Introduction to Psychopathology & Classification
Before we start…

• 1hr 30 min: 40, 10 min break, 40
• Don’t be afraid to make mistakes
Aims and overview of session

• Why learn about psychopathology?

• Definitions
  o Be able to define psychiatric phenomenology

• Be able to recognise common abnormal phenomena seen in psychiatry
  o Disorders of perception
  o Disorders of thought

• Classification systems
  o Describe how psychiatric disorders are classified
Psychopathology

“The systematic study of abnormal experience, cognition and behaviour"

“The study of the products of a disordered mind.”

Why bother?
Can’t we just have some coffee?
Why bother?

• Assessment and diagnosis

• Communication e.g. with colleagues

• State of condition
  ○ Response to treatment
  ○ Getting better/worse

• Research – evolving disease concepts

• You will be doing some of this – even if you’re not a psychiatrist
Models of psychopathology

Karl Jaspers
Allgemeine Psychopathologie
(1913)

(from Andrew Sims: Symptoms in the Mind, 1995)
Example of phenomenology

- What’s the capital of France?

- Remember your 18\textsuperscript{th} birthday – what was it like?

- How do these 2 types of memory differ in the experience you had remembering?
One way these 2 types of memory (semantic and episodic) differ is in their…

**Phenomenology**

- The study of subjective experience
- Doesn’t try to explain (remember, *descriptive*)
- Describe psychological events, without embellishing
- These events may be abnormal, even alien, to us
- “The *empathic* method for eliciting symptoms"

(Andrew Sims, Symptoms in the Mind, 1995)
Why ‘empathy’?
Empathy – a clinical instrument

• Try to **imagine** what it’s like to experience another person’s world using your own cognitive and emotional experience as a yardstick

• Allows doctor to try and **understand** the patient’s experiences

• Can you identify what the doctor is doing in the following example?
So, you believe that MI5 might be interfering with your thoughts, perhaps removing them?

Yes, exactly – **SUCCESS**
No, that’s not it – **RETURN TO SYMPTOMS**
The method of empathy (Sims)

The indirect approach

questioning

clarifying

rephrasing, reiterating

(pictures from Andrew Sims: Symptoms in the Mind, 1995)
Observation

- Other part of ‘descriptive’ psychopathology
- Observing the **objective** expression (i.e. behaviour & appearance) of a patient’s subjective experience

- Understanding a person’s experience comes from more than just what they say – gesture, posture etc.
- What might be going on here?
Mental State Examination

“Always Bring Something More Than Purely Clinical Information”

Is a screening instrument for psychopathology

Appearance
Behaviour
Speech – a bit today
Mood – affective disorders teaching
Thoughts* main focus today
Perception* main focus today
Cognition – e.g. dementia/delirium teaching
Insight
“There’s a nose, some eyes, a paw, a tail. I don’t know what it is”

What’s going on?
Sensation versus perception

- What is sensation?
- How does it relate to perception?
Sensation

- 1st stage in receiving sensory info from the world
- Receptors receive, transform and transmit sensory info to CNS
- Any modality (visual, auditory, olfactory, gustatory, tactile, proprio)

Receptor – **sensation** e.g. visual, auditory etc.
Perception

- The *interpretation* of sensory info, allowing the environment (internal or external) to be *represented* and *understood*
- Normal perception of external object

- Return to the previous kitten example…
Sensation with impaired perception

- Case of ‘Virgil’ described by Sachs
- Distinction sensation and perception well illustrated by visual agnosia
  - Inability to recognise things
  - Tell there’s an object in field of vision (sensation intact)
  - Unable to identify what it is (impaired perception)
Sensory distortion

- A real object is perceived as such but in a **distorted** way
- Involve any component e.g. size, shape, colour, motion
- Critically, the perceived object is correctly identified, but there is deviation from its normal appearance

E.g. macropsia, micropsia, dysmegalopsia, visual hyperaesthesia, hyperacusis
What do you see? What’s going on?
What do you see? What’s going on?
Illusion

- Misinterpretation of a *real* stimulus – the object you perceive doesn’t correspond to the source object in the real world
- Mixing of *false* perceptions with true perceptions.

- Why is this different to **hallucination**?
Hallucination

- A perception without an object (Esquirol, 1817)
- Any modality – auditory most significant

“One of the simplest facts about hallucinations is often the most difficult to understand. That is, what the doctor calls a hallucination is a normal sensory experience to the patient” (from Andrew Sims: Symptoms in the Mind, 1995)
Modality of hallucination

• Can happen in any of the 5 special senses (i.e. external) and somatic (i.e. internal)

• **Visual hallucinations**
  o More characteristic of *organic* states e.g. delirium, drugs (LSD), epilepsy (temporal lobe), Charles de Bonnet

• **Haptic (tactile) hallucinations**
  o Formication (ants crawling) – cocaine, ETOH withdrawal
  o Thermic (feeling of temperature) – psychotic, rare
  o Hygric (feeling of water) – LSD
Modality of hallucination

• Auditory hallucinations
  • Most relevant to psychiatry
  • Some types are particularly important
    • Audible thoughts (thought echo)*
    • Voices giving a running commentary on pt’s actions*
    • Voices arguing/discussing pt in the 3rd person*
    • Command hallucinations

*these are ‘first rank symptoms’ of schizophrenia
“Sometimes the devil talks to me. I can hear his voice inside my head. He tells me to murder cats. I see him at night sometimes too. It all feels pretty real.”
Pseudohallucination

“A perceptual experience, which is *not concretely real* and occurs in *inner* subjective space, not in external objective space. It may have definite outline and vivid detail. It may be retained for some time and it cannot be deliberately evoked.”

(from Andrew Sims: Symptoms in the Mind, 1995)
“That was when the ship came out of the book, and it was night time. And then they had a sword fight at the top of the mast.”
Fantasy

Fantasy is volitional!
Quick break
Disorders of thought

Is normally divided into:

- **Form**
  - How you’re thinking (“no FTD”)
- **Content**
  - What you’re thinking about
  - Can encompass delusions (see later)

Remember:

- Thought disorder can sometimes be observed objectively (e.g. in how someone speaks), but is also experienced subjectively by the patient
- i.e. you need to **ASK** about it!
Disturbances of the **FORM** of thought

- Get into small groups
- 5 minutes
- Match the quotation with the correct term
- What do you notice about how the person is thinking?
Disturbances of the **FORM** of thought

“...about my soul, sole survivor of my childhood, hood, good, wood, that’s where they race all those vintage cars at Goodwood, I went there a while ago but I was too sneechy to drive, so I drove them up the wall instead, hahaha, can’t drive a car but I can still drive people crazy.”

**Speed of thought**

- **Flight of ideas**
  - Accelerated thinking (pressured speech)
  - Logical connection between consecutive thoughts
  - Goal may be lost due to distractibility
  - May show neologisms, rhyming, clanging, puns
  - Most common in mania, but also schizophrenia
Disturbances of the **FORM** of thought

“I suppose… that… I might be… y’know, a bit… a bit… down really. That seems… quite… likely… I don’t know… it’s quite hard to… to explain. This cloud seems to be… hanging over me… all the time.”

**Speed of thought**

- **Retardation of thought**
  - Slowing of thought
  - Goal-directed but so slow, may never reach this
  - Difficulty making decisions
  - Slow, laboured speech, considerable answer delay
  - Most common in depression
Disturbances of the **FORM** of thought

“Am I getting side effects? Well, I’ve been on the new medication since Thursday. I was upset on Thursday because it rained all day, so I didn’t get to use my leave. Still, I’m making progress and I think the medication’s helping. I’ve been feeling drowsy, which might be a side effect?”

**Going off topic**

- **Circumstantial thinking**
  - Thought is delayed in reaching its goal because of excessive and unnecessary detail, but it **does** get there.
  - Characteristic of more organic conditions but also mania and obsessional personalities
Disturbances of the **FORM** of thought

“Am I getting side effects? Well, I started the drug this week and it’s made me think about why I’m in hospital. I think you doctors like to give us medications. It makes you feel powerful, like judges. I don’t think it’s right that medications should be foisted on people when they haven’t asked for them.”

Going off topic

- **Tangential thinking**
  - Deviates from initial train of thought but **never** gets to it goal; it drifts from one point to the next
  - More commonly seen in mania, schizophrenia, organic
Disturbances of the **FORM** of thought

A

“The doc said I’m a bit low in my vitamins, which is worrying. I went to buy some milk yesterday morning, but the problem is, it’s just so expensive to get tested for lactose intolerance, isn’t it?”

B

“My mother’s coming to visit pretty soon, she is, uh the traffic’s been noisy outside my window… all those pantomime heroes, always played by young women, though, which is… taking control of the music”

C

“Windows the books dogs, hands, the hands running. It’s not, not like, wetness smooth canyon, tart… tart. I’m only… the sheep dancing old moon… clustered fixed greased lightning legs… teeth exit time”

Less coherent
Disturbances of the **FORM** of thought

Loosening of associations

- Reduced/lack of coherence between individual thoughts in the person’s chain of thought – spectrum of increasing psychosis

- **Knight’s move thinking** (example A) – seems like jumping between topics, but there is an underlying logic (even if odd)

- **Derailment** (example B) – severe breakdown in chain of thought that there’s no understandable connection between thoughts

- **Word salad** (example C) – unintelligible mixture of random words and phrases.
Disturbances of the **FORM** of thought

“I’ve noticed that people have found it a bit hard to talk to…

…sorry what? It’s not been easy to get on with things because of the problems with…”

**Thought blocking**

- Sometimes called “snapping off”
- Experience of a patient when their chain of thought suddenly, and unexpectedly stops, even mid sentence.
- May be explained by the patient as thought withdrawal
Disturbances of the **FORM** of thought

“I was born in Bristol and lived there until I was Bristol… Bristol, Bristol. I lived there until I was 7 years old.”

**Perseveration**

- Repetition of ideas or words, even when the person tries to change topic
- More characteristic of organic brain disease e.g. iPD
Disturbances of the **CONTROL** of thought

Control of thought

- **Passivity of thought**
  - The control of thought is experienced as being **external**
  - 3 particularly important examples of this
    - Thought withdrawal*
    - Thought insertion*
    - Thought broadcasting*

*these are ‘first rank symptoms’ of schizophrenia
What do you think about these beliefs?

I believe that when I die, I will go to a far better place than here. This place will be a kingdom, of sorts, and I will be reunited with my loved ones for all time.

Delusional?
What do you think about these beliefs?

I believe that God has blessed me with the ability to heal. I can channel His powers through my palms to cure things like cancer, blindness and paedophilia.

Delusional?
What do you think about these beliefs?

I used to play for the England cricket team. I got 15 caps and enjoyed being a local hero when I came back from tour.

Delusional?
What do you think about these beliefs?

I am an immortal, spiritual being who is one of the ghosts of an ancient race sacrificed on Earth 75 million years ago, when hydrogen bombs were used to destroy me in a volcano.

Delusional?
What do you think about these beliefs?

I had my legs broken by the IRA after I was working undercover for the army in Northern Ireland. They’re still after me – they spy on me.

Delusional?
What is it about a belief that makes it DELUSIONAL?
Disturbance of thought content – delusions

A false, unshakeable idea or belief which is out of keeping with the patient’s educational, cultural and social background; it is held with extraordinary conviction and subjective certainty.

- Can’t be distinguished phenomenologically from normal ideas
- Jasper’s definition
  - They are held with unusual conviction
  - They are not amenable to logic
  - The absurdity or erroneousness of their content is manifest to other people
Types of delusion

Can be considered in a number of ways:

**Primary vs. Secondary Delusions**

- **Primary delusions**
  - Ultimately *not* understandable (‘un-understandable’)
  - Arise spontaneously (autochthonous), mainly in Sz

- **Secondary delusions**
  - *Understandable* in the context of other psychopathological phenomena
  - Can be seen as patient’s attempt to make sense of their experience e.g. thought insertion → CIA ‘beaming’ in thoughts
Types of delusion

**Content** – overall theme more important than specific content

- Persecutory
- Grandiose
- Nihilistic
- Delusions of reference
- Delusional misidentification
  - Capgras’
  - Fregoli’s
- Erotomania e.g. de Clerambault’s
- Morbid jealousy (Otello)
- Control (passivity phenomena)
- Many more....

Leopoldo Fregoli
1867 – 1936
Types of delusion

Mood congruence

• **Yes** e.g. grandiose in mania, nihilistic in psychotic depression

• **No** e.g. in schizophrenia (but watch for schizoaffective)
Overvalued idea (Wernicke)

- It is a solitary, abnormal belief that is *neither delusional nor obsessional* in nature

- It is both *reasonable* and *understandable* in itself, but it comes to unreasonably dominate the sufferer's life.

- Not considered to be psychotic, but can be viewed as being on a continuum with delusions at the extreme

- It is usually associated with abnormal personality e.g. anankastic, body dysmorphophobia
Psychiatric classification

• Do we need diagnoses?
• Potential problems?
The problem with diagnosis . . .

“Clinical diagnosis splits the world into two: with regard to each disease there are those who have it and those who do not. This dichotomy serves well enough in clinical practice, both because treatment decisions are dichotomous and selective referral brings to the doctor only the more severe examples of a condition . . . In population studies the situation is not like this, and rating scales for mental illness show continuous, unimodal distributions. It follows that to ask what fraction of a population is psychiatrically disturbed is a meaningless question.”

(Rose, 1989 quoting Goldberg, 1972)
Modern psychiatric classification

- The best available “working solution” – not the ultimate answer!
- **International Classification of Diseases (ICD-10)**
  - Developed by the WHO
  - Tend to use this in the UK
- **Diagnostic and Statistical Manual (DSM-V)**
  - Developed by the APA
# ICD-10 hierarchical categories

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>F00 – F09</td>
<td>Organic, including symptomatic mental disorders</td>
</tr>
<tr>
<td>F10 – F19</td>
<td>Mental and behavioural disorders due to psychoactive substance abuse</td>
</tr>
<tr>
<td>F20 – F29</td>
<td>Schizophrenia, schizotypal and delusional disorders</td>
</tr>
<tr>
<td>F30 – F39</td>
<td>Mood [affective] disorders</td>
</tr>
<tr>
<td>F40 – F48</td>
<td>Neurotic, stress-related and somatoform disorders</td>
</tr>
<tr>
<td>F50 – F59</td>
<td>Behavioural syndromes associated with physiological disturbances and physical factors</td>
</tr>
<tr>
<td>F60 – F69</td>
<td>Disorders of adult personality and behaviour</td>
</tr>
<tr>
<td>F70 – F79</td>
<td>Mental retardation</td>
</tr>
<tr>
<td>F80 – F89</td>
<td>Disorders of psychological development</td>
</tr>
<tr>
<td>F90 – F98</td>
<td>Behavioural and emotional disorders with onset usually occurring in childhood and adolescence</td>
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ICD-10 definition of “psychotic”

- ICD-10 discontinued the traditional split between Psychoses and neuroses (still present in ICD-9)

*Psychotic* simply indicates the presence of hallucinations, delusions, or a limited number of severe abnormalities of behaviour (gross excitement and overactivity, marked psychomotor retardation, catatonic behaviour)
Psychopathology is limited

“Psychopathology is limited in that there can be no final analysis of human beings as such, since the more we reduce them to what is typical and normative the more we realise there is something hidden in every human individual which defies recognition. We have to be content with partial knowledge of an infinity which we cannot exhaust.”

Karl Jaspers, General Psychopathology