HISTORY OF PSYCHIATRY
&
GENERAL PSYCHOPATHOLOGY
Seminars for Residents in Psychiatry
1994

Part Two: General Psychopathology

Thomas A. Ban
Professor of Psychiatry

International Network for the History of Neuropsychopharmacology
2014
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Part Two

GENERAL PSYCHOPATHOLOGY
For Residents in Psychiatry

Eight Seminars
1994
February 17 – March 9

Thomas A. Ban, MD, FRCP(C)
Professor of Psychiatry
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<table>
<thead>
<tr>
<th></th>
<th>Author(s)</th>
<th>Title</th>
<th>Publisher/Press</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Karl Jaspers</td>
<td>General Psychopathology</td>
<td>University of Manchester, Chicago and Tronto Press</td>
<td>1962</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Manchester, Chicago and Tronto</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Max Hamilton (ed)</td>
<td>Fish's Clinical Psychopathology</td>
<td>Signs and Symptoms in Psychiatry</td>
<td>1985</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Wright, Bristol</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Thomas A. Ban</td>
<td>Conditioning and Psychiatry</td>
<td>Aldine, Chicago</td>
<td>1964</td>
</tr>
</tbody>
</table>
DEFINITION: SCOPE AND BOUNDARIES

First Seminar
PLACE IN PSYCHIATRY

Two Major Disciplines which Serve as Foundation for Modern Psychiatry

<table>
<thead>
<tr>
<th>PSYCHOPATHOLOGY</th>
<th>NOSOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Psychopathology</td>
<td>Clinical Psychopathology</td>
</tr>
</tbody>
</table>

1. Pathology of subjective experiences                                           Formation of disease entities
2. Pathology of objective performances                                            Classification of disease entities
3. Symptoms and signs "create" illness                                             Illness "creates" symptoms and signs
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Concept</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descartes</td>
<td>1642</td>
<td>Dualism</td>
<td>Mind and Body</td>
</tr>
<tr>
<td>Stahl</td>
<td>1707</td>
<td>Animism</td>
<td>Soul (Psyche) Maintains the Functioning of the Body</td>
</tr>
<tr>
<td>Reil</td>
<td>1803</td>
<td>Mentalist tradition</td>
<td>Psychiaterie (Introduction of Term)</td>
</tr>
<tr>
<td>Heinroth</td>
<td>1818</td>
<td>Mentalist tradition</td>
<td>Psychiatrie (Psychiatry) (Introduction of Term)</td>
</tr>
<tr>
<td>Feuchtersleben</td>
<td>1845</td>
<td>Mentalist tradition</td>
<td>Psychosis (Introduction of Term)</td>
</tr>
<tr>
<td>Emminghaus</td>
<td>1878</td>
<td>Mentalist tradition</td>
<td>Psychopathology (Introduction of Term)</td>
</tr>
<tr>
<td>Jaspers</td>
<td>1913</td>
<td>Mentalist tradition</td>
<td>General Psychopathology (Introduction of Term)</td>
</tr>
</tbody>
</table>
DEFINITION

General Psychopathology is the Scientific Discipline that deals with the
IDENTIFICATION
DESCRIPTION
CONCEPTUALIZATION

of Symptoms and Signs which Occur in Psychiatric Disorders
ROLE

General Psychopathology Provides:

1. SYMPTOMS AND SIGNS WHICH ARE DETECTABLE
   Essential prerequisite for psychiatric clinical practice

2. SET OF CONCEPTS WHICH CAN BE COMMUNICATED TO OTHERS
   Essential prerequisite for psychiatric education and training

3. CONCEPTUAL FRAMEWORK WHICH CAN BE REFERRED TO
   Essential prerequisite for psychiatric research
COMPONENTS

THE FOUR COMPONENT DISCIPLINES OF GENERAL PSYCHOPATHOLOGY:

PHENOMENOLOGY or SUBJECTIVE PSYCHOPATHOLOGY

Provides a concrete description of the psychic states experienced by the patient.

Presents these psychic states accessible for observation.

Renders (pathologic) psychic realities intelligible by concepts and provides a suitable terminology which can be communicated to others.

OBJECTIVE PSYCHOPATHOLOGY

Deals with observable performances and

Somatic (physical) accompaniments or consequences of psychic events.

UNDERSTANDING PSYCHOPATHOLOGY

Deals with meaningful connections and

Comprehensible relations.

EXPLANATORY PSYCHOPATHOLOGY

Deals with causal connections and

Causal explanations.

(i.e., with findings by repeated experience that a number of phenomena are regularly linked together in a particular manner with another intrinsic or extrinsic factor.)
RELATED DISCIPLINES

A closely related discipline to general psychopathology is PATHOPSYCHOLOGY or ABNORMAL PSYCHOLOGY

In PATHOPSYCHOLOGY Abnormal Mental Phenomena Are Perceived and Understood in Terms of Deviations From The Statistical Mean (Norm) Accepted as Normal For Subject’s Social Background

In PSYCHOPATHOLOGY Pathological Mental Phenomena Are Perceived And Understood in Terms of And Within The Frame of Reference of Patient’s Mental Illness
PURPOSE

To Establish Psychopathologic Symptom Profile on the Basis of

PHENOMENOLOGIC EXPLORATION
&
OBJECTIVE PERFORMANCE TESTING

Limitations of Psychopathologic Symptom Profile in Terms of

PRACTICAL USEFULNESS
&
HEURISTIC IMPLICATIONS

Led to a Loss of Interest in General
Psychopathology by the 1950's
REVIVAL

Development of psychopharmacology and introduction of modern biochemical and neurophysiological instrumentation led to better understanding about the biologic substrate of pathologic mental phenomena.

Increasing acceptance that identification of psychopathologic symptoms and signs plays a similar role in the diagnosis of mental illness as identification of signs and symptoms in the diagnosis of other medical illness (Galen) led to revival of interest in general psychopathology.
BASIC CONCEPTS: THE PSYCHIC REFLEX

Second Seminar
UNIT

Elementary Unit: Psychopathologic Symptom - Pathologic Subjective Experience
Psychopathologic Sign - Pathologic Objective Performance

Psychopathologic Symptom (Sign): Concept

Content - derived from past experience (subject matter a person talks about)
Form - characteristic of illness (how a person is talking, i.e., process)
PHENOMENOLOGY

Pathology of Subjective Experience

KANT
Critiques of Pure Reason 1781
Practical Reason 1788
Judgement 1790

Experience through senses provides only the
surface of things
Transcendental leap through the mind to know
"the thing in itself"
Knowledge is the result of sensations and the
activity of the mind that organizes them in
time and space with the help of a priori
(categories: quantity, quality, relation, modality)

HUSSERL
Ideen zu einer reinen Phänomenologie 1913

Phenomenology, or the study of subjective experience
is the science that preceded all others
Phenomenology describes the form and content of
subjective psychological experiences
Psychology "explains these experiences" and their
"causal relationships"

DILTHEY (1833-1911)

Introduced the concept of understanding in psychology
Pointed out the need to understand individual as a whole
Contrasted "understanding" with analytical explanatory methods
of natural science
<table>
<thead>
<tr>
<th>Discipline</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathic Psychology</td>
<td>&quot;... must think ourselves into his/her situation or try to understand why he/she is behaving in certain way...&quot;</td>
</tr>
<tr>
<td>Interpretative Psychology</td>
<td>&quot;... ideas which have been obtained by empathizing with patient are formulated in terms of some general theory...&quot;</td>
</tr>
<tr>
<td>Psychoanalytic Interpretative Psychology</td>
<td>&quot;... understanding of patient is formulated in terms of general theory derived to some extent from mythology...&quot;</td>
</tr>
<tr>
<td>Existentialist Interpretative Psychology (Binswanger 1958)</td>
<td>&quot;... understanding of patient is formulated in terms of general theory derived from the philosophy of Heidegger (1889 - 1976) ...&quot;</td>
</tr>
</tbody>
</table>
CLINICAL PSYCHIATRY: DEALING WITH FORM

DEFINITION: Mode -- perception, thought -- by which subject is presented with object

EXAMPLE: Hypochondriacal complaints, a content may appear in the form of bodily hallucinations, compulsive ideas, hypochondriacal delusions, etc.

PATIENT: deals with CONTENT
(Lay Person)

PSYCHIATRIST: deals with FORM
(Diagnostician)

Psychic life: total relational context in constant flux with patients' conscious state and mood simultaneous presence (or quick succession) of same content in varied forms not an agglomeration of isolated phenomena

Mental status: separate form from content identify all different forms in which content (behavior) is presented to and (experienced or displayed by) patient forms relevant to patient's illness clearer and sharper than others
<table>
<thead>
<tr>
<th>Name</th>
<th>Year</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCARTES</td>
<td>1649</td>
<td>Introduced term (Des Passions de l’Ame)</td>
</tr>
<tr>
<td>WHYTT</td>
<td>1751</td>
<td>Adopted term into physiology (On the Vital and Other Involuntary Motions of Animals)</td>
</tr>
<tr>
<td>GRIESINGER</td>
<td>1843</td>
<td>Described psychic reflex</td>
</tr>
<tr>
<td>SECHENOV</td>
<td>1866</td>
<td>Extended concept of psychic reflex to include all activities of the brain (Reflexes of the Brain)</td>
</tr>
<tr>
<td>WERNICKE</td>
<td>1899</td>
<td>Adopted psychic reflex as the functional unit of psychiatric disease</td>
</tr>
</tbody>
</table>
### WERNICKE’S CONCEPTUAL FRAMEWORK

<table>
<thead>
<tr>
<th>Psychosensory Path</th>
<th>Intrapsychic Path</th>
<th>Psychomotor Path</th>
</tr>
</thead>
<tbody>
<tr>
<td>hyperesthesia</td>
<td>hyperfunction</td>
<td>hyperkinesia</td>
</tr>
<tr>
<td>paresthesia</td>
<td>parafunction</td>
<td>parakinesia</td>
</tr>
<tr>
<td>anesthesia</td>
<td>afunction</td>
<td>akinesia</td>
</tr>
</tbody>
</table>

#### Consciousness
Integrating Function

- **Body** - Somatopsyche
- **External World** - Allopsyche
- **Personality** - Autopsyche
NYIRO'S SYNTHESIS  
(1958)

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
</table>
| WERNICKE | 1899  | Psychic Reflex  
(psychosensory, intrapsychic and psychomotor) |
|          | (1900)|                                                  |
| PAVLOV   | 1900  | Conditional Reflex  
(differential and retarded inhibition) |
| JASPERS  | 1913  | General Psychopathology  
(phenomenology) |
MENTAL STRUCTURE

COGNITIVE  RELATIONAL  ADAPTIVE
(Psycho-sensory)  (Intrapyschic)  (Psychomotor)

Abstract Ideation
Concrete Ideation
Image Formation
Differentiated Perception
Diffuse Sensation

Ethical, Moral &
Social Emotions

Intellectual Emotions

Sensorial Emotions

Vital Emotions

Undifferentiated

Primitive Signal

Automatisms

Voluntary Coordinations

Instinctual (Emotional)

Stereotypes

Uncoordinated Activities

Simple Autonomic

Reflexes

CONSCIOUSNESS

SCREENING

Awareness - lowered
clouded
narrowed

Attention - concentration
vigilance
tenacity

INTEGRATION

Self - identity
integrity
boundaries

Memory - acquisition
retention
recall

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PSYCHOPATHOLOGIC SYMPTOMS: BIOLOGIC SUBSTRATE

Recognition that psychopathologic symptoms are accessible to pharmacologic manipulation and control by psychotropic drugs.

Psychotropic drugs are substances with an effect on the transmission of impulses at the synaptic cleft.

Psychopathologic symptoms are manifestations of pathology in the processing of experience in the brain.

Recognition that the grouping of psychopathologic symptoms at a particular point in time alone does not express mental illness as a whole.
DISORDERS OF THE PSYCHORENOSORY PATH

Third Seminar
## DEVELOPMENT OF CONCEPTS

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GRIESSINGER</td>
<td>1843</td>
<td>Psychic reflex described</td>
</tr>
<tr>
<td>WERNICKE</td>
<td>1899</td>
<td>Psychic reflex adopted&lt;br&gt;Psychosensory path -  (sensory area)&lt;br&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intrapsychic path - (association area)&lt;br&gt;Psychomotor path - (motor area)</td>
</tr>
<tr>
<td>JASPERS</td>
<td>1913</td>
<td>General Psychopathology (terminology)</td>
</tr>
<tr>
<td>NYIRO</td>
<td>1958</td>
<td>Terminology adopted (pathology)&lt;br&gt;Sensation&lt;br&gt;Perception&lt;br&gt;Ideation</td>
</tr>
</tbody>
</table>
CONCEPTUAL FRAMEWORK

In the development of "cognitive structure" (from "diffuse sensation" to "abstract ideas" differential inhibition plays a prominent role.

DIFFUSE SENSATION
  Differential Inhibition
DIFFERENTIATED PERCEPTION
  Differential Inhibition
IMAGE FORMATION
  Differential Inhibition
IDEATION - CONCRETE
  Differential Inhibition
IDEATION - ABSTRACT
MORPHOLOGY OF SENSATION

"... primary phenomenon is the sensation produced by an impulse conducted by sensory nerves from external and internal world to CNS ..."

The primary sensory center is modality specific:

<table>
<thead>
<tr>
<th>Modality</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>visual</td>
<td>along the calcarine fissure in occipital lobe (Brodman 17)</td>
</tr>
<tr>
<td>auditory</td>
<td>Heschl gyrus in the temporal lobe (Brodman 41 &amp; 42)</td>
</tr>
<tr>
<td>somatosensory</td>
<td>postcentral gyrus in parietal lobe (Brodman 1, 2 &amp; 3)</td>
</tr>
</tbody>
</table>
PATHOLOGY OF SENSATION

CHANGES IN INTENSITY
Hyperesthesia  hyperacusis  depression
Hypoesthesia  hypoacusis  delirium
Anesthesia  conversion  hysteria

SHIFTS IN QUALITY
Xanthopsia  yellow  treatment with "santonin"
Chloropsia  green  toxic substance
Erythropsia  red  pre-retinal vitreous hemorrhage

ALTERATIONS IN SPATIAL FORM
Dysmegalopsia  object seen larger  delirium
  Macropsia
  Micropsia  object seen smaller  temporal lobe lesion
  Porropsia  object seen farther  retinal disease

OTHER PATHOLOGY
Concomitant perception  sensation of color with normal (Franz Liszt)
  musical note  or schizophrenia
Splitting of perception  bird separated mescaline  or schizophrenia
  from chirruping
MORPHOLOGY OF PERCEPTION

"... perceptions arise when new sensations activate traces of similar former sensations ... the excitation induced by the sensation becomes restricted (differentially inhibited) ..."

"... content of perception is determined by the characteristics of the object, that through the sense organs acts on parietal, temporal and/or occipital analysers of the brain ..."
Esquirol (1838) subdivided false perceptions into

1. ILLUSIONS - distortion or misinterpretation of a real perception

2. HALLUCINATIONS - perceptual experience without corresponding stimulus in the environment
ILLUSIONS

"... in all illusions stimuli from a perceived object are combined with a mental image ... and all illusions are perceptions which are transpositions and distortions of real sensations ... ."

Illusions usually result from:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Example</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>INATTENTIVENESS</td>
<td>overlooking a misprint</td>
<td>normal subjects</td>
</tr>
<tr>
<td>AFFECT</td>
<td>mistaking a tree trunk</td>
<td>normal subjects</td>
</tr>
<tr>
<td></td>
<td>or a rock for a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>human when walking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>alone in woods</td>
<td></td>
</tr>
<tr>
<td>FATIGUE</td>
<td>pareidolia -- sees</td>
<td>normal subjects</td>
</tr>
<tr>
<td></td>
<td>vivid pictures in fire</td>
<td></td>
</tr>
<tr>
<td>ILLNESS</td>
<td>fantastic illusions --</td>
<td>schizophrenic patients</td>
</tr>
<tr>
<td></td>
<td>sees the head of a pig</td>
<td></td>
</tr>
<tr>
<td></td>
<td>instead of his/her own</td>
<td></td>
</tr>
<tr>
<td></td>
<td>head in mirror</td>
<td></td>
</tr>
</tbody>
</table>
HALLUCINATIONS: TRUE vs. PSEUDO

Perceptual Experiences without Corresponding Stimuli in the Environment

<table>
<thead>
<tr>
<th>TRUE</th>
<th>PSEUDO (PALE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appears as Concrete Reality</td>
<td>Does not Appear as Concrete Reality</td>
</tr>
<tr>
<td>Has Character of Objectivity</td>
<td>Has Character of Subjectivity</td>
</tr>
<tr>
<td>Appears in External Objective Space</td>
<td>Appears in Inner Subjective Space</td>
</tr>
<tr>
<td>Cannot Be Distinguished from Real Perception</td>
<td>Can Be Distinguished from Real Perception</td>
</tr>
<tr>
<td>Cannot Be Controlled Voluntarily</td>
<td>Can Be Controlled Voluntarily to Some Extent</td>
</tr>
</tbody>
</table>

PALE  | Griesinger  | 1845  
        | Baillarger | 1846  
        | Kahlbaum   | 1866  

PSEUDO | Hagen       | 1868  
        | Kandinski - Jaspers | 1913  

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HALUCINATIONS: SENSORY MODALITIES

AUDITORY
- Akoasmas (elementary)
  Phonemes (voices)  Functional psychoses
  Organic functional psychoses

VISUAL
- Photomes (elementary)  Organic psychoses
- Scenic (elaborate)  Alcoholic delirium/schizophrenia
- Autoscopic (self)  Epileptic aura
- Extracampine (outside visual field)  Functional psychoses

OLFACTORY/GUSTATORY  Organic psychoses
- Temporal lobe epilepsy
- Schizophrenic subtypes
- Depressive subtypes

VESTIBULAR
- Flying through air  Acute organic states (delirium tremens)
  Sinking through the bed  Normal subjects

COENESTHETIC
- Formication (animals crawling)  Cocaine psychosis
- Sexual  Hypochondriacal depression
- Phantom Limb  Hypochondriacal paraphrenia
  Eccentric hebephrenia
  Amputees
HALLUCINATORY SYNDROMES

CONFUSIONAL HALLUCINOSIS
prominent visual hallucinations with clouded consciousness

SELF-REFERENCE HALLUCINOSIS
voices are talking about him/her, but cannot reproduce content

VERBAL-HALLUCINOSIS
voices are talking about him/her and can reproduce content

FANTASTIC HALLUCINOSIS
hallucinations with impossible content

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HALLUCINATIONS; NORMALS vs. PSYCHOTICS

NORMALS

Phantom Limb (amputees)
Hypnagogic (going to sleep)
Hypnopompic (awakening from sleep)

PSYCHOTICS

Catatonic Schiz Command
Paraphrenic Schiz Fantastic
RESPONSE TO HALLUCINATIONS

DELIRIOUS PATIENTS . . . . . Feel terrified
DEPRESSED PATIENTS . . . . . Not bothered
PHONEMIC PARAPHRASIS . . . Troubled by abusive content
HYPOCHONDRIACAL PARAPHRASIS . Troubled by hearing voices
INCOHERENT PARAPHRASIS . . . Interact with voices
### MORPHOLOGICAL SUBSTRATE OF HALLUCINATIONS

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AUDITORY</strong></td>
<td>Stimulation of first temporal convolution on both sides</td>
</tr>
<tr>
<td><strong>VISUAL</strong></td>
<td>Stimulation of visual projection areas in the walls of calcarine fissure</td>
</tr>
<tr>
<td></td>
<td>(Brodman areas 17, 18 and 19)</td>
</tr>
<tr>
<td><strong>TACTILE</strong></td>
<td>Stimulation of parietal cortex and adjacent subcortical area</td>
</tr>
<tr>
<td><strong>GUSTATORY</strong></td>
<td>Stimulation in the depth of the Sylvian fissure around the transverse temporal gyrus</td>
</tr>
<tr>
<td><strong>MULTISENSORY</strong></td>
<td>Temporal lobe epilepsy (somatic sensory area is separated from temporal lobe by Sylvian fissure)</td>
</tr>
</tbody>
</table>
DISORDERS OF THINKING

Fourth Seminar
"... ideas or concepts are at the highest level of the cognitive structural organization. They develop from perceptions through image formation ..."

<table>
<thead>
<tr>
<th>PERCEPTIONS</th>
<th>CONCEPTS - IDEAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptions are of concrete reality</td>
<td>Ideas are figurative</td>
</tr>
<tr>
<td>They have a character of objectivity</td>
<td>They have a character of subjectivity</td>
</tr>
<tr>
<td>Perceptions appear in external objective space</td>
<td>Ideas appear in inner subjective space</td>
</tr>
<tr>
<td>Perceptions are clearly delineated, are complete and detailed</td>
<td>Ideas are not clearly delineated, are incomplete and crude</td>
</tr>
<tr>
<td>Perceptions are constant and can easily be retained unaltered</td>
<td>Ideas dissipate and have always to be recreated</td>
</tr>
<tr>
<td>Perceptions are independent of will and cannot be voluntarily recalled or changed</td>
<td>Ideas are dependent on will and can be voluntarily recalled or altered</td>
</tr>
<tr>
<td>Perceptions are accepted with feeling of passivity</td>
<td>Ideas are produced with feeling of activity</td>
</tr>
</tbody>
</table>
THINKING

Thinking refers to any train of ideas and/or ideational activity initiated and directed to the solution of a problem.

Thinking differs from association of ideas by its goal directedness.

Rational or Conceptual Thinking - Reality oriented and goal directed that attempts to solve a problem

Imaginative Thinking - A form of rational thinking which even if not reality oriented it is goal directed and does not go beyond the rational and possible

Dereistic or Autistic Thinking - Undirected fantasy thinking governed by personal needs and fantasies
## DISORDERS OF THINKING

<table>
<thead>
<tr>
<th>Disorders of content</th>
<th>- beliefs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorders of form</td>
<td>- reasoning</td>
</tr>
</tbody>
</table>

### FORMAL THOUGHT DISORDERS

<table>
<thead>
<tr>
<th>Symbolization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Symbols</td>
</tr>
<tr>
<td>Stream of Thought</td>
</tr>
<tr>
<td>Tempo</td>
</tr>
<tr>
<td>Processing</td>
</tr>
<tr>
<td>Continuity</td>
</tr>
</tbody>
</table>

### CONTENT DISORDERS OF THOUGHTS

<table>
<thead>
<tr>
<th>Regressive Thinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Incoherence</td>
</tr>
<tr>
<td>Overvalued Ideas</td>
</tr>
<tr>
<td>Obsessive Thoughts</td>
</tr>
<tr>
<td>Delusions</td>
</tr>
</tbody>
</table>
DISORDERS OF SYMBOLIZATION

Disorders of symbolization are disorders of the form of thinking which may lead to the formation of faulty concepts, the faulty use of symbols and/or idiosyncratic speech.

Formation of Faulty Concepts

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contamination</td>
<td>Fusing elements from two words into one word, e.g., surstonished from surprised and astonished</td>
</tr>
<tr>
<td>Condensation</td>
<td>Combination of more or less unrelated widely diverse ideas into one concept; two ideas with something in common are blended into a false concept</td>
</tr>
</tbody>
</table>

Faulty Use of Symbols

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concreteness</td>
<td>Using the concrete aspects of the concept instead of its symbolic meaning (e.g., &quot;there's a stork clapping in my body&quot;, i.e., I am pregnant)</td>
</tr>
<tr>
<td>Substitution</td>
<td>Replacement of a familiar concept with an unusual one</td>
</tr>
</tbody>
</table>

Idiosyncratic Speech

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neologisms</td>
<td>Building new words in which the usual language conventions and not observed</td>
</tr>
<tr>
<td>Onomatopoeisis</td>
<td>Building new phrases (language) in which the usual language conventions are not observed</td>
</tr>
</tbody>
</table>
DISORDERS OF TEMPO

Disorders of tempo are disorders of the form of thinking which may lead to acceleration or deceleration of thinking process.

ACCELERATION (in mania)
  Accelerated thinking
  Prolinity
  Flight of Ideas

  Increase in the number of ideas and in the flow of ideas with voluble speech
  Ordered flight of ideas
  Ideas flow so rapidly that sentences are not complete because thinking is continuously interrupted by diverse associations - often clang associations

  Pressured thinking
  Flight of ideas subjectively experienced

  Secondary incoherence
  Thoughts and speech as a result of acceleration have no longer understandable connections

DECELERATION
  Retarded thinking (depression)
  Inhibited thinking (schizophrenia)

  Thinking is slowing down
  Thinking is slowed down (by force)
**DISORDERS OF PROCESSING**

Disorders of processing are disorders of the form of thinking which may lead to a variety of characteristic manifestations.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alogia</td>
<td>No new thoughts emerge</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Restricted Thinking</td>
<td>Poverty of ideas</td>
<td>Depression</td>
</tr>
<tr>
<td>Rumination</td>
<td>Endless repetitions of and/or incessant concern with unpleasant thoughts</td>
<td>Depression</td>
</tr>
<tr>
<td>Circumstantial</td>
<td>Overbearing elaboration on insignificant details without loosing track</td>
<td>Neuropsychiatric disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Early dementia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Epilepsy</td>
</tr>
<tr>
<td>Overinclusive</td>
<td>Cannot maintain boundaries of determining idea</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Tangential</td>
<td>Talking past the point</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Derailment</td>
<td>Slips into new direction</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Drivelling</td>
<td>Grammar and syntax good but content is utter drivel</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Asyndetic</td>
<td>Lack of causal links (vague)</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Primary Incoherence</td>
<td>Thought and speech has no understandable connections</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Agrammatism</td>
<td>Less necessary words are omitted</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Omission</td>
<td>Part of thought is dropped</td>
<td>Schizophrenia</td>
</tr>
</tbody>
</table>
Disorders of continuity are disorders of the form of thinking which interfere with the proceeding toward determining idea (goal).

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Description</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thought Blocking</td>
<td>Sudden interruptions in the flow of thought process without obvious reason</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Perseveration</td>
<td>Persistent repetition of words, phrases or sentences</td>
<td>Coarse brain disease</td>
</tr>
<tr>
<td>Verbigeration</td>
<td>Severe form of perseveration; through the repetition the words, phrases or sentences become senseless and meaningless</td>
<td>Coarse brain disease</td>
</tr>
<tr>
<td>Palilalia</td>
<td>Form of perseveration characterized by repetition with increasing speed but diminishing audibility</td>
<td>Alzheimer's disease</td>
</tr>
<tr>
<td>Logoclonia</td>
<td>Form of perseveration in which the last syllable of the last word is repeated</td>
<td>Alzheimer's disease</td>
</tr>
</tbody>
</table>
DISORDERS OF CONTENT.

Disorders of content of thought refers to pathologically overvalued ideas which include

OBSESSIVE THOUGHTS
DELUSIONS

Obsessive thoughts: Thoughts which persist against one’s will. Their persistence and penetrance is senseless and meaningless. (Prevalent in obsessional disorders)

Delusions: False beliefs based on a priori evidence, which are unaffected by reasonable demonstration of their untruth and are not in keeping with one’s sociocultural background. Delusions are contradictions of reality which are not supported by the collective beliefs and concepts of mankind. (Present in psychoses)
DELUSIONS

Formal Aspects:
- Onset (origin) - delusional mood
  - delusional perception
  - sudden delusional ideas
- Course - fleeting
  - persistent
- Intensity - delusional dynamics
- Outcome - unsystematized
  - systematized
  - interpretative
  - passionate

Content:
- Reference (schizophrenia, delusional disorder)
- Love (erotomania) (delusional disorder)
- Persecution (litigious) (delusional disorder, schizophrenia)
- Jealousy (delusional disorder)
- Guilt (depression)
- Grandeur (mania)
- Nihilistic (schizophrenia, depression)
- Hypochondriacal (schizophrenia, depression)
**PRIMARY vs. SECONDARY**

<table>
<thead>
<tr>
<th>Primary or True</th>
<th>Secondary or Delusional or Delusion-like ideas (may result from mood)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Result from Delusional mood</td>
<td>affect which forms the background of delusional experience. An atmosphere of perplexity and involvement in which one feels that &quot;something is in the air&quot;</td>
</tr>
<tr>
<td>Delusional perceptions</td>
<td>a normally perceived event endowed with abnormal significance; a delusional misinterpretation of a real perception.</td>
</tr>
<tr>
<td>Sudden delusional ideas</td>
<td>out of the blue experience of a delusional notion</td>
</tr>
</tbody>
</table>
STRUCTURE ANALYSIS

First Axis - constituting elements
   Paralogical or bizarre
   vs.
   Logical or non-bizarre

Second Axis - in relationship to mood state
   Mood incongruent
   vs.
   Mood congruent

Third Axis - in relationship to environment
   Autistic - patient lives exclusively in delusional world
   Polarized - delusional ideas meshed with real world
   Delusions in juxtaposition - independent coexistence of real and delusional world

Fourth Axis - in relationship to reality
   Impossible
   vs.
   Implausible
DISORDERS OF INTRAPSYCHIC PATH

Fifth Seminar
INTRAPSYCHIC PATH
Relational or Emotional

Emotions
are

subjectively experienced psychic phenomena in which one's relations to
his/her external and internal experiences are reflected (Emotions are
immediate subjective relational responses; feelings are the subjective
experience of emotions)

<table>
<thead>
<tr>
<th>COGNITIVE (Psycho sensory)</th>
<th>RELATIONAL (Intrapsychic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diffuse Sensation</td>
<td>Undifferentiated Primitive Signal</td>
</tr>
<tr>
<td>Differentiated Perception</td>
<td>Vital (including Instinctual) Emotions</td>
</tr>
<tr>
<td>Image Formation</td>
<td>Sensorial Emotions</td>
</tr>
<tr>
<td>Concrete Ideation</td>
<td>Intellectual Emotions</td>
</tr>
<tr>
<td>Abstract Ideation</td>
<td>Ethical, Moral &amp; Social Emotions</td>
</tr>
</tbody>
</table>
CHARACTERISTICS OF EMOTIONS

Source
Range

Accessibility
Quality

Intensity
Duration
Effects (or effectiveness)
### SOURCE AND RANGE OF EMOTIONS

| SOURCE                  | Sensorial emotions | Instinctual  |
|                        |                   | Vital        |
|                        |                   | Sensory - Perceptual |

| Activity emotions |
| Intellectual emotions |

| RANGE               | Restriction (Constriction) |
| Conditions:         | Mental Subnormality        |
|                     | Organic Dementias          |
|                     | Schizophrenias             |
|                     | Depressions                |
### ACCESSIBILITY OF EMOTIONS

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>APATHY</strong> (Negative Pole)</td>
<td>Inaccessibility of emotions with absence of feelings (psychoses)</td>
</tr>
<tr>
<td><strong>ANXIETY</strong> (Positive Pole)</td>
<td>Extreme accessibility of emotions with feelings of apprehension and physiologic arousal (neuroses)</td>
</tr>
<tr>
<td>FEAR</td>
<td>Reaction to identifiable external danger</td>
</tr>
<tr>
<td>PHOBIAS</td>
<td>Persistent fear reactions to specific external stimuli which are not rationally recognized as threatening</td>
</tr>
<tr>
<td>FREE FLOATING ANXIETY</td>
<td>Persistent anxiety that is unrelated to external stimuli</td>
</tr>
<tr>
<td>PANIC</td>
<td>Spontaneous attacks of intense anxiety</td>
</tr>
</tbody>
</table>
QUALITY OF EMOTIONS

POLARITY of Emotions

VITAL Emotions
- Euphoria vs. Dysphoria
  - tired - fit
  - limp - vigorous
  - weak - strong
  - ill - healthy

OTHER Emotions
- Pleasant vs. Unpleasant
  - (Signaling Reward) (Signaling Punishment)

AMBIVALENCE of Emotions
- Coexistence of opposite feelings with regard to a person or situation

INAPPROPRIATE Emotions
- Emotional response discordant with the content of speech
INTENSITY OF EMOTIONS

Sensorial > Activity > Intellectual

BLUNTED - observable decrease in emotional responsiveness (emotional indifference)

FLAT - severe blunting with lack of signs of emotional expression (e.g., immobile face, monotonous speech)
DURATION OF EMOTIONS

Sensorial < Activity < Intellectual

<table>
<thead>
<tr>
<th>EMOTIONAL RIGIDITY</th>
<th>Persistence of emotions without modulation or oscillation regardless of external situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMOTIONAL PERSEVERATION</td>
<td>Persistence of certain emotions (e.g., anger) over extended periods (epilepsy)</td>
</tr>
<tr>
<td>EMOTIONAL LABILITY</td>
<td>Rapid and abrupt shifts in emotions</td>
</tr>
<tr>
<td>EMOTIONAL INCONTINENCE</td>
<td>Extreme form of lability with lack of control (SDAT &amp; MID)</td>
</tr>
</tbody>
</table>
EFFECTS (EFFECTIVENESS) OF EMOTIONS

NORMAL
Changes in autonomic (vegetative) nervous system activity
Changes in endocrine system activity

PATHOLOGICAL
Narrowed (restricted) consciousness
Affective amnestic transformation
Katathymic changes
<table>
<thead>
<tr>
<th>MORPHOLOGIC SUBSTRATE OF EMOTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AROUSAL</strong></td>
</tr>
<tr>
<td><strong>EMOTION</strong></td>
</tr>
<tr>
<td><strong>APPERCEPTION</strong></td>
</tr>
<tr>
<td>of feelings</td>
</tr>
<tr>
<td><strong>LIMBIC SYSTEM</strong></td>
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DEFINITION OF MOOD

Emotions are relations which depend on the presence of an object, while mood is independent of object although it may affect the subjects relations (experienced in the emotions) to the object.

Mood is not just an integral sum of simultaneously present emotions or an emotion of prolonged duration.

MOOD IS A CERTAIN FEELING TONE WHICH UNDERLIES ALL OUR EXPERIENCES.
### POLARITY OF MOOD

<table>
<thead>
<tr>
<th>Negative Pole</th>
<th>Middle Position</th>
<th>Positive Pole</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysthymia</td>
<td>Euthymia</td>
<td>Hyperthymia</td>
</tr>
</tbody>
</table>

**Quantitative Pathology:**
1. Morbid Depression
2. Morbid Elation

**Qualitative Pathology:**
3. Morbid Anxiety
4. Irritability
5. Expansiveness
6. Perplexity
7. Delusional Mood
8. Parathymic Mood
MORBID DEPRESSION

A state of lowered affect, a mood of prevailing sadness which predetermines one's perceptual, cognitive and emotional experiences with an effect on overt behavior

Characteristic Symptoms: Feelings of
- Inadequacy
- Guilt
- Impoverishment
- Loss of vitality
- Loss of feelings
- Complaintativeness

Morbid Sadness may be associated with Morbid Thinking which may reach Delusional Intensity
MORBID ELATION

A state of heightened affect, a mood of prevailing joy and pleasure, which transforms all experiences. It is a positively tinged affective state which covers a wide spectrum of feelings.

Characteristic Symptoms: Euphoria
Cheerful thoughts
Exaggerated self esteem
Lack of consideration for others
Faulty judgement

Morbid Elation may be associated with Morbid Thinking which may reach Delusional Intensity
OTHER DISORDERS OF MOOD

Anxious - Feeling of apprehension and psychologic arousal (from mild unease to intense dread); associated with anticipation of impending calamity or disaster

Irritable - Feeling of tension; easily annoyed and provoked to anger

Expansive - Lack of restraint in one's feelings; overvaluation of one's significance or importance

Perplexed - A mood of uncertainty or puzzlement ("What's the matter? What is happening? I don't understand")

Delusional - Background of delusional experience ("Something is in the air, something's about to happen")

Parathymic - Paradoxical mood (e.g., laughing while describing torment)
<table>
<thead>
<tr>
<th>MOOD STATES AND DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysthyemic/Hyperthymic</td>
</tr>
<tr>
<td>Anxious</td>
</tr>
<tr>
<td>Perplexed</td>
</tr>
<tr>
<td>Delusional</td>
</tr>
<tr>
<td>Affective Disorders</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
</tr>
<tr>
<td>Mixed (or Cycloid) Psychoses</td>
</tr>
<tr>
<td>Schizophrenic Disorders</td>
</tr>
</tbody>
</table>
MORPHOLOGICAL SUBSTRATE OF MOOD

Original Proposition
Reserpine produces depression (early 1950's)
depression and inactivation of NE centrally
depression and inactivation of 5HT centrally
central cholinomimetic

Imipramine lifts depression (late 1950's)
NE re-uptake inhibition
5HT re-uptake inhibition
central anticholinergic

Revised Proposition
Antidepressants Bind with high affinity to ACh muscarinic receptors
Highly significant correlation between potencies of
TA's for inhibition of ^3H-Imipramine binding
sites and inhibition of ^3H-5HT uptake sites
Beta-adrenergic receptor down regulation (up-
regulation by reserpine) and down regulation of
NA transmission

Pharmacological manipulation of mood - Reserpine
Cyclic Antidepressants
MAOI's
Lithium
DISORDERS OF THE PSYCHOMOTOR PATH

Sixth Seminar
STRUCTURAL CONNECTIONS

**Psychosensory**
- Diffuse Sensation
- Differentiates Perception
- Image Formation
- Ideation – Concrete
- Ideation Abstract

**Psychomotor**
- Simple Autonomic Reflexes
- Uncoordinated Activities
- Instinctual (Emotional) Stereotypes
- Voluntary Coordinations
- Automatisms

**Intrapsychic**
- Undifferentiated Primitive Signal
- Vital Emotions
- Sensorial Emotions
- Intellectual Emotions
- Ethical, Moral & Social Emotions

**Psychomotor**
- Simple Autonomic Reflexes
- Uncoordinated Activities
- Instinctual (Emotional) Stereotypes
- Voluntary Coordinations
- Automatisms
NEUROLOGIC vs. PSYCHIATRIC

Neurology
- Well defined neurologic signs
- Intrinsically linked to structural impairment of the brain
- Indicating the site of the lesion

Psychiatry
- Ill defined changes in the formal characteristics of psychomotility
- In the absence of structural impairment of the brain
- Interpretable only within the context of a well defined mental illness
<table>
<thead>
<tr>
<th>Phenomenologic (German)</th>
<th>Behavioral (American)</th>
<th>Social (British)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorders of Drive and Psychomotility</td>
<td>Motor Behavior and Catatonic Syndrome</td>
<td>Motor Disorders Adaptive Movements Non-adaptive Movements Motor Speech Posture Abnormal Complex Patterns</td>
</tr>
</tbody>
</table>

(Drive is perceived as the energizing force, i.e., the impetus behind the tempo, intensity and endurance of psychologic performances that is independent of will)
Disorders of drive are dealt with primary consideration of patient's subjective experience, i.e., within a phenomenological context

1. Lack of drive
   - Feeling of deficient energy and/or initiative
   - Subjectively experienced
   - Objectively observed

2. Increased drive
   - Feeling of increased energy and/or initiative
   - Subjectively experienced
   - Objectively observed

3. Inhibition of drive
   - Feeling of being slowed down (without the feeling of deficient energy and/or initiative)
   - Subjectively experienced as braking once energy and/or initiative in such a forceful manner that is not possible to overcome the restraint
   - Objectively observed as slowed down - braking

4. Motor restlessness
   - Feeling that one must move (without the feeling of increased energy and/or initiative)
   - Subjectively experienced as unpleasant and that it is difficult to overcome it
   - Objectively observed as aimless and purposeless motor activity with or without (circumscribed) locomotion
Disorders of psychomotility are dealt with almost exclusively on the basis of the formal characteristics of motor behavior

1. Mutism
   - Parsimonious speech or the absence of speech

2. Logorrhea
   - Voluble speech (comprehensible or incomprehensible)

3. Mannerisms
   - Natural--expressive--movements, such as gestures, facial expression and speech, are exaggerated, posed and/or baroque

4. Histrionics
   - Natural--reactive--movements are theatrical and/or demonstrative

5. Parakinesis
   - Qualitatively abnormal complex movements which often affect gestures, facial expressions or speech
PHENOMENOLOGIC APPROACH: PARAKINESIAS

A. 1. Posturing • Assuming odd posture
    2. Waxy flexibility • Allows to be placed in odd postures
    3. Catalepsy • Maintaining odd posture

B. 4. Motor stereotypy • Tendency to repeat—in exactly the same form and often for a long time—spontaneous speech or motoric expressions
    5. Automatic acts • The carrying out of acts of behavior spontaneously, i.e., automatically, without perceiving in having them carried out intentionally

C. 6. Echo symptoms • The immediate and involuntary repetition of words (Echolalia) and/or acts (Echopraxia) displayed by someone in proximity
    7. Automatic obedience • The immediate and involuntary following of commands
BEHAVIORAL APPROACH: MOTOR BEHAVIOR
Quantitative Changes in Behavior

Stupor
- Extreme form of hypoactivity

Hypoactivity
- Decreased frequency of activities
- Goal directed (activity)

Excitement
- Extreme form of hyperactivity
- Interrupts one activity to begin with another

Agitation
- Increased frequency of motor behavior
- Non-goal directed

Restlessness
- Circumscribed
  - e.g., hand rubbing, foot stepping
- General
  - e.g., pacing

Catatonic Activity
- Periods of extreme HYPERACTIVITY (excitement)
  and/or HYPOACTIVITY (stupor)
BEHAVIORAL APPROACH: CATATONIC SYNDROME
Qualitative Changes in Behavior

A. 1. Unresponsive  • Passive Negativism
   2. Gegenhalten • Active Negativism
      • Oppositional
      • Resist with equal strength for being moved

B. 3. Flat face • Expressionless face
   4. Mutism • Lack of responsiveness
      • Assuming odd postures
C. 5. Posturing • Mild form of facial posturing
   Grimacing • Severe form of facial posturing
   Snout cramp

6. Waxy flexibility
7. Catalepsy

D. 8. Stereotypy • Repetitive non-goal directed behavior (different definition)
      • It is not experienced as foolish (distinct from obsessive-compulsive behavior)

E. 9. Echolalia • Repetition of words displayed by someone in proximity
   10. Echopraxia • Repetition of acts displayed by someone in proximity

F. 11. Automatic obedience • Going with Cooperation
      Non-verbal automatic obedience Responds to light pressure even if instructed to the contrary
      Making with Non-verbal automatic obedience The cooperation followed by slow return to prior position

12. Mitgehen

13. Mitmachen
A. Disorders of Expressive Movements

1. Diminished or Absent
2. Excessive or Exaggerated
3. Tearfulness
4. Grimacing
5. Snout Spasm

6. Athanassio's Omega Sign

Greek letter "Omega" (Ω) in the forehead above the root of the nose (excessive action of corrugator muscle)

7. Veraguth's Fold

Main fold in the upper lid is angulated upwards and backwards at the junction of the inner third with the middle third of the fold

B. Disorders of Reactive Movements

8. Diminished or Lost
9. Increase in the startle reflex

C. Disorders of Goal-Directed Movements

10. Psychomotor retardation

11. Obstruction

Psychomotor inhibition Sperrung Reaction at the last moment (Kleist)
SOCIAL APPROACH: NON-ADAPTIVE MOVEMENTS

A. Spontaneous Movements
   1. Stereotypy
   2. Parakinesis • Continuous irregular movements of the musculature (different definition)
   3. Handling • Touching and handling everything within reach
   4. Intertwining • Continuously intertwining fingers, grasps clothes and kneads a small piece of cloth

B. Abnormal Induced Movements
   5. Automatic Obedience
   6. Echopraxia
   7. Forced Grasping • Magnet reaction (Kleist)
   8. Mitgehen
   9. Mitmachen
   10. Opposition
   11. Ambitendency • Presence of opposing tendencies to action
   12. Adversion • Turning towards examiner
   13. Aversion • Turning away from examiner
Motor Speech Disorders

1. Muteness
2. Voluble Speech • Speak excessively and nonstop
3. Wurgstimme • Whispers or speaks with a strange strangled voice • Lack of intonation
4. Monotonous • Lack of modulation
5. Echolalia
SOCIAL APPROACH: POSTURE

Disorders of Posture

1. Flexibilitas Cerea (Wernicke)  Waxy flexibility
2. Catalepsy  Maintenance of odd postures
3. Psychological Pillow  • Lies with head two or three inches off the pillow
SOCIAL APPROACH: COMPLEX PATTERNS

Non-Goal Directed

Stupor (Bumke) • A state of more or less complete loss of activity with no reaction to external stimuli

Catatonic • Dead-pan facial expression • Changes in muscle tone • Catalepsy • Stereotypes • Urinary incontinence

Depressive • Depressive faces • Normal muscle tone • Response to emotional stimuli • Absence of incontinence

Goal Directed

Compulsive Rituals • Repetition of particular activity to ensure that it is properly done
CONSCIOUSNESS: ORIGINAL DEFINITION

In psychic (mental) life everything is connected with everything else and each element is colored by the state and content within which it occurs.

An analysis of an individual case cannot consists simply in breaking up the situation into its elements, but needs to have a constant referral to the psychic state as a whole.

JASPERS (1913): Refers to the "state of consciousness" as the "momentary whole" of the "psychic state".
CONSCIOUSNESS: CURRENT DEFINITION

State of Awareness of the SELF and the ENVIRONMENT.

One may distinguish the CONTENT of consciousness from the
ACTIVITY of consciousness which entails
the functions of: SCREENING
INTEGRATION
DISORDERS OF CONSCIOUSNESS

Disorders of consciousness are manifest in the following states of consciousness:

  a. LOWERED (depressed)
  b. HEIGHTENED (expanded)
  c. CLOUDED (dream-like)
  d. RESTRICTED (narrowed)
LOWERED CONSCIOUSNESS

Lowered consciousness is experienced as a rise in the threshold of incoming stimuli resulting in a situation in which patients respond poorly or not at all to environmental contingents.

Level of awareness are:  
- BENOMENHEIT
- SOMNOLENCE
- SOPOR (TORPOR)
- PRECOMA
- COMA
HEIGHTENED CONSCIOUSNESS

Heightened or expanded consciousness refers to an intensified awareness of inner and outer events and is seen in:

AURA to precede EPILEPTIC ATTACK
PRELUDE for development of COMPULSIVE STATES

Special forms of expanded consciousness are:

ECSTASY
Meditation
Drug induced

DISTORTED CONSCIOUSNESS
Endogenous psychoses
schizophrenia
mania
Pharmacologically induced
CLOUDED CONSCIOUSNESS

Clouded consciousness may be displayed in 1 of 3 forms:

<table>
<thead>
<tr>
<th>STATE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONEROID STATE</td>
<td>Dream-like state of consciousness. Seen in:</td>
</tr>
<tr>
<td></td>
<td>Bouffée delirante</td>
</tr>
<tr>
<td></td>
<td>Oneirophrenia</td>
</tr>
<tr>
<td></td>
<td>Physical illness</td>
</tr>
<tr>
<td></td>
<td>Induced by tea or coffee</td>
</tr>
<tr>
<td>SUBACUTE DELIRIOUS STATE</td>
<td>Confusional state with incoherence of thinking and disintegration of mental</td>
</tr>
<tr>
<td></td>
<td>faculties.</td>
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<tr>
<td></td>
<td>Seen in:</td>
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<tr>
<td></td>
<td>Toxic confusional state</td>
</tr>
<tr>
<td></td>
<td>Senescence (Sundowner)</td>
</tr>
<tr>
<td></td>
<td>Senility (PDDAT, MID)</td>
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<tr>
<td>DELIRIUM</td>
<td>Inability to distinguish between mental images and perceptions; illusions,</td>
</tr>
<tr>
<td></td>
<td>hallucinations with severe anxiety and restlessness (more severe at night).</td>
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<tr>
<td></td>
<td>Seen in:</td>
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<tr>
<td></td>
<td>Symptomatic psychoses</td>
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<tr>
<td></td>
<td>Organic dementias</td>
</tr>
</tbody>
</table>
NARROWED CONSCIOUSNESS

Break in the continuity of consciousness with restriction of what enters into consciousness. Seen in: HYSTERIA EPILEPSY

The two closely related forms of narrowed consciousness are:

| TWILIGHT STATE | Break in continuity |
| FUGUE STATE    | Ordered twilight state |
MORPHOLOGY OF CONSCIOUSNESS

LATERAL LEMNISCAL PATHWAYS
Conduction of sensory impulses which contribute to perception, recognition, localization and qualitative discrimination of stimuli

MEDIAL LEMNISCAL PATHWAYS (Ascending Reticular System)
Screening incoming information and integration of incoming information with continuously changing background of internal (somatic) and external (environmental) data

Initiation and maintenance of conscious state
DRUGS AND CONSCIOUSNESS

**ANTICHOLINERGIC DRUGS**
- **Atropine**: Produce manifestations related to integrative function of consciousness: Mental disintegration, Toxic confusional state, Delirium

**CHOLINERGIC DRUGS**
- **Physostigmine**: Corrects atropine-induced disintegration

**SEDATIVES**
- **Barbiturates**: Decreases arousal reaction to peripheral and direct stimuli

**NEUROLEPTICS**
- **Chlorpromazine**: Decrease arousal reaction to peripheral stimuli only. Increase of screening function. SCHIZOPHRENIA: Favorable effect. NORMAL: Somnolence. SENILITY: Confusion
ATTENTION: DEFINITION

The field of clear consciousness within the total conscious state is termed the FIELD OF ATTENTION.

Constellation of consciousness in which sensorial perceptions are foremost.
ACTIVE AND PASSIVE ATTENTION

**Active**

Purposeful Focusing on some External or Internal Event

**Passive**

One or Another Object Becomes Center of Consciousness Spontaneously

**Diminished**

Diminished Ability to Maintain and Focus Attention on Topic

**Decreased**

Attention Wanders from One Object to Another

**Distractable**

Diminished active or Decreased passive attention
DISORDERS OF ATTENTION

Disorders of attention are displayed in one or more of the following variables:

**CONCENTRATION**
- **Disturbance**: Ability to exclude all associations irrelevant to a certain theme
- **Disturbance**: Inability to focus on a topic and remain focused

**TENACITY**
- **Disturbance**: Ability to keep one's attention focused on a certain subject continuously
- **Disturbance**: Decreased ability to keep one's attention focused on a certain subject
- **Disturbance**: Decreased ability to distract one's attention from a certain subject

**VIGILANCE**
- **Disturbance**: Ability to direct one's attention to a new subject
- **Disturbance**: Hypervigilance
- **Disturbance**: Hypovigilance

**PATHOLOGY OF ATTENTION**

Hyperprosexia: hypervigilance with hypotenacity

Hypoprosexia: hypovigilance with hypotenacity
CONSCIOUSNESS: DISORDERS OF INTEGRATION AND MEMORY

Eighth Seminar
DISORDERS OF THE SELF

EGO refers to the SELF which in the course of its development grows aware of itself (PERSONALITY)

SELF AWARENESS or SELF REFLECTION at every moment and across time is the highest integrative function of consciousness.

Disorders of the self are displayed on 1 of 4 parameters:

1. UNITY
2. IDENTITY
3. BOUNDARIES
4. INTEGRITY
UNITY OF THE SELF

The oneness of the self (ego) at any moment of time.

Disorders of the Unity of the Self:

Simultaneous Presence: BEING IN TWO
                     BEING DOUBLES

Disorders: Schizophrenias
IDENTITY OF THE SELF

The sameness of the self (ego), i.e., one's identity, through the passage of time.

Disorders of the Identity of The Self:  
- BEING BORN AGAIN
- TRANSFORMATION DELUSIONS
- Lycanthropy
- Other Sex

Disorders:  
- Schizophrenias
- Dissociative Disorders

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INTEGRITY OF THE SELF

Experiencing psychic manifestations as they were not one's own, but alien, automatic and/or coming from elsewhere.

Disorders of the Integrity of the Self (Schneider's First Rank Symptoms):
- Thought Insertion
- Thought Withdrawal
- Audible Thoughts
- Thought Broadcasting
- Thought Alienation

Disorders: Schizophrenias
BOUNDARIES OF THE SELF

Experiencing one’s self as distinct from environment.

Disorders of the Boundaries of the Self:

DEREALIZATION    The experience that one’s environment being unreal, strange or otherwise changed

DEPERSONALIZATION The experience that one’s self is being unreal, detached, strange, changed or unidentifiable

Disorder: Panic Disorder
Phobix - Anxiety - Depersonalization Syndrome (Roth)
DISORDERS OF PSYCHIC INTEGRATION

Integration of experiences from the outer world, one's own body and one's self; and orientation regarding the outer world, one's own body and one's self.

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>INTEGRATION</th>
<th>ORIENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALLOPSYCHIC</td>
<td>Experiences from the outer world</td>
<td>Time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Place</td>
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<td></td>
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<td>Person</td>
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<tr>
<td>SOMATOPSYCHIC</td>
<td>Experiences from one's own body</td>
<td>Body</td>
</tr>
<tr>
<td>AUTOPSYCHIC</td>
<td>Experiences from one's self</td>
<td>Self</td>
</tr>
</tbody>
</table>

Orientation Disorders: Disorientation in Situation Double Orientation

Disorders of (Integration):

Allopsychic: Exogenous Psychoses
Somatopsychic: Somatization disorders
Autopsychic: Dissociative disorders

Disorders of (Orientation):

Neuropsychiatric Disorders (Dementias)
MEMORY: DEFINITION

General term to denote the conscious revival of past experiences.

Refers to specific reflections of the experience in subjects' thoughts which are revived.

The three phases of the "memory" are:

REGISTRATION
Acquisition
Learning
Memorization

RETENTION
(Engram)

RECALL
DISORDERS OF REGISTRATION

Amnesias are memory gaps; they are perceived as disorders of Memorization or Registration.

There is no memorization if consciousness is lost; and depending on the time relationship between the loss of consciousness and lack of memorization one may distinguish among:

ANTEROGRADE AMNESIA
CONGRADE AMNESIA
RETROGRADE AMNESIA

Other amnesias:

SYSTEMATIZED (specific to content). . . psychogenic
DISORDERS OF RETENTION

Reduction or loss of ability to retain previously learned material:

- Focal Cerebral Pathology
- Generalized Cerebral Pathology
DISORDERS OF RECALL

Difficulty or loss in the recollection of facts or events.

Abnormality of Form:  Hypomnesia  -  Decreased
                      Hypermnesia  -  Increased
              Conditions:  Hyperpyrexia
                         Life-threatening
                         situation
                         Drug-induced

Pathology of Content:  Distortion of Memories
                      Distortion of Recognition
**DISTORTION OF MEMORIES**

Distortions or falsifications of memories are referred to as paramnesias. Paramnesias include:

<table>
<thead>
<tr>
<th>PARAMNESIA</th>
<th>Details</th>
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<tbody>
<tr>
<td>ECMMESIA</td>
<td>Disturbance in time sequencing of past</td>
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<td></td>
<td>Emotionally loaded states</td>
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<td>Senility</td>
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<tr>
<td>RETROSPECTIVE</td>
<td>Distortion of memories from past</td>
</tr>
<tr>
<td>FALSIFICATION</td>
<td>Affective Disorders</td>
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<tr>
<td>DELUSIONAL</td>
<td>Backdating one’s delusions</td>
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<tr>
<td>MEMORIES</td>
<td></td>
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<tr>
<td>CONFABULATION</td>
<td>Filling in memory gaps with imagined or supposedly experienced events</td>
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<td></td>
<td>Organic states</td>
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<tr>
<td>PSEUDOLOGIA FANTASTICA</td>
<td>Pathological lying</td>
</tr>
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<td></td>
<td>Psychopathy</td>
</tr>
</tbody>
</table>

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DISTORTION OF RECOGNITION

FALSE RECOGNITIONS - Deja - Vu (Aura)
                    Jamais - Vu

MISIDENTIFICATIONS - Positive (strangers as friends)
                    Negative (friends as strangers)
                    In cycloid and schizophrenic psychoses

CAPGRAS SYNDROME - Person is double of person he claims to be

AMPHITYRON ILLUSION - Believes that spouses are double

SOSIAS ILLUSION - Believes that other people are doubles
KORSAKOFF PSYCHOSIS

Amnesia - Disturbance of Memorization
Allopsychic Disorientation - Time, Space & Person
Confabulations - Filling in of Memory Gaps
Impairment - Lack of Spontaneity & Absent Insight

Pathology: Lesion of mammillary bodies
dorsomedial thalamic nuclei
diencephalon
region of 3rd & 4th ventricles
along the pathway of monoamine
containing neurons: low CSF-NE conc
low CSF-MHPG conc

Related to absolute or relative thiamine (B₁) deficiency.
Associated with abnormality of transketolase, a thiamine regulated enzyme.

Seen: Chronic Alcoholism
Aged
Learning involves a synthesis of mRNA with a highly specific base composition, and the synthesis of certain specific acidic protein fractions, the biochemical substrates of memory (Hyden, 1970).

Drugs which inhibit protein synthesis e.g., puromycin, impair memory storage.