Oxford textbook of psychiatry

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Preface

This book is written primarily as an introductory textbook for trainee psychiatrists, and also as an advanced textbook for clinical medical students. We hope that the book will also be useful, for purposes of revision and reference, to psychiatrists who have completed their training and to general practitioners and other clinicians.

The subject matter of this book is the practice of clinical psychiatry. Recent years have seen the increasing development of sub-specialties such as child and adolescent psychiatry, forensic psychiatry, and the psychiatry of mental retardation. This book is mainly concerned with general psychiatry, but it also contains chapters on the sub-specialties. Throughout the whole book, our purpose has been to provide an introduction to each subject, rather than a fully documented account. It is assumed that the trainee psychiatrist will go on to consult more comprehensive works such as the *Handbook of psychiatry* (Shepherd 1983), the *Comprehensive textbook of psychiatry* (Kaplan *et al.* 1980), and specialized textbooks dealing with the sub-specialties. In some chapters references are made to basic sciences such as psychology, genetics, biochemistry, and pharmacology. Discussion of these subjects is based on the assumption that the reader already has a working knowledge of them from previous study.

The chapters dealing with psychiatric treatment fall into two groups. First, there are three chapters wholly devoted to treatment and concerned only with general issues. In this group, Chapter 17 deals mainly with drug treatment and electroconvulsive therapy; Chapter 18 deals with psychological treatments; and Chapter 19 discusses the organization of services for the rehabilitation and care of patients with chronic psychiatric disorders. Second, there are the various chapters on individual syndromes, which include sections on the treatments specific to those syndromes. In these chapters, treatment is usually discussed in two parts. The first part examines the evidence that a particular treatment is effective for a particular syndrome; the second part discusses (under the heading of management) practical issues in treatment, such as ways of using various treatments singly or in combination at different stages of a patient's illness. The separation of chapters on general issues from those on specific issues means that the reader has to consult more than one chapter for complete information on the treatment of any disorder. None the less this arrangement is preferred because a single treatment may be used for several syndromes. For example, antipsychotic drugs are used to treat mania and schizophrenia, and supportive psychotherapy is part of the treatment of many disorders.

In this book there is no separate chapter on the history of psychiatry. Instead certain chapters on specific topics include brief accounts of their history. For example the chapter on psychiatric services contains a short historical review of the care of the mentally ill; and the chapter on abnormal personality includes some information about the development of ideas about that subject. This arrangement reflects the authors' view that, at least in an introductory text, historical points are more useful when related to an account of modern ideas. The historical references in this book can be supplemented by reading a history of psychiatry such as that by Ackerknecht (1968) or Bynum (1983).

The use of references in this book also needs to be explained. As this is an introductory postgraduate text, we have not provided references for every statement that could be supported by evidence. Instead we have generally followed two principles: to give references for statements that may be controversial; and to give more references for issues judged to be of topical interest. In an introductory text it also seemed appropriate to give references mostly to the Anglo-American literature. For all these reasons the coverage of the literature may seem uneven; but – as explained above – the book is written in the expectation that the trainee psychiatrist will progress to other works for more detailed literature surveys. Suggestions for further reading are given at the end of each chapter.

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M.G.
D.G.
R.M.

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While every effort has been made to check drug dosages in this book, it is still possible that errors have been missed. Furthermore, dosage schedules are being continually revised and new side-effects recognized. For these reasons the reader is strongly urged to consult the drug companies' printed instructions before administering any of the drugs recommended in this book.

Contents

1. Signs and symptoms of mental disorder

Psychiatry can only be practised if the psychiatrist develops two distinct capacities. One is the capacity to collect clinical data objectively and accurately by history taking and examination of mental state, and to organize the data in a systematic and balanced way. The other is the capacity for intuitive understanding of each patient as an individual. When the psychiatrist exercises the first capacity, he draws on his clinical skills and knowledge of clinical phenomena; when he exercises the second capacity, he draws on his general understanding of human nature to gain insights into the feelings and behaviour of each individual patient.

Both capacities can be developed by accumulating experience of talking to patients, and by learning from the guidance and example of more experienced psychiatrists. From a textbook, however, it is inevitable that the reader can learn more about clinical skills than about intuitive understanding. In this book the first four chapters are concerned with various aspects of clinical skills. This greater coverage of clinical skills in no way implies that intuitive understanding is regarded as unimportant but simply that it cannot be learnt from reading a textbook.

The psychiatrist can only acquire skill in examining patients if he has a sound knowledge of how each symptom and sign is defined. Without such knowledge, he is liable to misclassify phenomena and make inaccurate diagnoses. For this reason, questions of definition are considered in this first chapter, before the examination of patients is described in the next.

Once the psychiatrist has elicited a patient's symptoms and signs, he needs to decide how far these phenomena resemble or differ from those of other psychiatric patients. In other words, he must determine whether the clinical features form a syndrome, which is a group of symptoms and signs that identifies patients with common features. The purpose of identifying a syndrome is to be able to plan treatment and predict the likely outcome by reference to accumulated knowledge about the causes, treatment, and outcome of the same syndrome in other patients. The principles involved are discussed in Chapter 4, which is concerned with classification, and also in the chapters dealing with the different syndromes.

Since the present chapter consists mainly of definitions and descriptions of symptoms and signs, it may be less easy to read than those which follow. It is

suggested that the reader should approach the chapter in two stages. The first reading can be applied to the introductory sections and to a general understanding of the more frequent abnormal phenomena. The second can focus on details of definition and the less common symptoms and signs.

Before individual phenomena are described, it is important to consider some general issues concerning the methods of studying symptoms and signs and the terms used to describe them.

Psychopathology

The study of abnormal states of mind is known as **psychopathology**, a term which denotes two distinct approaches.

The first approach, **phenomenological psychopathology** (or **phenomenology**), is concerned with the objective description of abnormal states of mind in a way that avoids, as far as possible, preconceived theories. It aims to elucidate the basic data of psychiatry by defining the essential qualities of morbid mental experiences and by understanding what the patient is experiencing. It is entirely concerned with conscious experiences and observable behaviour. According to Jaspers (1963), phenomenology is 'the preliminary work of representing, defining and classifying psychic phenomena as an independent activity'.

The second approach, **psychodynamic psychopathology**, originates in psychoanalytical investigations. Like phenomenological psychopathology, it starts with the patient's description of his mental experiences and the doctor's observations of his behaviour. However, unlike phenomenological psychopathology it goes beyond description and seeks to explain the causes of abnormal mental events, particularly by postulating unconscious mental processes. These differences can be illustrated by the two approaches to persecutory delusions. Phenomenology describes them in detail and examines how they differ from normal beliefs and from other forms of abnormal thinking such as obsessions. On the other hand, the psychodynamic approach seeks to explain the occurrence of persecutory delusions, in terms of unconscious mechanisms such as repression and projection. In other words, it views them as evidence in the conscious mind of more important disorders in the unconscious.

This chapter is concerned mainly with phenomenological psychopathology, although reference will also be made to relevant ideas from dynamic psychopathology.

The most important exponent of phenomenological psychopathology was the German psychiatrist philosopher, Karl Jaspers. His classical work, *Allgemeine Psychopathologie [General psychopathology]*, first appeared in 1913, and was a landmark in the development of clinical psychiatry. It provides the most complete account of the subject and contains much of interest, particularly in its early chapters. The seventh (1959) edition is available in an English translation by Hoenig and Hamilton (Jaspers 1963). Alternatively, useful outlines of the

principles of phenomenology have been given by Jaspers (1963) and by Scharfetter (1980).

The significance of individual symptoms

Individual psychological symptoms are not necessarily evidence of pathology. Even hallucinations, which are often regarded as hallmarks of mental illness, are sometimes experienced by healthy people, for example when falling asleep. Symptoms are often recognized as abnormal because of their intensity and persistence. None the less, even when intense and persistent, a single symptom does not necessarily indicate illness. It is the characteristic grouping of symptoms into a syndrome that is important.

Primary and secondary symptoms

The terms primary and secondary are used in describing symptoms, but with more than one meaning. The first is temporal; primary meaning antecedent and secondary meaning subsequent. The second is causal; primary meaning directly related to the pathological process and secondary meaning a reaction to the primary symptom. The two meanings are often related – the symptoms appearing first in time are those most directly related to the pathological process.

It is preferable to use the terms primary and secondary in the temporal sense, since this is factual rather than arbitrary. However, when first seen, many patients cannot give a clear account of the chronological development of their symptoms. If this happens, it is only possible to conjecture whether one symptom could be a reaction to another; for example, whether the fixed idea of being followed by persecutors could be a reaction to hearing voices.

The form and content of symptoms

When psychiatric symptoms are described, it is usual to distinguish between form and content, a distinction that can be best explained with an example. If a patient says that, when he is entirely alone, he hears voices calling him a homosexual, then the form of his experience is an auditory hallucination (i.e. a sensory perception in the absence of an external stimulus) while the content is the statement that he is homosexual. A second person might hear voices saying he is about to be killed: the form is still an auditory hallucination but the content is different. A third might experience repeated intrusive thoughts that he is homosexual but realize that these are untrue. He has an experience with the same content as the first (concerning homosexuality) but the form is different – in this case an obsessional thought.

DESCRIPTION OF SYMPTOMS AND SIGNS

Introduction

In the following sections, symptoms and signs are described in a different order from the one adopted when the mental state is examined. This is because it is useful to begin with the most distinctive phenomena – hallucinations and delusions. This should be borne in mind when reading Chapter 3 in which the description of the mental state examination begins with behaviour and talk rather than hallucinations and delusions.

The definitions in this section generally conform with those in the Present State Examination (PSE) a widely used standardized rating system described by Wing *et al.* (1974) and adopted by the World Health Organization for an international study of major mental disorders. The PSE definitions were developed in several stages. The original items were chosen to represent the clinical practice of a group of psychiatrists working in western Europe. The first definitions were modified progressively through several editions. The seventh edition was used in a large Anglo-American diagnostic project; the eighth included modifications arising from a study of schizophrenia carried out in countries in Europe, Asia, and the Americas; while the ninth, published in 1974, incorporates further refinements suggested by analysis of the previous studies. The PSE therefore provides useful common ground between psychiatrists working in different countries and contains definitions that can be applied reliably.

Before we consider individual symptoms it is appropriate to remind the reader that it is important not only to study individual mental phenomena but also to consider the whole person. The doctor must try to understand how the patient fulfils social roles such as worker, spouse, parent, friend, or sibling. He should consider what effect the disorders of function have had upon the remaining healthy parts of the person. Above all he should try to understand what it is like for this person to be ill, e.g. to care for small children while profoundly depressed or to attempt to live as a schizophrenic. The doctor will gain such understanding only if he is prepared to spend time listening to patients and their families and to interest himself in every aspect of their lives.

DISORDERS OF PERCEPTION

Perception and imagery

Perception is the process of becoming aware of what is presented through the sense organs. **Imagery** is an experience within the mind, usually without the feeling of reality that is part of perception. **Eidetic imagery** is a visual image which is so intense and detailed that it has a 'photographic' quality. Unlike perception, imagery can be called up and terminated by voluntary effort. It is usually obliterated by seeing or hearing. Occasionally, imagery is so vivid that it

persists when the person looks at a poorly structured background such as plain wallpaper. This is called **pareidolia,** a state in which real and unreal percepts exist side by side, the latter being recognized as unreal. Pareidolia can occur in the delirium of fever and a few people can induce it deliberately.

Alterations in perception

Perceptions can alter in intensity and quality. They can seem more intense than usual, e.g. when two people experience the same auditory stimulus, such as the noise of a door shutting, the more anxious person may perceive it as louder. In mania, also, perceptions often seem very intense. Conversely, colours may seem less intense to someone who is depressed. Changes in quality occur in schizophrenia, sensations sometimes appearing distorted or unpleasant. For example, a patient may complain that food tastes bitter or that a flower smells like burning flesh.

Illusions

Illusions are misperceptions of external stimuli. They are most likely to occur when the general level of sensory stimulation is reduced. Thus at dusk a common illusion is to misperceive the outline of a bush as that of a man. Illusions are also more likely to occur when the level of consciousness is reduced, as for example in an acute brain syndrome. Thus a delirious patient may mistake inanimate objects for people when the level of illumination is normal, though he is more likely to do so if the room is badly lit. Illusions occur more often when attention is not focused on the sensory modality, or when there is a strong affective state ('affect illusions'), e.g. a person who is afraid in a dark lane is more likely to misperceive the outline of a bush as that of an attacker. (The so-called **illusion of doubles** or **Capgras syndrome** is not an illusion but a form of delusional misinterpretation. It is considered under paranoid syndromes in Chapter 11).

Hallucinations

A hallucination is a percept experienced in the absence of an external stimulus to the sense organs, and with a similar quality to a true percept. A hallucination is experienced as originating in the outside world (or within one's own body) like a percept, and not within the mind like imagery. Hallucinations may appear more or less real, varying from an experience that seems to have all the reality of a sensory experience to one that is little more real than mental imagery.

Hallucinations are not restricted to the mentally ill. A few normal people experience them, especially when tired. Hallucinations also occur in healthy people during the transition between sleep and waking; they are called

hypnagogic if experienced while falling asleep and **hypnopompic** if experienced during awakening.

Pseudohallucinations

This term has been applied to abnormal phenomena that do not meet the above criteria for hallucinations and are of less certain diagnostic significance. Unfortunately the word has two meanings which are often confused. The first, originating in the work of Kadinsky, was adopted by Jaspers (1913) in his book *General psychopathology*. In this sense, pseudohallucinations are especially vivid mental images; that is, they lack the quality of representing external reality and seem to be within the mind rather than in external space. However, unlike ordinary imagery, they cannot be changed substantially by an effort of will. The term is still used with this meaning (see, for example Scharfetter 1980). The second meaning of pseudohallucination is a hallucination that the subject recognizes as having no correlate in the external world. This is the sense in which the term is used by Hare (1973) and Taylor (1979).

Both definitions are difficult to apply because they depend on the patient's ability to give precise answers to difficult questions about the nature of his experience. Judgements based on the patient's recognition of the reality of his experience are, not surprisingly, difficult to make reliably because the patient is often uncertain himself. Although the percepts must be either in the external world or within the mind, patients often find this distinction difficult to make.

Taylor (1981) has suggested that two groups of pseudohallucinations should be recognized: 'imaged' pseudohallucinations that are experienced within the mind and 'perceived' pseudohallucinations that are experienced as located in external space but recognized as unreal. In everyday clinical work it seems better to abandon the term pseudohallucinations altogether, and simply to maintain the term hallucination as defined at the beginning of this section. If the clinical phenomena do not meet this definition, they should be described in detail rather than labelled with a technical term that provides no additional information useful for diagnosis. Readers requiring a more detailed account of these problems of definition are referred to Hare (1973), Taylor (1981), and Jaspers (1963, pp. 68–74). Further information about the phenomena themselves will be found in Sedman (1966).

Types of hallucinations

Hallucinations can be described in terms of their complexity and their sensory modality (see Table 1.1). The term **elementary hallucination** is used for experiences such as bangs, whistles, and flashes of light; **complex hallucination** is used for experiences such as hearing voices or music, or seeing faces and scenes.

Hallucinations may be auditory, visual, tactile, gustatory, olfactory, or of deep sensation. **Auditory hallucinations** may be experienced as noises, music, or voices. Hallucinatory 'voices' are sometimes called **phonemes**, but this usage

Table 1.1. *Description of hallucinations*

1. According to complexity
   - elementary
   - complex
2. According to sensory modality
   - auditory
   - visual
   - olfactory and gustatory
   - somatic (tactile and deep)
3. According to special features
   - (a) auditory: second person
     - third person
     - *Gedankenlautwerden*
     - *Écho de la pensée*
   - (b) visual: extracampine
4. Autoscopic hallucinations

of the term is at variance with its dictionary definition of a specific sound in a specific language. Voices may be heard clearly or indistinctly; they may appear to speak words, phrases, or sentences; and they may address the patient or sound as if talking to one another, referring to the patient as 'he' or 'she' (**third person hallucinations**). Sometimes voices seem to anticipate what the patient thinks a few moments later, or speak his own thoughts as he thinks them, or repeat them immediately after he has thought them. In the absence of concise English technical terms, the last two experiences are sometimes called ***Gedankenlautwerden*** and ***écho de la pensée*** respectively.

Visual hallucinations may also be elementary or complex. They may appear normal or abnormal in size; if the latter, they are more often smaller than the corresponding real percept. Visual hallucinations of dwarf figures are sometimes called lilliputian. **Extracampine visual hallucinations** are experienced as located outside the field of vision, that is, behind the head. **Olfactory and gustatory hallucinations** are frequently experienced together, often as unpleasant smells or tastes.

Tactile hallucinations, sometimes called **haptic hallucinations,** may be experienced as sensations of being touched, pricked, or strangled. They may also be felt as movements just below the skin which the patient may attribute to insects, worms, or other small creatures burrowing through the tissues. **Hallucinations of deep sensation** may occur as feelings of the viscera being pulled upon or distended, or of sexual stimulation or electric shocks.

An **autoscopic hallucination** is the experience of seeing one's own body projected into external space, usually in front of oneself, for short periods at a time. This experience may convince the person that he has a double (*doppelganger),* a theme occurring in several novels, including Dostoevsky's *The double.* In clinical practice this is a rare phenomenon, mainly encountered in a small

minority of patients with temporal lobe epilepsy or other organic brain disorders (see Lukianowicz 1958 and Lhermitte 1951 for detailed accounts).

Occasionally, a stimulus in one sensory modality results in a hallucination in another, e.g. the sound of music may provoke visual hallucinations. This experience, sometimes called **reflex hallucinations,** may occur after taking drugs such as LSD, or rarely in schizophrenia.

As already mentioned, **hypnagogic** and **hypnopompic hallucinations** occur at the point of falling asleep and of waking respectively. When they occur in normal people, they are brief and elementary – as for example of hearing a bell ring or a name called. Usually the subject wakes suddenly and recognizes the nature of the experience. Hallucinations of this kind are common in narcolepsy; here the experience is different, as the patient may spend a long time between sleeping and waking and may have elaborate hallucinations.

Diagnostic associations

Hallucinations may occur in all kinds of psychosis, in hysterical neuroses and, at times, among healthy people. Therefore the finding of hallucinations does not itself help in diagnosis. However, certain kinds of hallucinations do have important implications for diagnosis.

Both the form and content of **auditory hallucinations** can help in diagnosis. Of the various types – noises, music, and voices the only ones of diagnostic significance are voices heard as speaking clearly to or about the patient. As explained already, voices which appear to be talking to each other, referring to the patient in the third person (e.g. 'he is a homosexual') are called **third person hallucinations.** They are associated particularly with schizophrenia. Such voices may be experienced as commenting on the patient's intentions (e.g. 'he wants to make love to her') or actions (e.g. 'she is washing her face'). Of all types of hallucination, commentary voices are most suggestive of schizophrenia.

Second person hallucinations appear to address the patient (e.g. 'you are going to die') or give commands (e.g. 'hit him'). In themselves they do not point to a particular diagnosis, but their content and especially the patient's reaction may do so. For example, voices with derogatory content suggest depressive psychosis, especially when the patient accepts them as justified (e.g. 'you are wicked'). In schizophrenia the patient more often resents such comments.

Voices which anticipate, echo, or repeat the patient's thoughts also suggest schizophrenia.

Visual hallucinations may occur in hysteria, affective disorders, and schizophrenia, but they should always raise the possibility of an organic disorder. The content of visual hallucinations is of little significance in diagnosis.

Hallucinations of taste and smell are infrequent. When they do occur they often have an unusual quality which patients have difficulty in describing. They may occur in schizophrenia or severe depressive disorders, but they should also

suggest temporal lobe epilepsy or irritation of the olfactory bulb or pathways by a tumour.

Tactile and somatic hallucinations are not generally of diagnostic significance although a few special kinds are weakly associated with particular disorders. Thus, hallucinatory sensations of sexual intercourse suggest schizophrenia, especially if interpreted in an unusual way (e.g. as resulting from intercourse with a series of persecutors). The sensation of insects moving under the skin occurs in people who abuse cocaine and occasionally among schizophrenics.

DISORDERS OF THINKING

Disorder of thinking is usually recognized from the patient's speech or writings. It can also be inferred from actions; for example, a previously efficient librarian, who developed schizophrenia, became unable to classify books because each one seemed to belong to many different categories. Some psychological tests of thought disorder require the person to sort objects into categories.

The term disorder of thinking can be used in a wide sense to denote four separate groups of phenomena (Table 1.2). The first group comprises particular kinds of abnormal thinking – delusions and obsessional thoughts. The second

Table 1.2. *Disorders of thinking*

1. Particular kinds of abnormal thoughts
Delusions
Obsessions
2. Disorders of the stream of thought (speed and pressure)
3. Formal thought disorder (linking of thoughts together)
4. Abnormal beliefs about the possession of thoughts

group, disorder of the stream of thought, is concerned with abnormalities of the amount and the speed of the thoughts experienced. The third group, known as disorders of the form of thought, is concerned with abnormalities of the ways in which thoughts are linked together. The fourth group, abnormal beliefs about the possession of thoughts, comprises unusual disturbances of the normal awareness that one's thoughts are one's own.

The second and third groups are considered here, whilst the first and fourth will be discussed below.

Disorders of the stream of thought

In disorders of the stream of thought both the amount and the speed of thoughts are changed. At one extreme there is **pressure of thought,** when ideas arise in unusual variety and abundance and pass through the mind rapidly. At the other extreme there is poverty of thought, when the patient has only a few