PSYCHIATRIC Phenomenology From First Principles for Medical Students, Psychiatric Residents, and Practitioners

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WHAT THIS BOOK IS NOT

This book is not a work of genius.

This book is not a comprehensive immersion into the complex world of psychodynamic and psychoanalytic phenomenology.

DEFINITION

What is psychiatric phenomenology?

It is just how one explains away what is happening to oneself emotionally in addition to how others describe one's behaviour and actions. Psychiatric phenomenology is also called descriptive psychopathology.

DISORDERS OF MOVEMENT AND BEHAVIOUR

AGITATION OCCURS IN THE FOLLOWING CONDITIONS:

Severe mood disturbance with or without psychotic symptoms

Schizophrenia

Major psychiatric conditions due to general medical conditions

Severe anxiety disturbance

Personality disorder

Hyperthyroidism

Hypoparathyroidism

STUPOR IS MADE UP OF:

Akinesis (lack of movement)

Muteness (lack of speech)

Stupor occurs in organic psycho-syndromes, mania, and schizophrenia.

MOVEMENT DISORDERS OCCURRING IN SCHIZOPHRENIA INCLUDE:

Catatonia – lack of movement with body held in an unusual posture

Waxy flexibility – initial resistance to being moved slowly gives way, so that the patient can be positioned in another posture where they remain, just like working on a warm candlestick

Psychological pillow – observed when patient is seen lying on their back but elevating the head as if there is a pillow under the head when there is none

Stereotypy – a pattern of non-goal-directed movement that is repetitive and follows the same format; the patient can be distracted from this movement

Mannerisms – goal directed, ritualistic, but peculiar ways of moving or behaving that need not be repetitive or follow the same pattern

Grimacing – the face is held in a distorted fashion, with twisting of the mouth

Snout spasms – the nose and lips are held in a spastic fashion as if mimicking the snout of an animal

Parkinsonian syndrome movement – includes slowness of movement, tremulous movement, muscle rigidity, posture and gait problems, loss of ability to blink or smile

OTHER MOVEMENT DISORDERS IN SCHIZOPHRENIA INCLUDE:

Negativism – moves in the opposite direction that the patient is instructed to move, or lack of enthusiasm to move, or moving at variance to intended instruction

Automatic obedience – obeys movement request automatically irrespective of consequence

Ambitendency – moves or acts in the opposite direction of the examiner

Obstruction – moves to block the intended motion of examiner

Mitgehen – slight finger pressure on the patient elicits exaggerated movement in any direction despite the patient being told not to move

Echopraxia – involuntarily repeats the movement or behaviour of the examiner

Advertence – the patient, being mindful of examiner's intended direction of motion, tends to move in that direction

Opposition – resists the desire or instruction to move

PARKINSONISM INCLUDES:

Slowing of emotional and voluntary movements

Muscular rigidity

Akinesis

Tremor

Disorders of gait, speech, and posture

TYPES OF DYSTONIA:

Acute dystonia

Oculogyric spasm

Vocal dystonia

Segmental dystonia

Drug-related dystonia

Psychogenic dystonia

TICS ARE:

Rapid movements

Repetitive

Co-ordinated

Stereotyped

Able to be mimicked

Usually reproduced faithfully by the sufferer

SOME DISTURBANCES OF BEHAVIOUR THAT MAY OCCUR IN SCHIZOPHRENIA:

Movement disorders

Hoarding

Water intoxication

Mannerisms

Gross neglect, otherwise known as Diogenes syndrome

Flagrant stealing

Unprovoked aggression and nastiness

Childishness or grotesque behaviour

Self-immolation (setting self on fire) and suicide

DISORDERS OF SPEECH

DISORDERS OF SPEECH MAY INCLUDE THE FOLLOWING:

Flight of ideas: Speech changes from subject to subject with retention of connection between the speeches. Occurs in mania.

Thought blocking: Patient will suddenly say that their mind has gone blank and they cannot complete the sentence at hand. May occur in schizophrenia.

Overinclusive thinking: There is loss of conceptual boundaries, as in schizophrenia.

Pressure of speech: There is an increase in rate of speech production, as in mania.

Circumstantiality: Speech is burdened with unnecessary information; the person making the speech may be said to be beating about the bush. May occur in obsessive-compulsive disorder.

Echolalia: The patient repeats the speech of the interviewer verbatim.

Verbal perseveration: This may include palilalia, where the patient repeats the last word, or logoclonia, where the last syllable is repeated.

Clang association: Speech connections are based on their sound. Punning and rhyming are examples.

Loosening of association: An example of this is knight's move thinking, where there is no connection between ideas. This may occur in schizophrenia. Derailment and tangential thinking are examples.

Neologisms: This means new word formation or idiosyncratic use of a word. This occurs in schizophrenia.

Mutism: A total loss of speech in full consciousness, as may occur in catatonia.

One may consider disorders of the form of speech as disorders of speech, but this is discussed under disorders of thought and beliefs.

SPEECH BECOMES UNINTELLIGIBLE WHEN THE FOLLOWING ARE PRESENT:

Dysphasia: The loss of ability to produce speech and understand spoken language.

Paragrammatism: Speech is full of grammatically incorrect sentences, as occurs in fluent aphasia/receptive aphasia.

Neologism: New word formation.

Use of stock words and phrases: The patient has poverty of words to use in speech; for example, where the patient is supposed to use Coca-Cola, Sprite, Fanta, or ginger ale

in speech, they will use a stock phrase like "sweetened liquids".

Use of private language: For example, the patient may use cryptolalia when spoken and cryptographia when written. Private language in schizophrenia known as "schizophrenese" cannot be understood by others except the patient.

THE FOLLOWING ARE FORMS OF MOTOR APHASIA:

Pure word-dumbness

Pure agraphia

Alexia with agraphia

Isolated speech area defect

Mutism

SCHIZOPHRENIC LANGUAGE DISORDERS INCLUDES:

Akataphasia: Use of inappropriate or grammatically incorrect words

Loosening of associations

Regression: Loss of quality and quantity of previously acquired speech

Asyndesis: Comprising derailment, loosening of association, knight's move thinking, entgleisen, giving rise to nonsensical speech

Concrete thinking: Literal thinking, based on the "here and now" interpretation of information

Defect of deductive reasoning

Neologisms and blocking

SCHNEIDERIAN SCHIZOPHRENIC SPEECH DISORDERS INCLUDE:

Derailment

Substitution

Omission

Fusion

Drivelling

IN SCHIZOPHRENIC LANGUAGE:

There is intrusion of dominant meaning of word when the situation demands the use of a less common meaning (unintentional puns).

Neologisms are used to fill semantic gaps.

Clang associations occur with the initial syllable of a previous word (in mania and poetry, terminal clanging occurs).

Punning, clanging and ideational similarity can be provoked by a word in a clause.

Disturbances of words and their meaning are more common than disturbances of grammar and syntax.

More syntactic errors occur in schizophrenia than mania.

ACCORDING TO THE BEHAVIOURAL CONCEPT OF LANGUAGE:

Language is a learned behaviour.

Schizophrenics will give more unusual answers to stimulus words than controls.

Schizophrenics will respond to a word's dominant meaning regardless of context.

WITH REGARDS TO SPEECH:

Predictability is the ability to predict accurately the missing words in a cloze test.

Schizophrenics are unpredictable in the cloze test.

Type-token ratio is lower in schizophrenics since more token words are used.

PSYCHOGENIC SPEECH ABNORMALITIES IN SCHIZOPHRENIA INCLUDE:

Flight of ideas

Pressure of talk

Hysterical mutism

Approximate answers

Paraphasia

Pseudologia fantastica

Eccentric and pedantic use of words

THOUGHT AND BELIEFS

OBSESSIONS:

Obsessions are recurrent, intrusive, persistent thoughts, urges, or images that are unwanted and cause marked anxiety and distress. The patient believes these thoughts, images or impulses are theirs and not alien. Because they are distressing, they are therefore ego dystonic. A patient with obsessional imagery and thoughts of throwing down their baby from the 10th floor window of their apartment is so heavily distressed by this thought that they are very unlikely to harm their baby. They will stay away from the window and actively seek help for their anxiety. However, a mother who believes the baby is a reincarnation of the devil and hears a voice telling her to throw down the baby is likely to obey the voice and harm the baby, and hence, in delusions, the feelings are ego syntonic.

Obsessional themes include contamination, doubt, safety, symmetry, religion, illness, sex, violence, and so on.

Ritualistic behaviours called compulsions accompany the obsessions in an attempt to neutralise the obsessional anxiety.

FORMAL THOUGHT DISORDER IS ABNORMALITY IN THE MECHANISM OF THINKING. IT INCLUDES:

Acceleration of thinking

Retardation of thinking

Circumstantial thinking

Thought blocking

EXAMPLES OF FORMAL THOUGHT DISORDER:

Crowding of thought

Perseveration

Concrete thinking

Fusion

Derailment

TYPES OF THINKING:

Fantasy or dereistic or autistic thinking

Imaginative thinking

Rational or conceptual thinking

FANTASY THINKING OCCURS:

In daydreams

As a way of life

In shy, reserved people

In schizophrenics

THE FOLLOWING REVEAL FANTASY THINKING:

Pathological lying

Hysterical conversion and dissociation

Delusion-like ideas

Slips of tongue

Forgetting an emotionally laden word during a speech

THE PSYCHOLOGICAL THEORIES OF SCHIZOPHRENIC THINKING INCLUDE:

Asyndesis manifesting as overinclusive thinking

Broadening of category boundaries

Kelly's personal construct theory using the repertory grid, which suggests that schizophrenics have a personal way of interpreting and predicting events going on around them.

Kelly, G. (1955). *The psychology of personal constructs* (Vols 1–2). New York: WW Norton.

THE THREE COMPONENTS OF A DELUSION, ACCORDING TO JASPERS, ARE:

Belief held with unusual conviction

Belief not amenable to logic

Belief is absurd and erroneous to other people

Jaspers, K. (1959). General Psychopathology (transl. Hoenig J and Hamilton MW, 1963). Manchester University Press.

THE PROPERTIES OF A DELUSION ARE:

Falsity

Unshakeability

Out of keeping with the cultural background

Held with extraordinary conviction and subjective certainty

Like a true belief to the patient

EXAMPLES OF FALSE BELIEFS:

Primary delusion

Secondary delusion

Overvalued ideas

Sensitive ideas of reference

THERE ARE FOUR TYPES OF PRIMARY DELUSIONS:

Delusional perception (there is a normal perception that the patient gives a delusional false interpretation to)

Delusional intuition

Delusional atmosphere (mood)

Delusional memory

PRIMARY DELUSION:

Is an autochthonous delusion arising de nuevo, out of the blue

Is un-understandable

Occurs in the absence of any other psychopathology

According to Cutting, occurs in schizophrenia and not in any other condition

Cutting, J. (1985) The Psychology of Schizophrenia. Edinburgh: Churchill Livingstone.

EXAMPLES OF DELUSIONS ARE:

Delusion of persecution

Delusion of jealousy

Delusion of love

Delusion of misidentification

Delusion of grandiosity

Religious delusion

Delusion of guilt

Delusion of nihilism (in an extreme form known as Cotard's syndrome, the patient believes they are dead, nonexistent, and rotting)

Delusion of hypochondriasis

Delusion of infestation (Ekbom's syndrome)

Delusion of control

Communicated delusion (folie à deux)

PROPERTIES OF AN OVERVALUED IDEA:

Acceptable, understandable

Pursued beyond bounds of reason

Neither delusional nor obsessional

It is not senseless to the patient

It has the quality of a passionate political or religious conviction

The patient may invariably act on the idea

EXAMPLES OF OVERVALUED IDEAS:

Litigious type of paranoid states

Morbid jealousy

Hypochondriasis

Dysmorphophobia

Parasitophobia

Anorexia nervosa

FIRST RANK SYMPTOMS:

There are eleven first rank symptoms. They are not diagnostic of schizophrenia or any other condition. They can occur in any other condition apart from schizophrenia.

Their presence is strongly suggestive of schizophrenia. They are made of three hallucinations, three thought phenomena and four passivity or made experiences and delusional perception.

Voices running a commentary on patient's actions in the third person (e.g., "He has just left", "He has put down his plate")

Voices discussing or arguing among themselves about the patient

Thought echo, whereby patient hears his thought spoken out aloud

Thought insertion

Thought withdrawal

Thought broadcast

Made actions

Made feelings

Made impulses

Somatic passivity: Sensations are imposed on the body by an external force

Delusional perception

DISORDERS OF PERCEPTION

THERE ARE TWO TYPES OF ABNORMAL PERCEPTION:

Sensory distortion

False perceptions, which include illusions, hallucinations and pseudohallucinations

SENSORY DISTORTION MANIFESTS AS:

Changes in intensity and quality of perception or the spatial form of the perception

Changes in the feelings associated with perception

Splitting of perception

ILLUSIONS:

Are transformations of perceptions

Types are completion, affect and pareidolic

Fantasy (imagery) plays a role in formation of illusions

Paying attention to a completion illusion makes it disappear

Completion illusion demonstrates the principle of gestalt psychology

PAREIDOLIC ILLUSIONS:

Could occur in normal people

Images are seen from shapes

Are not banished by attention (vs completion illusion)

Paying attention to the illusion increases its intensity

Are more common in children

SLADE'S THREE CRITERIA FOR HALLUCINATIONS:

It is a percept-like experience in the absence of an external stimulus

It has the full force and impact of a real perception

It is unwilled, it occurs spontaneously, and it cannot be readily controlled by the patient.

Slade, P. D., & Bentall R. P. (1988.) *Sensory deception: a scientific analysis of hallucinations*. London: John Hopkins University Press.

REGARDING AUDITORY HALLUCINATIONS:

Elementary (unstructured) sounds that occur in organic states are unpleasant and frightening

Phonemes (voices) occur in schizophrenia, chronic alcoholic hallucinations, and affective psychosis

In schizophrenia, thought echo, commentary voices, or voices discussing with each other may occur

May be abolished by wearing ear plugs

Paying attention to distracting noise diminishes auditory hallucinations

STRATEGIES THAT HELP WITH COPING WITH AUDITORY HALLUCINATIONS ARE:

Change of posture of spatial position

Relaxation and physical exercises

Control of attention, active suppression of hallucination, and cognitive reappraisal

REGARDING VISUAL HALLUCINATIONS:

Occur in organic states, including occipital, temporal, and parietal lobe tumours

May occur with dyslexia

May occur with cortical blindness

OTHER CONDITIONS GIVING RISE TO VISUAL HALLUCINATIONS ARE:

Post-concussion states

Epileptic twilight states

Metabolic disturbances

Alzheimer's disease

Huntington's chorea

Multi-infarct dementia

Recreational drug use

VISUAL HALLUCINATIONS:

Are uncommon in schizophrenia

Do not occur in uncomplicated mood disorders

In schizophrenia, auditory hallucinations may be commonly associated with visual pseudohallucinations

Are vivid and elaborate in oneiroid states where there is coexistent alteration of consciousness

CHARLES BONNET SYNDROME:

Phantom visual images occur

Visual hallucinations are complex

There is absence of psychopathology

There is no disturbance of consciousness

Occurs at any age

More common in the elderly

Associated with central or peripheral reduction of vision

Could last from days to years

The images could be static, moving, or animated

IN AUTOSCOPIC HALLUCINATIONS:

Patient sees an image of themselves in external space

More common in males

Neurological and psychiatric disorders occur in 60% of patients

Epilepsy occurs in 33% of patients

Most common psychiatric diagnosis in people showing autoscopy is depression

Episodes of autoscopy last less than 30 minutes

Fear and anxiety are provoked

HALLUCINATIONS OF BODILY SENSATIONS:

May be superficial, kinaesthetic, or visceral

Superficial hallucinations include thermic, haptic, and gyric hallucinations

Are common in schizophrenia where they are elaborated as delusions of control

REGARDING OLFACTORY AND GUSTATORY HALLUCINATIONS:

Frequently occur together

Associated with powerful emotions

Occur in schizophrenia, epilepsy, and organic states

Temporal lobe epilepsy is associated with hallucinations in all sensory modalities

PSEUDOHALLUCINATIONS:

Are figurative

Are not concretely real

Are experienced in inner subjective space

May have definite outline and vivid detail

Cannot be deliberately evoked

Are experienced as an "as if" experience

PSEUDOHALLUCINATIONS OCCUR:

In normal people

In bereavement as a hallucination of widowhood/ widowerhood, which can be reassuring and helpful

EXTRACAMPINE HALLUCINATIONS OCCUR:

Outside the limits of sensory field

In schizophrenia

In epilepsy

In organic states

In normal people as hypnagogic (when going to bed) or hypnopompic (when rising from sleep) hallucinations

HYPNAGOGIC (WHEN GOING TO BED) AND HYPNOPOMPIC HALLUCINATIONS (WHEN RISING FROM SLEEP):

Occur in normal people

Occur in narcolepsy

Occur in sleep paralysis

Occur in toxic states

Occur in phobia

Are of sudden onset

May be visual, auditory, or tactile

FUNCTIONAL HALLUCINATION:

A real external stimulus is needed for the functional hallucination to occur

Both the stimulus and the hallucination are in the same modality (e.g., a sound like running water will prompt the auditory hallucination)

Above occur simultaneously

REFLEX HALLUCINATION:

Is a hallucinatory form of synaesthesia

A stimulus occurs in one modality

In response, a hallucination occurs in another modality

An example: A patient hears a certain word in a normal conversation but feels pain as a result

ABOUT THE AUTHOR

Dr Daniel Chinedu Okoro graduated with a Bachelor of Medicine, Bachelor of Surgery (MB. BS) degree from the University of Lagos, Lagos, Nigeria. After completing his psychiatric rotational training posts in the United Kingdom, he immigrated to Canada in 2000. He successfully passed both the Licentiate of the Medical Council of Canada (LMCC) and Fellowship of the Royal College of Physicians of Canada (FRCPC) examinations, both required for foreign-trained doctors to practise in Canada at the time. In 2006, he passed the American Board of Psychiatry and Neurology examination, becoming American Board Certified.

Dr Okoro has an abiding interest in the practice of psychiatry in rural settings, delivering psychiatric services to disadvantaged populations, such as Black people, Indigenous people, other people of colour, LGBTQ people, and homeless urban people. In the heat of the Afghan war, with the consequent epidemic in military suicides, Dr Okoro volunteered to be contracted as a civilian psychiatrist to the Canadian Forces. He served in a remote military base for three years, and during this period his unique approach to treating suicidal patients reduced the suicide occurrence to zero in this base.

Dr Okoro firmly believes that psychiatric training today must chart a different trajectory with the inculcation of cultural psychiatry in the curriculum. He is enthusiastic in welcoming medical students, psychiatric residents, and other trainees into his rural and Indigenous mental health clinics. He emphasises the interface of psychiatric phenomenology and culture. Dr. Okoro is a clinical assistant professor in the department of Psychiatry, University of Calgary.

For relaxation, Dr Okoro plays golf, plays the conga drums very well, and is a jazz buff.

Dr Okoro has been elected a Fellow of the American Psychiatric Association (FAPA).