatry and are used in medicine more generally.

Awareness refers broadly to whether a person is attentive, and it involves recognising and perceiving information, whether internal (thoughts, emotions) or external (environment, stimuli). In contrast, ***consciousness*** refers to the broader and more complex state of being awake and having an ongoing subjective experience. It encompasses awareness and self-awareness and entails the sense of one's own existence through perception, thoughts and emotions. When an individual has diminished awareness of the environment, and becomes confused, and has difficulty in maintaining concentration the sensorium is said to be clouded (*clouding of consciousness*). If this progresses to a profound state of unconsciousness this is termed a *coma*. The latter can be rated using the Glasgow Coma Scale. Altered consciousness occurs in delirium – an acute confusional state that is characterised by a fluctuating level of consciousness, disorientation, and impaired attention. Delirious individuals often exhibit restlessness and bizarre behaviour. Delirium is typically caused by underlying medical conditions, such as infections, adverse reactions to medications or metabolic imbalances. (Note: in contrast, dementia involves a global impairment of executive functioning in a *clear state of consciousness.* Though of course delirium and dementia can cooccur and often do.) An important component of being aware is self-awareness, which is necessary for insight and the execution of judgement (See below).

Insight

An understanding that one is sick and that one requires treatment is basic to health and help seeking but is often absent or only partial in psychiatry. Being self-aware and having an understanding of one's own thoughts, emotions, behaviours, and mental health condition is described as having ***insight***. It involves recognising and acknowledging one's strengths, weaknesses, and motivations. It also involves understanding the impact of one's actions on oneself and others and that these actions may constitute an illness. Not only that it may be an illness but that this requires change or treatment. Hence, it plays a crucial role in therapeutic and self-improvement processes. Insight can be graded as being full, partial or absent (lacking).

Insight is also linked to ***judgement***, the ability to make well-considered decisions. This is also referred to as *deliberative capacity* and it refers to the individual having the ability to weigh up contingencies and arrive at a reasoned decision. Like insight, having good judgement is important for making decisions regarding clinical

care. In psychiatry the judgement of patients may be overridden by that of health professionals to maintain their mental well-being and ensure their safety (See also Chapter 8).

Table 9.2. Phenomena of movement

Voluntary Purposeful Movements	
Mannerism	The unnecessary repetition of normal (goal diverted) movements or habitual poses, such as blinking or flicking one's hair. It can also involve the adoption of exaggerated postures and the strange use of words or expressions that are not in keeping with the situation with excessive frequency.
Dyspraxia	The impaired ability to perform a familiar task despite having intact coordination, sensation, and motor pathways. It involves difficulties in executing coordinated movements efficiently.
Compulsive act	An unnecessary action that is performed as a means of relieving inner tension. It is typically a specific task or behaviour carried out repetitively. In contrast, a motor tic (see later) is generally characterised by the presence of repetitive and involuntary movements without a specific purpose. Note, obsessions and compulsions can be considered as disorders of behaviour as they involve the disruption of the normally subjective experience that entails the progression of thoughts and actions.
Voluntary Non-Purposeful Movements	
Stereotypy	A non-goal direction action that results in purposeless repetitive movements, such as excessive foot-tapping or rocking, that are frequently observed in an individual to the point that it appears characteristic for them. Can occur in organic states and catatonia. Sometimes a vestige of purposeful movement remains and may be discernible. Thus, can be confused with mannerisms (see above).
Involuntary Movements	
Akathisia	A subjective feeling of restlessness, that entails an irresistible urge to move the legs or body. Individuals with akathisia find it challenging to stay still or sit, and often exhibit repetitive movements or pacing. The distress is relieved temporarily by movement of the affected part of the body – most commonly the legs. It is a side effect of some medications (e.g., antipsychotics, see Chapter 35 on psychopharmacology).

Ambitendency	The individual experiences conflicting urges between carrying out and resisting a specific action. There is the coexistence of contradictory actions or thoughts, resulting in hesitation or difficulty in decision-making. It can be conceptualised as a combination of altering automatic obedience and negotiation.
Athetosis	Slow, writhing, and twisting movements of the limbs, face, and sometimes the trunk. The movements are sinuous fluid and continuous, and muscle contractions and relaxations are evident.
Automatism	Involuntary and unconscious actions, behaviours, or movements that occur without the person's deliberate control or awareness. These actions can range from simple movements such as lip-smacking or repeatedly using the same phrase to more complex behaviours such as sleepwalking and automatic writing.
Automatic obedience (command automatism)	The individual carries out another person's instructions without a subjective appraisal or consideration of the consequences. The actions are executed automatically and reflexively, without questioning motives. **Mitmachen** is a form of automatic obedience (cooperation) in which the individual, allows their body to be freely positioned even though the individual has been told to resist all movements. Once the displacing force is removed the body part returns to its original resting position. **Mitgehen:** an exaggerated and extreme form of Mitmachen that is characterised by the individual exhibiting movement in response to minimal force/pressure in any direction. Individuals with this condition perceive even slight pressure as forceful and respond with involuntary movement, again despite instructions to resist.
Blepharospasm	Tonic spasms of the eyelid muscle, leading to involuntary blinking or closure of the eye. This involuntary movement can be persistent and disruptive, causing discomfort and functional impairment.
Bruxism (bruxomania or stridor dentium)	The persistent habit of grinding, clenching, or gnashing of teeth, typically occurring during sleep. It is often associated with feelings of tension, anger, frustration, or fear.

Catalepsy (catatonic rigidity, flexibilitas cerea or waxy flexibility)	This refers to the condition in which the limb of a patient can be moved (positioned) by another person to any posture. The individual then maintains this position or a fixed body posture for an extended period. It is observed in catatonic schizophrenia.
Cataplexy	A sudden loss of muscle tone, which can be either localised or generalised. Localised cataplexy may lead to the loss of grip or nodding of the head, while generalised cataplexy causes the collapse of the entire body. The condition is usually temporarily and typically triggered by intense emotional stimuli, such as overwhelming anxiety, excitement, or anger. It is also a symptom of narcolepsy.
Catatonia	This involves an increase in resting muscle tone. In contrast to the visibility caused by Parkinson's disease and extrapyramidal side effects, the increase in muscle tone is not present on active or passive movement. It is a psychomotor syndrome that can be categorised into two main subtypes. Catatonia of the **retarded** type is characterised by immobility, mutism, staring, and rigidity. **Excited catatonia** is less common and involves prolonged periods of psychomotor agitation. While catatonia was previously considered a subtype of schizophrenia, it is now known to occur in various medical and psychiatric conditions, especially affective disorders.
Chorea	Rapid, jerky, and irregular movements that flow unpredictably from one muscle group to another. These movements are often described as dance-like and can affect various parts of the body, including the face, limbs, and trunk. The migration of movement across muscle groups can make the action appear voluntary.
Cog-wheeling	A term used to describe a distinctive Parkinsonian sign. It involves the combination of lead-pipe rigidity, which is a constant resistance to passive movement, with superimposed tremor. This phenomenon results in a jerky, interrupted movement resembling the turning of gears, hence the term "cog-wheeling."
Copropraxia	The involuntary expression of obscene or socially inappropriate gestures, e.g., offensive or obscene hand

	movements or gestures. It may cause significant distress and impairment in social interactions. The movements can be resisted but only temporarily and resistance causes significant anxiety. Seen in Gilles de la Tourette's syndrome (see Named Syndromes below).
Dyskinesia (dyskinesis)	A broad term encompassing various involuntary, abnormal, and often repetitive movements. These movements can include tics, chorea, athetosis, and other motor abnormalities. Dyskinesia can result from neurological disorders, medication side effects, or other underlying conditions.
Dystonia	Impairment of normal muscle tone, leading to recurrent prolonged muscle contractions that cause abnormal postures, twisting, or repetitive movements. While dystonia typically manifests in a focal area, it can also spread to other parts of the body. An example of dystonia is opisthotonus, characterised by an arched posture caused by spasms in the paraspinal muscles.
Echopraxia	Automatic mimicry. The involuntary mechanical imitation or repetition of another person's actions, gestures, or movements. It persists even after being told to stop.
Grasp reflex	An involuntary, automatic response observed in infants and some neurological conditions. When an object is placed in the palm of the hand or touches the fingers, the individual's fingers close around the object and grip it tightly.
Grimacing	The involuntary exaggerated contraction of facial muscles, resulting in distorted or contorted facial expressions.
Lead-pipe rigidity	A type of muscle hypertonicity characterised by constant, uniform resistance to passive movement throughout the range. It is commonly seen in conditions like Parkinson's disease and is caused by basal ganglia dysfunction.
Myoclonus	Sudden, brief involuntary twitching or jerking of a muscle or group of muscles. Occurs spontaneously and cannot be suppressed by the individual.
Nystagmus	Involuntary, rapid oscillating movement of the eyes. Motion may be rotatory, horizontal, vertical, or a mixture.

Oculogyric crises	Involuntary, spasmodic movements of the eyeballs, typically in an upward direction. These episodes, lasting minutes to hours, may be accompanied by increased blinking, pain, and associated symptoms like neck dystonia and tongue protrusion. Neuroleptics and dopamine receptor antagonists are two identified triggers for oculogyric crises.
Oppositional paratonia	Also known as **gegenhalten** (a German word meaning resisting), is characterised by involuntary resistance to passive movement of the limbs.
Parkinsonism	A motor syndrome characterised by movement abnormalities similar to those seen in Parkinson's disease. Typically manifests as tremors, bradykinesia (slow movements) and rigidity (stiffness). Commonly occurs as the extra-pyramidal side effect of medications (see Chapter 35, Basic Principles of Psychopharmacology).
Posturing	Individuals adopt bizarre or inappropriate body postures for an extended period of time. Observed in psychotic disorders and may hold delusional significance.
Psychological pillow	Individual holds their head a few centimetres above the floor/bed while lying on their back. The person is able to maintain this position for a prolonged period of time even though it is uncomfortable.
Schnauzkrampf	The involuntary contraction of facial muscles, particularly those around the mouth, leading to a grimacing or pained expression resembling pouting. It is also known as a 'snout spasm'.
Tardive dyskinesias	A group of late-onset dyskinesias associated with prolonged antipsychotic therapy. Characterised by disabling and potentially irreversible symptoms, including tremors, choreoathetoid movements, and spasticity in orofacial and limb muscles. Most commonly there is continuous involuntary movement of the lower face and tongue, more severe cases extend to the upper face and limbs.
Tic	Abrupt and involuntary movements that occur despite efforts to suppress them. Tics can be simple (isolated muscle movement) or complex (coordinated movement of multiple muscles) and typically involving jerking actions affecting the face, neck, and trunk. They tend to

	worsen during periods of marked anxiety and emotional distress.
Titubation	A rhythmic, involuntary movement of the head characterised by a back-and-forth or side-to-side nodding motion. Titubation can be observed in various neurological conditions, including disorders affecting the cerebellum or its connections.
Torticollis	Also known as "wry neck," is characterised by involuntary and sustained contraction of neck muscles, causing the head to tilt to one side and the chin to rotate in the opposite direction. It can be a side effect of some neuroleptic medications.
Trismus (lockjaw)	Sustained, tetanic spasm of masticatory muscles causing reduced mandible motion.
Waxy flexibility (catalepsy; catatonic rigidity; flexibilitas cerea)	Prolonged maintenance of fixed body posture or physical attitude, with a plastic tone allowing the body to be positioned and held in various positions for an extended duration (see **Catalepsy**).

Tremors	
Postural tremor	Occurs when an individual sustains a position against gravity, such as holding their arms outstretched.
Kinetic tremor	Manifests during the movement of a specific body part, such as moving the wrists up and down. It becomes more pronounced with purposeful motion and tends to diminish or disappear when the limb is at rest.
Intention tremor	Trembling of a body part that occurs towards the end of a purposeful, voluntary movement. For example, it may be observed when an individual attempts to touch their finger to their nose. The tremor becomes more noticeable as the intended movement target is approached. Intention tremor is often associated with disorders affecting the cerebellum or its connections.
Task-specific tremor	Occurs specifically during the performance of highly skilled, goal-oriented tasks. Examples of such tasks include handwriting, playing a musical instrument, or performing fine motor activities. The tremor is typically isolated to the specific task and may not be present during rest or other activities.
Isometric tremor	Arises during a voluntary muscle contraction without any associated movement of the affected body part. The shaking or oscillations occur within the contracted

	muscle itself. It can occur in various muscles and can be observed in tasks that involve sustained muscle contractions, such as gripping an object tightly or maintaining a fixed position against resistance.
Essential tremor	An action tremor, either postural or kinetic in character, mainly affecting the hands. It is usually bilateral, with a frequency of 4 Hz to 12 Hz and largely symmetrical. It is hereditary and the most common type of movement disorder.
Physiological tremor	A normal occurrence in all individuals when muscles are activated. It is typically postural and has a frequency of 8-12 Hz. It is often so subtle that it is barely visible to the naked eye and does not disrupt daily activities. The frequency of physiological tremors tends to decrease when the limb is subjected to larger loads or inertia.
Increased physiological tremor	The heightened visibility of a high-frequency, postural tremor that occurs without any indication of an underlying neurological disorder. This type of tremor can be resolved by addressing the underlying cause. Various factors can exacerbate physiological tremors, such as stress and anxiety, especially in situations involving public performance. Other conditions that can amplify physiological tremors include thyrotoxicosis, pheochromocytoma, hypoglycaemia, withdrawal from opioids or sedatives and taking Valproic acid or Lithium.
Resting tremor	Resting tremor manifests when the affected body part is at rest and not engaged in any voluntary movement. It is typically more prominent when the individual is relaxed or sitting still. Resting tremor is often associated with conditions such as Parkinson's disease, where it is considered a hallmark symptom.
Parkinsonian tremor	The most prevalent type of resting tremor. In Parkinson's disease, the tremor typically manifests when the affected body part is at rest and diminishes during voluntary movement. Initially, the tremor is observed in the distal upper extremity and gradually progresses proximally. Subsequently, it may also affect the opposite upper extremity, following a pattern from distal to proximal.

Named Syndromes

Table 9.3. Named Syndromes. Named syndromes refer to specific sets of signs and symptoms that occur together and are recognised as distinct clinical entities.

Capgras syndrome	A form of delusional misidentification in which the individual falsely believes that familiar people such as their loved ones have been replaced by identical-looking strangers. The person therefore regards them as impostors. It occurs rarely in schizophrenia or psychotic mood disorders. The syndrome was named after the psychiatrist Jean Marie Joseph Capgras, who first described it in 1923.
Charles Bonnet syndrome	Characterised by recurring and detailed visual hallucinations, commonly depicting animals or people in various settings. These hallucinations occur in elderly individuals who maintain clear consciousness and possess intact insight and cognitive abilities. The syndrome may have an organic basis, often associated with visual impairments. It is named after the Swiss naturalist and philosopher Charles Bonnet.
Cotard's syndrome	Individuals usually suffering from psychotic depression have nihilistic and/or hypochondriacal delusions and firmly believe that their bodies, or even reality itself, have disintegrated or no longer exist. The person often claims they are already dead, and they are rotting internally. Usually seen in elderly people. It was first reported by Jules Cotard in 1880.
Couvade syndrome	The occurrence of abdominal pain or other non-specific physical symptoms in male partners of pregnant women such as nausea, vomiting and food cravings. It typically manifests during the third and ninth months of pregnancy, and the man does not actually believe himself to be pregnant. It is a conversion symptom, not a delusion.
Pseudocyesis	A false pregnancy in which a person, most commonly, a woman, exhibits the typical symptoms and sometimes signs of pregnancy, e.g. amenorrhea, abdominal distension, and breast enlargement, although conception has not occurred. It can be psychogenic in some cases, or it can be attributed to medical conditions like tumours or endocrine disorders.
Da Costa's syndrome (effort syndrome or	A somatisation disorder involving the cardiovascular system. Initially observed in soldiers during the American Civil War, it is now characterised as panic disorder that features symptoms of fatigue, heart palpitations, chest pain, and

soldier's heart)	difficulty breathing. It is named after the U.S. surgeon Jacob Méndes Da Costa.
De Clérambault's syndrome (Erotomania)	A delusional belief in which an individual is convinced that someone of higher status and therefore inaccessible to them is deeply in love with them. It is important to note that the syndrome does not necessarily involve a desire for a sexual relationship with that person. Named after Gaëtan Gatian de Clérambault, a French Psychiatrist, artist and photographer.
Dhat syndrome	The belief that passing semen in the urine causes a non-specific malaise, often attributed to excessive sexual activity. It is culturally influenced and may share similarities with other post-orgasmic disorders such as post-coital tristesse, post-orgasmic illness syndrome, and sexual headache.
Post-coital tristesse, or "post-sex blues"	A phenomenon characterised by feelings of sadness, melancholy, or even crying shortly after sexual activity, typically following orgasm. This emotional response can occur despite positive or satisfying sexual experiences.
Diogenes syndrome (senile squalor syndrome)	Extreme self-neglect, domestic squalor, social withdrawal, apathy, hoarding of useless objects or animals, and a lack of shame. May be caused by an organic condition and is seen in schizophrenia, depression, OCD and may occur in response to stress in predisposed personality. The condition was named after Diogenes of Sinope, an ancient Greek philosopher known for his minimalist lifestyle, which contradicts the hoarding behaviour seen in this syndrome.
Ekbom syndrome (delusional parasitosis)	A hypochondriacal monosymptomatic delusional disorder characterised by a strong belief of being infested by parasites crawling under, in, or on the skin. It can manifest as delusions, tactile hallucinations, or over-valued ideas. It is important to note that Ekbom's syndrome can also refer to restless legs syndrome, a separate condition involving discomfort and fidgeting in the legs, distinct from akathisia. It was named after Karl-Axel Ekbom (1907-1977), a Swedish neurologist mostly known for his detailed description of restless legs syndrome.
Fregoli syndrome	A form of delusional misidentification in which the individual mistakenly identifies strangers as familiar people, in contrast to **Capgras syndrome**. The person believes that a persecutor can change their appearance and identifies them in different individuals they know, such as neighbours, doctors, or attendants. It was first identified in 1927 and named after

	Italian actor Leopoldo Fregoli, known for his skill in altering his appearance.
Ganser syndrome	A rare dissociative syndrome characterised by nonsensical or incorrect answers to questions, along with other dissociative symptoms such as a fugue, amnesia, or conversion disorder. Typically, the person gives "appropriate answers to questions, which are incorrect but related. It is sometimes seen in prison inmates and may be perceived as an attempt to gain leniency. It was first identified by Sigbert Ganser, who described impaired consciousness and distorted communication, particularly in the form of approximate answers. This syndrome is often classified as a dissociative disorder rather than malingering.
Gilles de la Tourette's syndrome (GTS)	A childhood-onset neuropsychiatric movement disorder characterised by multiple motor tics and one or more vocal/phonic tics lasting more than a year. Tics are rapid, repetitive, uncontrolled movements or vocalisations that can be temporarily suppressed but reappear during periods of inactivity or relaxation. The syndrome is sometimes associated with inappropriate vocalisation or socially embarrassing actions.
Koro (also known as shrinking penis or genital retraction syndrome)	A culture-bound delusional disorder where individuals strongly believe that their sex organs are retracting and will disappear, despite no actual physical changes. It causes immense anxiety and likely arises because of poor understanding of anatomy. The term "koro" comes from Malay and refers to the resemblance of a turtle retracting its head into its shell.
Munchausen syndrome	Individuals deliberately fake or induce symptoms of illness in themselves and the syndrome is best regarded as a variant of pathological lying. Named after Baron Munchausen, known for his exaggerated tales, people with this syndrome lie about their symptoms, manipulate test results, self-inflict harm, and seek medical attention from multiple healthcare providers. Unlike hypochondriasis (genuine belief in being ill) or malingering (feigning illness for personal gain), individuals with Munchausen's know they are fabricating symptoms and engage in manipulative behaviour without obvious benefits, often undergoing unnecessary medical procedures.
Munchausen by proxy	An individual, typically a caregiver or parent, deliberately induces or falsely reports symptoms in a dependent, such as a

	child. The person undertaking this behaviour aims to draw attention to themselves, and their actions often lead to unnecessary medical interventions for the dependent. It is a form of abuse that requires recognition and intervention to safeguard the well-being of the dependent individual.
Othello syndrome (delusional jealousy, morbid jealousy)	A form of paranoid delusional jealousy where an individual firmly believes, without evidence, that their partner is being unfaithful. It leads to obsessive thoughts and preoccupation with the imagined infidelity, causing significant distress and relationship difficulties. The term "Othello Syndrome" originates from Shakespeare's play Othello, where the character mistakenly believes his wife is unfaithful and tragically kills her. However, there is ongoing debate as to whether Othello was genuinely deluded or deceived about his wife's infidelity, questioning his representation of the syndrome.

Further Reading

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