CHAPTER 3

Experiences good and bad: an introduction to psychopathology, classification, and diagnosis for philosophers

Chapter contents

This chapter provides an introduction to psychopathology, classification, and diagnosis in psychiatry for philosophers.

The two aims of this chapter

The chapter has two aims. The first is to give philosophers (or anyone with no background practical experience of mental distress and disorder) a taste of the more formal aspects of psychopathology and the classifications of mental disorder used by professionals working in mental health.

The materials in this chapter, it should be said straight away, are perhaps more characteristic of medical, nursing, and psychological professional work, than, say, social work. The materials, it is true, are the result of over a hundred years of careful observation and development of ideas (covered in detail in Parts II and III). All the same, just as the concept of mental disorder remains subject to widely different interpretations (the various 'models' we explored in Chapter 2), so the classification of these disorders—the particular 'symptoms' identified, the groups and classes and clusters into which they are drawn together—remain much debated. The whole enterprise of classification of mental distress and disorder is indeed challenged by some (see, e.g. Kutchins and Kirk, 1997). As with all the materials in this book, then, this chapter is presented, not as a reflection of a settled or final view, but as a focus for critical engagement and collegial development of ideas.

The second aim of this chapter is to get across the idea that psychopathology and classification in psychiatry are not as easy as many outside the discipline sometimes imagine!

We want to be clear here. The point is not that the discipline is, somehow, arcane or otherwise impenetrable. The point is rather that it is a well-developed area of professional expertise, supported by a wealth of theory, clinical skills, empirical research, and narrative literature. Furthermore, unlike diagnosis and classification in, say, cardiology and renal medicine, psychiatric classification is conceptually as well as empirically difficult. As we noted in Chapter 2, and will develop further later in this part, this conceptual difficulty is at the heart of the engagement between philosophers and practitioners in psychiatry. We will be looking at the historical origins of this engagement in Part II, and at current 'hot topics' later on, in the philosophy of science (Part III), in value theory (Part IV, particularly on the role of values in diagnostic assessment), and in the philosophy of mind (Part V, which explores specific areas of psychopathology). Philosophy, then, has much to contribute here. And the point of this chapter is to encourage philosophers, in engaging with psychiatric classification and diagnosis, to get up to speed with the subject as it really is.

Sources and resources in clinical psychopathology and the aims of this chapter

There is no single source from which a philosopher can get up to speed with classification and diagnosis in psychiatry. Textbooks are written for particular groups of practitioners with particular backgrounds, levels of clinical experience, and training aims. Diagnostic manuals, similarly, although a helpful source (the DSM has invaluable summary 'boxes', see below), assume a shared 'craft knowledge' and professional expertise. The research literature, as another valuable source, encompasses a number of disciplines (psychological, phenomenological, neuroscientific, etc.), often highly specialized, and necessarily assuming technical expertise and common programme objectives. The growing first-hand narrative literature from users and carers is an especially rich resource, which is becoming increasingly accessible especially through web-based sources.

This chapter includes examples of materials from all these sources set within a framework of the main areas of descriptive psychopathology (symptoms) and categories of disorder (syndromes) recognized particularly by psychiatry and clinical psychology. Clearly, within the scope of this chapter we can claim neither comprehensive coverage nor in-depth treatment of any particular topic. However, we hope that the examples given, taken together with the reading guides here and in later chapters, will provide a clear introduction to *clinical* psychopathology as a basis for well-informed research in the growing discipline of *philosophical* psychopathology.

Structure of the chapter

The chapter is divided into three main sessions:

- *Session 1, diagnosis in medicine and psychiatry*, covers the principles governing diagnosis and classification in psychiatry and medicine (we outlined the *process* of diagnosis in Chapter 2, Session 1).
- *Session 2, descriptive psychopathology*, describes the range of psychiatric symptoms and signs recognized by psychiatry. As the scope of what has become widely known as 'descriptive psychopathology' (Sims, 1988) or, sometimes, 'descriptive phenomenology' (Sims *et al*., 2000), this will be the largest section of the chapter. It includes brief *Philosophical Annotations* on each of the main areas of symptomatology (anxiety, affect, etc.). These are by way of illustration of philosophical work in psychopathology and are not, of course, exhaustive of this rapidly expanding field. In particular, we have made no attempt to cover the rich resources of Continental phenomenology, which will be the subject of a later book in this series (Parnas *et al*., forthcoming). A general reading guide to psychopathology, clinical and philosophical, is given at the end of the chapter.
- *Session 3, categories of mental disorder*, outlines the main clinical syndromes included in our current diagnostic classifications of mental disorder, in particular ICD-10 (WHO, 1992) and DSM-IV (APA, 1994). The categories of disorder included in these classifications are built up primarily from the symptoms and signs described in Session 2.

In a brief *Conclusions* we will introduce some of the particular difficulties presented by psychiatric classification and diagnosis and indicate how these connect psychiatry with philosophy. These difficulties are all explored further in other chapters.

Session 1 Diagnosis in medicine and psychiatry

In all branches of medicine, disease classification develops by a kind of natural selection. As medical knowledge advances, so new and clinically more useful categories gradually replace those that have become less useful. In this respect, medicine and psychiatry are no different from other sciences. As Norman Sartorius, at the time Director of the Mental Health section of the WHO, reminded us in the Preface to ICD-10, a classification is no more, and no less, than 'a way of seeing the world at a point in time' (Sartorius, 1992, p. vii). A scientific classification (as we will explore in detail in Part III, chapter 13) thus represents a snapshot of the theory and knowledge base of the science in question at a given stage of its development.

Scientific knowledge in psychiatry has been advancing rapidly in recent years. Psychiatric diagnostic categories are thus correspondingly fluid and this has brought with it a degree of confusion. However, the more widely used classifications are nowadays all broadly similar. DSM-IV and ICD-10 were indeed bound by international treaty to converge as far as possible. They include many of the same overall categories of disorder and they are built up from essentially the same list of basic symptoms and signs. It is mainly in the details of particular category definitions that one classification differs from the next (though as we will see later, particularly in Part IV, chapter 20, some of these differences of detail are conceptually highly significant).

The purposes of diagnosis

In the first exercise in this chapter we consider one of those questions that, so far as doctors are concerned, is generally just taken for granted, namely what purposes are served by medical diagnosis?

Making the purposes of diagnosis explicit helps to explain, first, why diagnostic classifications have developed as they have in bodily medicine, second, why they remain in some respects different in psychiatry, and, third, why philosophy (as well as science) may be important in developing future classifications not only in psychiatry but also in bodily medicine.

EXERCISE 1 (20 minutes)

Write a list of a few medical diagnoses. These could be from your own experience as a doctor or as a patient. Think of minor as well as more serious conditions. Then write down what purposes these diagnoses serve, thinking about this particularly from the perspective of a doctor or other health-care professional.

Here are just a few examples: common cold, migraine, boil, chicken pox, pneumonia, pneumococcal pneumonia, anaemia, iron deficiency anaemia, diabetes mellitus.

Obviously, the list is endless! Each of these diagnoses, however, like any diagnosis in medicine, serves four main purposes. Briefly, these are:

1. *Descriptive*: a diagnostic label provides a summary description of a patient's symptoms, essential for communication, and the key to all other medically relevant decisions about the patient.
2. *Aetiological*: diagnoses, particularly in specialized areas of bodily medicine, are often based on information about aetiology (or causation).
3. *Therapeutic*: knowledge of symptoms and of aetiology is the basis for decisions about treatment and other aspects of clinical management.
4. *Prognostic*: symptoms and aetiology, together with the likely response to treatment, give an estimate of prognosis.

The four main purposes of diagnosis in medicine are served in different ways and to different extents by different kinds of diagnostic category. Thus the diagnosis 'migraine' conveys definite information about a patient's symptoms and their prognosis; however, it suggests only a range of possible treatments, and it tells us little if anything about aetiology. With 'diabetes mellitus', on the other hand, the reverse is the case. This diagnosis conveys definite information about aetiology, it suggests certain specific and effective treatments, and it allows an overall estimate of prognosis; but given the wide variety of possible clinical presentations of this condition, it provides no definite information about the patient's actual symptoms.

We can understand these differences in the terms of what in Chapter 5 we will call differences between strict and ordinary implication. Different kinds of disease category are *defined* in different ways, symptomatically, aetiologically, etc. This is *strict* implication. But they all carry by *ordinary* implication, or contingently, a degree of information relevant to all four purposes of diagnosis.

Differences between diagnosis in bodily medicine and psychiatry

The contested status of psychiatry as part of medicine, as we saw in the last chapter, has its origins in a number of differences between it and general bodily medicine. These are particularly evident in classification and diagnosis.

EXERCISE 2 (20 minutes)

Think about the diagnostic categories you are familiar with in psychiatry, either from your professional or user experience, or by referring back to Figure 2.1 and Box 2.1 in chapter 2. In terms of the four 'purposes' of diagnosis, and their respective representations in the definitions of particular categories, how do the categories of mental disorder differ overall from those in bodily medicine?

A key difference in classification and diagnosis between psychiatry and bodily medicine is that psychiatry's diagnostic categories

Table 3.1 Different kinds of diagnostic category as illustrated by depression

Diagnosis	Symptoms	Aetiology	Treatment	Prognosis
Major or psychotic depression	Severe, often relapsing depression with one or more of: (a) a number of biological symptoms (b) delusions, hallucinations. Sometimes alternating with periods of mania.	Various theories	Physical treatments (drugs, ECT) likely to be effective and may be life-saving (e.g. with suicide risk). Other treatments important but supplementary.	Good, especially with treatment. Likely to relapse but with (often long) periods of normality. When depressed beware high suicide risk.
Minor depression	Usually less severe depression, with neither specific biological symptoms nor delusions or hallucinations. May be chronic, is often relapsing	Various theories	Psychological treatments (e.g. cognitive therapy) often helpful together with counselling, support and social intervention. Physical treatments less likely to be helpful.	Generally good; but sometimes condition is chronic and/or relapsing (merging with personality disorder). Risk of attempted suicide rather than actual suicide.
Depressive personality	Depressive symptoms, usually similar to those of neurotic depression; but continuing largely unchanged throughout adult life	Various theories	Treatment unlikely to change the condition. Management thus concentrates on ameliorating the effects of the condition on the patient's life, and on the lives of those around the patient.	Poor. Likely to remain essentially unchanged.
Adjustment reaction	May include any of the range of depressive symptoms, but these are clearly provoked by loss (e.g. in bereavement) or other psychological trauma.	Experience of loss or other psychological 'trauma' is part of definition.	Counselling, support and social intervention indicated; psychological (and physical) treatments sometimes helpful.	Good. Even if very severe, likely to resolve; but may recur with further stressors.

are more often defined *descriptively*, ie in terms of *symptoms*, rather than aetiologically. Psychiatric diagnostic categories are thus more often like 'migraine' than like 'diabetes mellitus' in the kinds of information that they convey.

Both types of diagnostic category, however, as already noted, also carry important information about aetiology, treatment, and prognosis. This is illustrated by Table 3.1, which shows four important diagnoses of depression. The first three of these differential diagnoses (as a list of this kind is called) are defined primarily by the symptoms present and by their time course. The fourth diagnosis includes a reference to stress as an aetiological factor. However, all four categories carry by ordinary implication information about aetiology, treatment, and prognosis, as well as symptoms. (These categories are described further in Session 3 below, and Table 3.3 and Box 3.1)

The difference between psychiatry and bodily medicine in this respect is of course a difference of degree rather than a difference in kind. This is one reason why the radical antipsychiatry view that mental distress and disorder are *never* pathological, is perhaps not very plausible. As we saw in Chapter 2, though, the fact that there *is* this difference of degree makes the radical pro-psychiatry claim, that mental disorders are *no different* from bodily disorders, equally implausible.

Reasons for the differences: a negative and a positive view

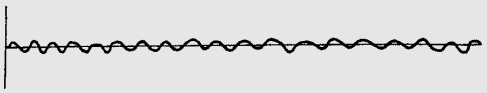
As to why there should be these differences of degree between the diagnostic categories of psychiatry and of bodily medicine, different interpretations are possible. One interpretation, noted in Chapter 2, is that psychiatry is scientifically primitive. Historically, as this somewhat negative line of thought goes, bodily medicine has moved from descriptive categories ('dropsy', the 'staggers', 'fever', etc.) to aetiological categories through a series of remarkable advances in medical science. Psychiatry, then, according to this interpretation, has remained stuck at a descriptive stage, roughly equivalent to pre-seventeenth century general medicine!

A more positive interpretation is that the sciences underpinning psychiatry are just a lot more *difficult* than those underpinning areas such as cardiology and gastroenterology. Psychiatry, then, consistently with this positive interpretation, is in this respect closer to neurology than to cardiology and gastroenterology. For in neurology, too, many of our diagnostic categories, like those in psychiatry, are still primarily descriptive, and for the same reason, namely, that neurological science is peculiarly *difficult* science.

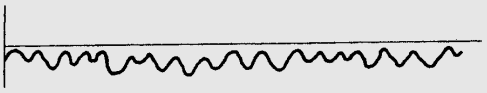
This is not in any way to minimize the importance of the scientific advances made in other areas of medicine. But it *is* firmly to

Box 3.1 Definition of personality disorder

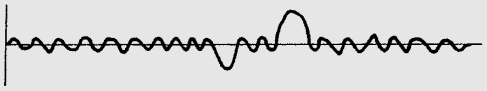
1. *Normal*. This shows the regular, moderate mood swings of a normal individual subject to the normal exigencies of an average life.



2. *Depressive personality disorder*. Here the subject's mood swings are mainly depressive.



3. *Illness superimposed on a normal personality*. The subject suffers a depressive illness, followed by a manic illness. Note that his symptoms during his first illness are the same as those that subject number 2 suffers most of the time. But for this subject, they represent a change from the norm.



4. *Illness superimposed on an abnormal personality*. Again, the essential difference between illness and personality disorder is a change from the norm for the patient in question, either quantitative (i.e. the first and second blips on the trace) or qualitative (the third, square-shaped blip). Here the personality disorder is cyclothymic, i.e. with excessive mood swings both up and down.

In this diagram, the four longitudinal axes represent the lifetimes of four peopole, from late adolescence through to old age (this being the period over which personality is normally stable). The four horizontal axes represent, for purposes of this example, mood swings – up for happy, down for sad. This axis could represent any other personality trait. (Source: Fulford, 1998).

endorse a positive rather than negative interpretation of the stage of development of psychiatric science. We can spell out this positive rather than negative interpretation in the form of three answers to three questions. Thus,

- *Question 1: Why have diagnostic classifications developed as they have in bodily medicine?* Disease classifications in most areas of bodily medicine have moved from a predominantly descriptive to predominantly aetiological basis over the last century or so, because the sciences underpinning them—physiology, bacteriology, and so forth—have developed to the point that an agreed corpus of causal disease theory has reached the threshold of clinically usefulness.
- *Question 2: Why do diagnostic classifications remain in some respects different in psychiatry?* Diagnostic classifications remain predominantly descriptive (symptom-based) in psychiatry because progress in the sciences underpinning the discipline has been slower; however, this is because the sciences concerned are a good deal more difficult than those involved in most areas of bodily medicine.
- *Question 3: Why may philosophy (as well as science) be important in developing future diagnostic classifications in psychiatry?* Philosophy has a role to play in psychiatric diagnostic classification, because the difficulties in psychiatric science are conceptual (hence in part matters for philosophy) as well as empirical in nature. This is well recognized by many neuroscientists. The American psychiatrist and neuroscientist, for example, Nancy Andreasen, who besides being Editor of the prestigious *American Journal of Psychiatry* has done seminal work both in descriptive psychopathology and in brain imaging, concludes a masterly review of the new neurosciences, concerned as they are with the 'higher' mental functions, of consciousness, personal identity, and so forth, with a ringing endorsement of the importance of the humanities alongside the sciences in psychiatry (Andreasen, 2001).

The positive interpretation in research and practice

A positive rather than negative interpretation of the continuing differences in classification and diagnosis between psychiatry and other medical disciplines is important scientifically. Productive as psychiatry's twentieth century imitation of medical disciplines such as cardiology and renal medicine has been, it can hardly expect to develop fully within a framework of disease theory that is sufficient for these relatively uncomplicated (conceptually speaking) areas of medicine: no more could quantum mechanics have developed within the conceptual framework of nineteenth century mechanical engineering—though of course it could not have developed without it!

We return to the particular conceptual challenges of psychiatric classification and diagnosis below, Conclusions, and in Part III. However, a positive rather than negative interpretation of the stage of development of psychiatric science is perhaps even more important clinically. Much of the difficulty we face in mental health, whether as users or providers of services, whether as psychiatrists, psychologists, nurses, or advocates, arises from the stigmatization of our discipline as being, somehow, an inadequate also-ran to general medicine. Well, it is easier to run up a small hill than a mountain! The scientific mountain of psychiatry is, partly, the empirical challenge of developing methods for investigating the brain. Psychiatry shares this empirical challenge with neurology. However, psychiatric science, in being concerned with the higher functions (of emotion, belief, volition, and so forth) has conceptual challenges as well. These challenges start with the structure of experience and of the disturbed experiences that are the subject matter of descriptive psychopathology.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. What are the four main purposes of diagnosis in medicine?
2. What is the main difference between the diagnostic categories used in psychiatry and in (most) areas of bodily medicine?
3. Give one positive and one negative interpretation of the differences between diagnostic categories in psychiatry and in bodily medicine.

Session 2 Descriptive psychopathology

In this session, the main psychiatric symptoms and signs recognized by psychiatry will be outlined. As we noted in the last session psychiatric diagnostic categories are mainly like 'migraine' rather than 'diabetes mellitus', in being defined descriptively rather than aetiologically. In Session 3 we will look at how the symptoms and signs that comprise psychiatry's descriptive psychopathology are aggregated, in various ways, to make up the broad categories of disorder common to most modern psychiatric classifications. A practical scheme giving the steps from symptoms to diagnosis in individual cases is described at the end of that session. Further details of many of psychiatry's diagnostic categories are given in later chapters, in particular in Part V.

The scope of descriptive psychopathology

Descriptive psychopathology covers the symptoms (expressed by the patient) and signs (observed by others) of psychiatric disorder. These symptoms and signs are of two main kinds, psychological and bodily. As to the bodily, almost any bodily symptom, and many signs, may sometimes be due to psychiatric disorder (just as any psychological symptom may sometimes be due to bodily disorder). We will be looking briefly at some of the bodily symptoms important in psychiatry below. But it is on the psychological symptoms that we will be concentrating in this section.

In what follows you may find it helpful to refer to Table 3.2 which gives a checklist of the main psychiatric symptoms and signs.

Table 3.2 Psychiatric symptom check-list

Psychological symptoms

Mood: morbid states of

1. Anxiety
   - generalized (free floating)
   - phobic: specific object, social phobic, agoraphobic
   - panic attacks
2. Affect (sadness/happiness)
   - depression
   - elation (hypomania)
   - mixed
   - diminished

Thought: disorders of

1. Stream
   - slowed
   - accelerated (pressure of thought; flight of ideas;)
2. Connection
   - thought block
   - knight's move
   - positive formal thought disorder (asyndetic thinking, interpenetration of themes, overinclusiveness)
   - negative formal thought disorder ('concrete' thinking)
   - 'word salad' (severe formal thought disorder + neologisms and metonyms)
   - perseveration
3. Possession
   - obsessive-compulsive symptoms
   - thought insertion**/withdrawal**/broadcasting** (schizophrenia)
4. Content
   - delusions,** differentiated by content (paranoid/self-referential; persecutory; grandiose; hypochondriacal; nihilistic; of guilt; of poverty) and origin (primary and secondary)
   - partial delusions*
   - morbid fears
   - overvalued ideas

Perception

1. Hallucinations,** differentiated by mode (auditory, visual, olfactory, gustatory, tactile) and form (simple, complex)
2. Pseudohallucinations*
3. Illusions/distortions

Cognitive function: disturbances of

1. orientation (for time, place, person)
2. attention/concentration
3. memory
   - recent
   - remote
4. IQ (verbal, performance)

Insight: for any symptom, lack of

1. awareness that something is wrong and/or
2. recognition that what is wrong is a symptom of mental illness

Physical symptoms

Any physical symptom may be due to a psychiatric disorder. Important examples include:

1. autonomic symptoms of anxiety (palpitation, tremor, globus, etc.)
2. biological symptoms of depression
3. pain (e.g. in 'masked' depression)
4. disorders of primary sense and voluntary motor systems (in hysteria)
5. disturbances of vegetative functions
   - appetite (loss, anorexia, bulimia); sexual (drive, orgasmic); sleep (increased, decreased)

Psychological signs

Disturbances of appearance, behaviour and speech. Important but mainly as pointing to psychological symptoms; e.g. 1. expressed affect (facial, postural, speech), 2. self-neglect (e.g. in dementia).

* Partial insight; ** psychotic symptoms, ie no insight.

Psychological symptoms

The subdivisions of descriptive psychopathology

As in bodily medicine, accurate diagnosis in psychiatry depends on the details of a patient's symptoms. For example, it is not enough to know that a patient is worried by the thought that he is dirty. You have to decide whether the thought in question is, say, an ordinary preoccupation, an obsession, a delusion, or thought insertion. Each of these has quite different features.

This brings us to the general problem, how to divide up the content of consciousness?

EXERCISE 3 (15 minutes)

Write down your own ideas about how the contents of consciousness might be divided up. Bodily medicine has a (relatively) easy task of dividing the body up into parts and systems—circulatory, gastroenterological, reproductive, etc. What might be the counterparts of these for the mind?

The psychological symptoms of psychiatric disorder are generally divided up by psychiatry for descriptive purposes into disorders of: (1) mood; (2) thought; (3) perception; and (4) cognitive function.

You will probably have had different ideas about the 'parts' of the mind! Different ideas are to be found among authors on psychopathology: delusion, for example, is usually included (as here) among disorders of thinking; however, it is sometimes separated out from disorders of thought as a disorder of belief. So there is work here for philosophy, this being just one of the ways in which psychiatry is conceptually more complex than bodily medicine. In this section, however, our aim is to follow through the categories of mental disorder as currently conceptualized in mainstream psychology and psychiatry.

Disorders of mood

Mood is the prevailing feeling state. In psychiatry, disorders of mood include extreme, or otherwise maladaptive, states of (1) anxiety, and (2) affect (sadness/happiness).

Mood (1): anxiety

EXERCISE 4 (10 minutes)

Think of a situation in which you have been frightened, worried, or just concerned. What did you feel? How did you react, i.e. what if anything did you do? And did you notice any bodily changes?

Anxiety as a symptom

Anxiety is of course a normal response to threat. *Anxiety as a symptom* is a disproportionate or otherwise maladaptive response. Thus, someone who feels anxious with no obvious cause, or who over-reacts to an object or situation, may have anxiety symptoms. But someone whose anxiety is an understandable response to an imagined threat (e.g. with delusions of persecution), does not: here the anxiety, as such, is proportionate.

Anxiety has three components: subjective (feelings of fear or apprehension); behavioural (avoidance); and bodily (autonomic changes, i.e. changes mediated particularly by the autonomic nervous system, such as palpitation, sweating, shaking, choking and difficulty getting one's breath).

Anxiety as a symptom may be relatively persisting and generalized. This is sometimes called *free-floating anxiety*. Anxiety that is directed or focused, on the other hand, is called *phobic anxiety*.

A phobia is an unreasonable or unfounded fear of an object or situation usually leading to avoidance behaviour. Phobias are of three main kinds: (1) *specific* phobias, i.e. of specific objects or situations, such as fear of thunder or spiders; (2) *social phobias*, in which anxiety is experienced in social situations, such as speaking or eating in public; and (3) *agoraphobia*. Agoraphobic symptoms are diverse but are related mainly to two situations, leaving one's home or other familiar surroundings (sometimes called the 'housebound housewife syndrome'), and being in crowded places (see example below).

A third kind of anxiety symptom is a *panic attack*. Panic attacks are what their name implies, circumscribed (they may last up to a few hours) and usually very intense attacks of anxiety. They are associated with particularly marked autonomic symptoms. These make it especially important to distinguish panic attacks from bodily conditions, such as thyrotoxicosis (overactive thyroid) and some forms of cardiac arrhythmia (disturbance in the rhythm of the heartbeat).

Case 1: the experience of agoraphobic anxiety

Pam Mason describes her experience of agoraphobia as a young woman:

> Before long I found the thought of going to Liverpool city centre, only seven miles away, a place I loved more than anywhere else in the world, too hard to imagine. And then Huyton village, a quarter of a mile away, became too far. School was about three hundred yards down the road—somehow I got there during the last few weeks. I got through all my exams, breaking down on the last day, but battling on, doing the papers, getting some good marks, incredibly.
>
> And then I just collapsed. It was a struggle to get as far as the garden gate.
>
> By now I realised I had a form of agoraphobia. I fought. I made myself go out of the house, brief and terrifying as such trips were. Although Mum was fighting her own problems at the time, she offered to go out with me. This meant I could get further from the house and the freedom was as precious to me as it would be to any prisoner travelling under escort. But instead of curing our problems, we had pooled them. I became acutely dependent on her. We acted out the roles of extremely protective mother and sick, frightened toddler. She

had to be there all the time now, to hold me and save me when That Feeling came, as it often did, blasting away at my self and all my hope. How could I ever live a normal life when I had this in my head? I read Claire Weekes's books and Open Door newsletters, desperate for a solution, but only terrified myself with other people's symptoms.

Mason (1996, pp. 3–8)

Philosophical annotations

Anxiety is perhaps the commonest psychiatric problem (it is often diagnosed by general practitioners rather than by hospital specialists), and it has a well-understood physiological basis. Yet it has also been a topic of particular interest to philosophers. Anxiety thus provides a unique bridge between medicine and the humanities. The existentialists are the philosophers best known for their distinctive focus on anxiety ('*Angst*'). Soren Kierkegaard who has sometimes been described as the father of existentialism wrote extensively about anxiety in *The Concept of Anxiety* (1981) and also in *The Sickness Unto Death* (1983). Later Martin Heidegger used an examination of anxiety to reveal the fundamental aspects of our 'being-in-the-world'. According to Heidegger, we are anxious when our natural, fluid engagement with the world is disrupted; in this state the fact that we are not in our essence self-contained but dependent on an engagement with the public world is revealed to us (Heidegger, 1962, see especially part 1, chapter 40). Heidegger's philosophical ideas were then deployed in a psychiatric context by Ludwig Binswanger (1975) and Medard Boss (1963; 1983). Similarly, the existential analyst Irving Yalom (1981) urges that an unacknowledged anxiety about our own death is the source of much psychopathology. For a recent attempt to build bridges between medical and philosophical accounts of anxiety, see the Dutch philosopher and psychiatrist, Gerrit Glas (2003).

Mood (2): affect

The term 'affect' is used in psychiatry to refer to the sadness/happiness aspect of mood. As with anxiety, sadness and happiness are of course normal affects, being responses respectively to loss and to success; and, also similarly, they are pathological if disproportionate or otherwise maladaptive. Depression of mood is a more common symptom than mania and (the less severe) hypomania (pathological elation). Anxiety and depression commonly occur together.

EXERCISE 5 (20 minutes)

Think of a situation in which you have had a disappointment or loss. This might be a major 'life event', such as bereavement, or a more minor loss. How did you react? How did you feel? Were your feelings limited to the loss or disappointment in question or were they generalized to other aspects of your life? As with anxiety (exercise 4 above), think also about what you did, if anything, and any bodily change you noticed.

Then repeat all this for a situation in which you had a particular success.

Depression and elation as symptoms

Depression as a symptom varies in intensity. When it is relatively mild it is like ordinary sadness, except that it is inappropriate to the patient's circumstances. More serious states of depression on the other hand ('major depression'—see below, Session 3) may differ qualitatively from normal. Often the seriously depressed patient does not complain of depressed mood as such, though he or she usually appears extremely sad, unsmiling, and inert. Depression of this kind is associated with motor and psychological slowing (*psychomotor retardation*), though sometimes with the opposite, *agitation*. There may be associated biological symptoms (fixed diurnal variation of mood, together with loss of appetite and weight, and early morning waking) and delusions (see below).

Sometimes depression is masked, i.e. the patient presents with bodily symptoms (such as unexplained pain, tiredness or weight loss) rather than with a complaint of lowered mood.

Hypomania is the counterpart of major rather than of minor depression in that the patient generally does not complain of

Case 2: The experience of depression

The comedian, Spike Milligan describes his depression in an interview with the Irish psychiatrist and broadcaster, Anthony Clare,

Clare: Could you try to describe how you feel when you are depressed? [Just answering this question was a struggle. This man, normally fast and furious with words, had to make a Herculean effort just to make conversation. Responding to questions about how he felt took an almost physical struggle.]
Milligan: There is this terrible emptiness. I just want it to go away, disappear, cover myself up until it goes away. It is like pain yet it is not a physical pain. I cannot describe it. It is like every fibre in your body is screaming for relief yet there is no relief. How can I describe it? I cannot really. I cannot, of course, escape because I have to keep working, which I just about do—though once or twice I have had to stop, had to just hide away and wait till I could summon up the energy just to keep going.

Later in the interview, Clare asks,

Clare: 'But do you retreat? Do you close the door behind you?
Milligan: Yes. The whole world is taken away and all there is, is this black void, this terrible, terrible, empty, aching, black void and the only thing that helps is the psychiatrist coming in with the right tablet. But of course there isn't really a right tablet. It is a little like jacking a car. The psychiatrist can jack up the car but he can't change the tyre. You have to wait. You need tremendous patience. You need the patience. You need the patience of Job.

Milligan and Clare (1993, pp. 16 and 18)

Among other powerful first-hand accounts of depression, see Styron (1991) and Wolpert (1999).

their altered mood state as such (see below, Insight). There is euphoria, self-confidence, pressure of speech and 'flight of ideas' (see below), excessive energy, lack of sleep, heightened sexuality, an infectious jollity (which often gives way to impatience and irritability), an expansive and grandiose manner, and, as the condition worsens, hallucinations and delusions.

Many of the features of both depression and hypomania (full-blown mania is rarely seen, nowadays) can be understood as exaggerations of our normal responses, respectively to loss and to success. These responses include the prevailing moods, of course, sad or happy; but also the tendency of our mood to generalize (we speak of seeing everything through rose-tinted spectacles when happy, for example, and, correspondingly, dark glasses when sad!); the emergence of associated behaviours (withdrawal when sad, engagement when happy); and marked bodily changes (inertia, tiredness, and loss of energy when sad; activity, alertness, and lots of energy when happy).

Case 3: The experience of hypomania

Kay Jamison, a professor of psychiatry at the Johns Hopkins University School of Medicine, includes a number of first-hand accounts of hypomanic symptoms in her study of the relationship between creativity and hypomania. From among poets, her examples include,

1) Euphoric Mood (p. 28). Theodore Roethke . . .

'For no reason I started to feel very good. Suddenly I knew how to enter into the life of everything around me. I knew how it felt to be a tree, a blade of grass, even a rabbit. I didn't sleep much. I just walked around with this wonderful feeling.'

2) Grandiosity (p. 29). Robert Lowell . . .

'The night before I was locked up I ran about the streets of Bloomington Indiana crying out against devils and homosexuals. I believed I could stop cars and paralyze their forces by merely standing in the middle of the high-way with my arms outspread . . . I suspected I was a reincarnation of the Holy Ghost, . . .

3) Pressure of speech and subjective ideomotor pressure (p. 29). John Ruskin . . .

'I roll on like a ball, with this exception, that contrary to the usual laws of motion I have no friction to contend with in my mind, and of course have some difficulty in stopping myself when there is nothing else to stop me . . . I am almost sick and giddy with the quantity of things in my head—trains of thought beginning and branching to infinity, crossing each other, and all tempting and wanting to be worked out'.

Jamison (1996a)

Mixed affective states are sometimes seen, in which features of both depressed and elated mood coexist. These are different again from states of *diminished affect* in which the person's actual *capacity* to feel happy or sad is reduced: examples of this include flattened affect in schizophrenia and 'belle indifference' in hysteria.

Philosophical annotations

Extremes of mood have been associated traditionally with creativity particularly in the arts: both melancholy and euphoria have provided inspiration for poetry, for example (as Jamison's, 1996a book, above, richly illustrates). Quantitative differences between (normal) sadness and (pathological) depression have been a focus of recent work in phenomenology (see, e.g. the German psychiatrist and phenomenologist, Alfred Kraus, 2003). Changes in mood provide particularly sharp tests of 'models' of mental disorder: see, e.g. on depression, the American philosopher, Jennifer Radden's (2003), *Is this Dame Melancholy*, and, another American philosopher, Loretta Kopelman's (1994a) study of 'normal grief'; also Eigen, 2001, on ecstasy. On hypomania, see, Moore *et al.* (1994), for the relationship between pathological elevation of mood and Aristotelian eudaimonia; also the British psychologist, Richard Bentall's (1992) brilliant spoof on the traditional medical model of mental disorder; and replies in the *British Journal of Psychiatry* by Harris (1993), Birley (1993) and Fulford (1993).

Mood is generally thought to be somehow quite distinct from intellectual understanding. But Heidegger, in particular, urged that we should not think of mood as something extrinsic to our reality contact—as something which merely subjectively colours our experience. Rather we are always in some or other mood, and it is in and through these moods that things in the world 'show up' for us in the first place. (See Dreyfus, 1991, chapter 10.)

Disorders of thought

Disturbances of thinking are usually divided into disorders of: (1) stream; (2) connection; (3) possession; and (4) content.

Thought (1): stream

Disorders of the stream of thought

The stream of thought—how fast one thought follows another—may be slowed (as with psychomotor retardation in depression) or accelerated. Acceleration of the stream of thought occurs typically in hypomania and may take the form of pressure of thought (thoughts rushing on one after another) and/or flight of ideas (rapid changes of topic that are none the less still connected up, e.g. through meaning, rhyme, pun, or metaphor).

Case 4: The experience of flight of ideas

The British psychiatrist and psychopathologist, Andrew Sims, gives a short sample of the speech of a woman, aged 45, with hypomanic symptoms: 'They thought I was in the pantry at home . . . Peekaboo . . . there's a magic box. Poor darling Catherine, you know, Catherine the Great, the fire grate, I'm always up the chimney. I want to scream with joy . . . Hallelujah!' Sims (1988, p. 108)

Like the third extract from Kay Jamison's book (above, case example 3), this patient shows pressure of speech. Flight of ideas is shown by her rapid, though still connected, changes of topic.

Sims, 1988, gives a particularly clear and well-illustrated account of the many different ways in which the form of thought may be disturbed. Besides acceleration and retardation, these include: circumstantiality, derailment, fusion, and other disturbances to the flow of thought, thought block (see below), crowding, perseveration, overinclusive and 'concrete' thinking.

Comment: This patient describes thought block but not thought withdrawal (see below). Leff and Isaacs (1990)

(Leff and Isaacs' slim volume is full of clear descriptions and vivid clinical examples of all the main areas of descriptive psychopathology.)

Thought (2): connection

Disorders of the connections between thoughts

A variety of *disorders of the connections between thoughts* are seen particularly in people with schizophrenia (though also sometimes in other psychotic disorders, see below, this section, also later in relation to Insight, and Session 3).

Thought block is a simple stopping of the line of thought. It can be a normal phenomenon in states of anxiety, fatigue, and stress. As a psychiatric symptom, it often occurs in an extreme form in schizophrenia when it may be associated with other symptoms of *schizophrenic thought disorder*: e.g. *knight's move* in thought, a shift from one topic to another without any logical connection. A more general *loosening of the associations* between thoughts occurring in schizophrenia is called *asyndetic thinking*. This may be combined with *interpenetration of themes* (two or more topics woven more or less haphazardly into the patient's speech) and with *overinclusiveness* (a tendency to excessive generalization beyond the normal boundaries of a given topic).

In addition to these aspects of thought disorder, people with schizophrenia sometimes produce *neologisms* (invented new words) and *metonyms* (approximately correct, idiosyncratic uses of real words and phrases). The net effect of schizophrenic thought disorder is to leave the listener baffled. In extreme form, the patient's speech may become wholly unintelligible (called *word salad* or *verbigeration*).

Case 5: the experience of thought block

The psychiatrists Julian Leff and Anthony Isaacs, describe a clinical interview with a patient experiencing thought block.

Interviewer: Do you ever find that your thoughts stop dead and leave your mind a complete blank?

Patient: This happens sometimes, yes.

I: What is it like?

P: It's not very good. You're just drifting around like a leaf.

I: Is it just that your thoughts drift off what you were thinking about or do they actually disappear?

P: Your mind just goes more or less blank. You just sort of tick over.

I: Is it as though your thoughts have been taken away or is it just that they've stopped?

P: No, not taken away. It's just as though they've stopped for a little while.

Neologisms and metonyms also occur in hypomania. Combined with flight of ideas, this may give a picture not unlike thought disorder in schizophrenia. Note, however, that flight of ideas differs from thought disorder in schizophrenia in that there is always a residual connection of meaning between the thoughts expressed (as described above).

Phenomena similar to those seen in schizophrenic thought disorder may occur in organic states, though usually associated with disturbance of cognitive function (e.g. clouding of consciousness, memory impairment, etc.—see below). In addition, organically impaired patients may show other disturbances of the connections between thoughts such as *concrete thinking*, namely an acquired inability to think in abstract terms (demonstrated for example by overliteral proverb interpretation), and *perseveration*—an inability to switch topics, manifesting as a senseless repetition of the last part of what is said . . . is said . . . is said; i.e. like a gramophone getting stuck. Perseveration may be shown in behaviour as well as in speech. Perseveration is a sign particularly of damage to both sides of the frontal lobes of the brain (behind the forehead).

Associationism was the school of psychology/philosophy of mind that stressed the importance of the connections between thoughts. Eugen Bleuler's ([1911]1950) notion of 'schizophrenia' or 'split mind' was developed and set out in associationist terms, the various symptoms being traced back to disorders of association. Thus, formal thought disorder, directly reflecting Bleuler's associationist sympathies, was for him the most basic symptom. (He also talked about dissociation of complexes as well as splitting of the associations, putting himself in both a prototypical psychoanalytic as well as an associationist camp.) The idea that the mind is constructed out of chains of associations, which in a sense was the first mechanistic psychology, was an important influence on European and American psychology/philosophy of mind throughout the nineteenth century.

Thought (3): possession

Disorders of the possession of thought

Disorders of possession of experience are of two very different kinds: (1) obsessive-compulsive, and (2) psychotic; the latter are divided into (a) thought insertion, withdrawal, and broadcasting, and (b) other passivity phenomena.

Obsessive-compulsive symptoms. An obsessional thought is stereotyped in form and comes back repeatedly into the patient's mind. The patient regards the thought as irrational and unpleasant and usually tries to resist it but is largely unable to do so. In

this respect it is like a very bad case of getting a tune stuck in your head. More generally, an obsession is any mental content with these features; e.g. ruminations, doubts, images, impulses, series of numbers, repeated words and phrases, and so on. Compulsive acts are the behavioural counterparts of obsessions. Common examples include compulsive hand-washing, tidying, touching, and cleaning.

Case 6: the experience of obsessive-compulsive symptoms

In an article in the *New Scientist*, Zulfikar Abbany describes his own (ultimately successful) attempt to overcome his obsessions and compulsive behaviour related to fear of contamination. In this extract, he describes the effect of builders coming into his flat to carry out essential repairs. On top of the general problems of dust and dirt, one builder had cut himself.

> No matter how I scrubbed the pot, it was impossible to convince myself that there was no risk of HIV or hepatitis.
>
> Empty bottles of bleach and disinfectant littered the tiny floor space. The walls of my flat began to cramp my already diminished style. All notions of autonomy, rationality and calm were being squeezed out of me as the walls closed in. Maybe I should try harder. Maybe if I wiped a little more vigorously, fears about disease and intrusion would all go away. It would be like starting again.
>
> That was the theory. In practice, the more I cleaned, the more I felt I had to. If I had used one bottle of bleach on Monday, I would use two—returning to the same spot—on Tuesday. My demand for the stuff was escalating and so was my need for new shops. The local sales assistants, I felt, already viewed me with suspicion.
>
> At the end of June, the builders finally finished. I had made it to the other side, but I was left with a heightened sense of insecurity. Order, and therefore equilibrium, had been restored, but what would it take to throw the fragile status quo off balance again? By now, I had closed down altogether to visitors, and the rigorous 'de-polluting' rituals of hand-washing and scrubbing when I came home were horribly time-consuming. I soon tired of going out at all.
>
> I had been avoiding a confrontation with my obsessions and compulsions for a decade. But this time I feared the situation was terminal. I gained strength through that fear—this was the last time it was going to overwhelm me. I set out to find a therapist. Abbany (2001, pp. 46–49)

Other common themes for obsessive-compulsive symptoms are violence, orderliness, religion and sexuality.

Psychotic disorders of possession of experience: (a) thought insertion, withdrawal, and broadcasting. Obsessional thoughts differ only quantitatively from normal experiences: as just noted, they are similar to a severe case of the experience of getting a tune stuck in one's mind. Obsessional thoughts are 'out of control' (Abbany, 2001, writes of having to 'confront' them) but they remain otherwise one's own thoughts. People with very violent or sexual obsessional thoughts, often describe these as not being their own. However, they mean by this only that they are completely out of character, rather than they are someone else's thoughts.

Thought insertion, withdrawal and broadcasting on the other hand, differ qualitatively from normal. With *thought insertion*, remarkably, the patient actually experiences the thoughts in their head, although thoughts that they are thinking (and in this sense first-personal thoughts), as those of *some other person or agency*, as thoughts *put there by somebody else*. (See also Chapter 29. This symptom, understandably, has been the subject of considerable philosophical interest.) *Thought withdrawal* is the experience of one's thoughts being taken out of one's head. *Thought broadcasting* is an extension of thought withdrawal, in which the patient experiences their thoughts travelling out of their head and being available for other people to inspect.

Case 7: the experiences of thought insertion, withdrawal, and broadcasting

The Canadian psychiatrist, C.S. Mellor, gave a series of case vignette examples of symptoms common in schizophrenia (and other psychotic conditions). His examples include disturbances in the possession of thought. We can pair these (Mellor, 1970) with the definitions in the glossary (Wing *et al.*, 1974) to one of the first standardized instruments for assessing the mental state, the Present State Examination (PSE). Developed by a group at the Institute of Psychiatry, London University, headed by the social psychiatrist, John Wing, the PSE provides an interview schedule and clear definitions allowing reliable identification of all the major symptoms of mental distress and disorder. Thus,

> *7.1 Thought Insertion.* PSE definition (Symptom 55, pp. 160–161) includes . . . 'The essence of the symptom is that the subject experiences thoughts *which are not his own* intruding into his mind' (emphasis in original).
>
> *Example* (C.S. Mellor, p. 17, example 6): A 29-year-old housewife said 'I look out of the window and I think the garden looks nice and the grass looks cool, but the thoughts of Eamonn Andrews come into my mind. There are no other thoughts there, only his . . . He treats my mind like a screen and flashes his thoughts on to it like you flash a picture.'
>
> *7.2 Thought Withdrawal.* The PSE (Symptom 58, pp. 162–163) treats thought withdrawal as an explanatory delusion for thought block' . . . The subject says that his thoughts have been removed from his head so that he has no thoughts.' C.S. Mellor (p. 16) describes thought withdrawal

as the 'experience (of the patient's thoughts) being withdrawn by some external force'.

Example (C.S. Mellor, pp. 16–17, example 5): A 22-year-old woman said 'I am thinking about my mother, and suddenly my thoughts are sucked out of my mind by a phrenological vacuum extractor, and there is nothing in my mind, it is empty . . .'

7.3 Thought Broadcasting. PSE definition (Symptom 56, pp. 161–162) includes '. . . the subject experiences his thoughts actually being shared with others, often with large numbers of people . . .'.

Example (C.S. Mellor, p. 17, example 7): A 21-year-old student said: 'As I think, my thoughts leave my head on a type of mental ticker-tape. Everyone around has only to pass the tape through their mind and they know my thoughts.'

Psychotic disorders of possession of experience: (b) passivity phenomena. Although often described as 'delusions of control', passivity phenomena are closely related to phenomena like thought insertion, in consisting of experiences of the will being taken over by some other agency: movements, volitions, even feelings are experienced as being out of one's own control and taken over by someone or something else. These are sometimes called 'made phenomena', e.g. made acts, made volitions, made affect.

Case 8: experiences of passivity

C.S. Mellor's brief descriptions and case vignettes illustrate the remarkable range of passivity phenomena (reference above).

8.1 Somatic passivity (p. 16)

The patient is a passive and invariably a reluctant recipient of bodily sensations imposed upon him by some external agency. According to Jaspers the perception is simultaneously experienced as being both a bodily change and externally controlled. It is a single experience and not simply the delusional interpretation of an abnormal bodily sensation.

Example: A 38-year-old man had jumped from a bedroom window, injuring his right knee which was very painful. He described his physical experience as, 'The sun-rays are directed by U.S. army satellite in an intense beam which I can feel entering the centre of my knee and then radiating outwards causing the pain.'

8.2 'Made' feelings (p. 17)

The patient experiences feelings which do not seem to be his own. The feelings are attributed to some external source and are imposed upon him.

Example: A 23-year-old female patient reported, 'I cry, tears roll down my cheeks and I look unhappy, but inside I have a cold anger because they are using me in this way, and it is not me who is unhappy, but they are projecting unhappiness onto my brain. They project upon me laughter, for no reason, and you have no idea how terrible it is to laugh and look happy and know it is not you, but their emotions.'

8.3 'Made' impulses or drives (p. 17)

The impulse to carry out an action is not felt to be one's own, but the actual performance of the act is.

Example: A 26-year-old engineer emptied the contents of a urine bottle over the ward dinner trolley. He said, 'The sudden impulse came over me that I must do it. It was not my feeling, it came into me from the X-ray department, that was why I was sent there for implants yesterday. It was nothing to do with me, they wanted it done. So I picked up the bottle and poured it in. It seemed all I could do.'

8.4 'Made' Volitional Acts (p. 17–18)

The patient experiences his actions as being completely under the control of an external influence.

Example: A 29-year-old shorthand typist described her actions as follows: 'When I reach my hand for the comb it is my hand and arm which move, and my fingers pick up the pen, but I don't control them . . . I sit there watching them move, and they are quite independent, what they do is nothing to do with me . . . I am just a puppet who is manipulated by cosmic strings. When the strings are pulled my body moves and I cannot prevent it.'

Philosophical annotations (see also Chapter 29)

The topic of the ownership of thought has been of interest to philosophers at least since Kant, who claimed that an 'I think' accompanies each and every one of my representations, which is to say that I must be able to be aware of all of my representations as being mine in order for me to have experience. The topic of 'immunity to error through misidentification' of the subject, has been taken up in the twentieth century by analytical philosophers such as Shoemaker (1968). Their significance for psychopathology has been examined (among others) by Campbell (1999) and Gallagher (2000, 2003).

The diagnostic significance of these phenomena has long been controversial. Schneider (1959), for example, stressed the pathognomic character of disorders of thought ownership and passivity experiences (made actions etc.) in the diagnosis of schizophrenia. This is reflected in DSM-IV-TR. However, for Schneider the passivity experiences were not criterial for, but merely pathognomic of (highly indicative of, mainly likely to occur in the context of), schizophrenia (See Bentall, 2003, pp. 31–35.) These and other traditional hallmark symptoms of schizophrenia are now known to occur in any of the psychotic disorders.

Thought (4): content

Delusions are the central symptom of psychotic disorders (see below). Psychotic disorders, in turn, as we noted in Chapter 2, and illustrated in the philosophical map of psychiatry (Figure 2.), are a conceptually central kind of mental disorder—it was for just this reason, that Thomas Szasz (1974), the author of 'The Myth of Mental Illness', called schizophrenia, in another book (Szasz, 1976), the 'Sacred Symbol of Psychiatry'.

Yet despite their importance, the proper place of delusions in descriptive psychopathology, remains highly contentious. They are generally included as the most important of the disorders of the content of thought, and then described as abnormal beliefs, of one kind or another. As such, they are closely related to other abnormalities of the content of thinking, e.g. *morbid fears* in anxiety and obsessional states, such as a fear of collapsing or of 'losing control' in public; also, *overvalued ideas*—beliefs of a highly idiosyncratic nature with which the patient is much preoccupied. Overvalued ideas are like delusions in being firmly held (see below); but they are understandable given the patient's particular circumstances and background.

Partial delusions are like delusions except that they are not held with complete conviction. They are ideas with which the patient is much preoccupied while yet not quite believing that they are true.

Delusional mood is a state of perplexity in which the patient senses that something important is going to happen but they are not sure what. With delusional mood, the patient often experiences brief delusion-like ideas that fluctuate in content over short periods of time.

Delusions take various forms (see below) but are usually defined as (1) false beliefs, which (2) are not susceptible to the ordinary processes of reasoning and appeal to evidence, and which (3) are culturally atypical, i.e. out of step with the beliefs conventionally held among people of the same cultural and ethnic background as the person concerned. To be a delusion, a belief must be held with complete conviction (see e.g. the definition in Harré and Lamb, 1987).

The difficulties with clauses (2) and (3) of this standard definition have been widely recognized (see Spitzer, 1990; and for a review of failures of empirical research to demonstrate disturbances of cognitive functioning that are characteristic of delusion, Garety and Freeman, 1999, pp. 113–154 for a valuable review). More radically, as the below examples illustrate, delusions, contrary to clause (1), may be neither false beliefs, nor, even, beliefs at all (at any rate as to matters of fact), but value judgements. With delusion, then, we have, in the terms than we will be adopting in Chapter 4, an excellent example of the use of the concept being far richer and more subtle than received definitions.

Case 9: the varieties of delusional experience

Any theory of the meaning of delusion must explain the wide variety of different logical forms that delusions may take in practice. Examples include,

False Factual Belief

Example: Mr P.D. Age 48. Bank manager [Diagnosis—major depression with hypochondriacal delusions of cancer]

Attended psychiatric clinic with biological symptoms of depression and the delusion that he had HIV infection (repeated tests normal). History of attempted suicide. Refused to believe that he was suffering from depression.

True Factual Belief

Example: Mr O.S. Age 45. Publican [Diagnosis—Othello syndrome or delusions of infidelity]

Attended general practitioner's surgery with his wife who was suffering from depression. On questioning, delivered an angry diatribe about his wife being 'a tart.' Unable to talk about anything else. Offered unlikely evidence (e.g. pattern of cars parked in road). Psychiatric referral confirmed diagnosis even though the doctors concerned knew that Mrs. O. was depressed following the break up of an affair.

Paradoxical

Example: Mr. M.I. Age 40. [Diagnosis—Delusional Disorder with hypochondriacal delusion of mental illness]

Brought to casualty after an overdose. Had tried to kill himself because he believed he was mentally ill. Diagnosis of monosymptomatic hypochondriacal delusional psychosis.

Delusional Value Judgement (Negative)

Example: Mr. E.D. Age 40. Postman [Diagnosis—major depression with delusions of guilt]

Emergency admission with depressed affect, early morning waking and weight loss. Had forgotten to give his children their pocket money, but believed this to be the 'worst sin in the world,' himself 'worthless as a father,' and so on.

NOTE: 1) delusions of guilt may also be factual in form, e.g. the person believes he has caused the HIV epidemic and feels (appropriately) guilty; 2) evaluative delusion with positive rather than negative content are common in hypomania, (see Fulford, 1989, chapter 10).

These examples, which are all based on real cases with biographical details changed, are all described in Fulford (1989, chapter 10). See also, for further examples, Fulford (1991).

Delusions are conventionally divided up, not according to their logical form, but mainly according to their subject matter, i.e. what they are about. The most important kinds are: paranoid, reflecting a distorted relationship between the patient and the world about them, e.g. persecutory, self-referential, and grandiose delusions; hypochondriacal; nihilistic, e.g. that the person has lost all their money; that their body is rotting away, or even that they are actually dead (Cotard syndrome); delusions of guilt; and delusions of impoverishment.

Delusions are also divided up according to their apparent relationship to other pathology. Most delusions are *secondary*, that is they are secondary to some other morbid phenomenon, e.g. delusions of guilt or of impoverishment in depression. Some delusions are *primary*, however, springing into the patient's mind

with minimal or no understandable relationship to other aspects of their mental state. A *delusional perception* is a primary delusion sparked by some quite normal percept. Primary delusions are nearly always symptoms of schizophrenia or of some related psychotic condition (but see Chapter 20, which includes an example of a non-pathological delusional perception).

Philosophical annotations

The question of how to define delusion has proved a struggle for philosophers at least since Jaspers (1913, *General Psychopathology*, see especially, Vol. 1 pp. 93–108, 195–198, 409–413). Jaspers (as we describe in Part II) offered a preliminary characterization (which in a related guise is still in general use today) of delusion as false judgement, held with extraordinary conviction, impervious to other experiences and compelling counter-arguments, and with an impossible content—but then went on to urge (p. 93) that this definition 'gives only a superficial and incorrect answer to the problem' of the meaning of delusion. In short, the definition does not explain to us what the distinctive ('internal') irrationality of delusion consists in, but merely documents some standard ('external') features that many (but not all) delusions happen to have. The tendency of definitions of delusion to simply presuppose rather than actually provide an understanding of the distinctive irrationality of delusion has been made clear by Schmidt (1987). Early (modern) discussions of delusion in the philosophical literature include Quinton (1985), Flew (1973), and Glover (1970). Fulford, 1989, chapter 10, and 1996, develops a model of delusion in terms of practical reasoning. The failings of the standard definitions are noted, and an attempt at a more adequate understanding of the character of delusion is attempted, in Gipps and Fulford (2004).

Disorders of perception

A variety of abnormalities of perception may be significant diagnostically but the most important in psychiatry are hallucinations.

Hallucinations in general are perceptions occurring in the absence of a stimulus. These may be normal: for example, hearing a voice calling as you fall asleep (hypnagogic hallucination) or on waking up (hypnopompic hallucination); or the experience during grief of glimpsing the deceased loved one. *True, or psychotic hallucinations*, on the other hand, are hallucinations that the person concerned takes to be real, e.g. a patient hearing voices shouting obscenities at him. *Pseudohallucinations* are similar to true hallucinations except that they lack the full qualities of true perceptions; for example, an auditory hallucination heard in one's head rather than in outside space; or voices coming from the outside world but which the patient regards as possibly not being real.

Hallucinations can affect any sensory modality and come in many forms. Besides *auditory*, as in the above case, they may be *visual, olfactory* (smell), *gustatory* (taste), *tactile* (touch), or *somatic* (bodily or visceral sensations). Then again, they may be well or ill defined in content—*simple* or *complex* hallucinations, respectively. Voices speaking clearly would be complex hallucinations; simple auditory hallucinations include mutterings, scrapings, slitherings. Similarly, complex visual hallucinations include well-formed images of people, animals, etc., while simple visual hallucinations may take the form of geometric shapes, or brief flashes, or patches of colour.

Illusions differ from hallucinations in being deceptions of the senses, e.g. a stick that looks bent when it is partly immersed in water. Unless very frequent or bizarre, illusions are not generally of pathological significance. Certain distortions of perception may be pathological, however, e.g. micropsia (things looking too small) and hyperacusis (things sounding too loud).

Déjà vu and *jamais vu* experiences, i.e. things seeming excessively familiar or excessively unfamiliar respectively: these are both sometimes significant medically, e.g. in temporal lobe epilepsy. *Derealization* is the experience of things appearing unreal, like a stage set, or as though made of cardboard. *Depersonalization* is a similar experience of one's self or one's body feeling unreal. These are often anxiety-related symptoms but may occur in other psychiatric conditions. *Disturbances of body image*, for example in *anorexia* (in which the patient may perceive her body as being fatter than it is), and *body dysmorphophobia* (in which some part of the body is misperceived as ugly).

There are also a remarkable variety of disturbances of the perception of the body related to neurological lesions (for example, visual neglect, in which a person can see their arm, say, but fails to recognize it as their own).

Philosophical annotations

A standard 'empiricist' or 'non-disjunctivist' line has supposed that perception is to be understood as the having of inner 'sense impressions' or 'representations', which are caused in the right way by the outer objects of which they are impressions or representations. On this view hallucination is to be understood as the occurrence of inner impressions in the absence of the appropriate outer stimuli. Other 'disjunctivist' philosophers of perception, however, have urged that there is no need to think that there is anything 'inner' in common between cases of veridical perception and hallucination. Thus experience is a disjunction of either perceptually taking in a fact or it is a mere appearance (see, e.g. Hyman, 1992, pp. 277–296). Now, however, the challenge is to offer an account of hallucination that does not leave out its sensory element (i.e. doesn't construe it simply in terms of belief—as in an 'intellectualist' account.). An attempt to understand hallucination, not in terms of aberrant inner experiences, but in terms of alterations in the structure of the modalities of experience, can be found in Straus (1958). The failures of 'empiricist' and 'intellectualist' accounts of hallucination, and an alternative (which views hallucination as 'much less the presentation of an illusory object than the spread and, so to speak, running wild of a visual power which has lost any sensory counterpart') can be found in Merleau-Ponty (1996, pp. 334–345).

Disorders of cognitive functioning

Disturbances of cognitive functioning (as the term is used in psychiatry) include: (1) *disorientation* (for time, place, and person); (2) *defects of attention* and *concentration*; (3) impaired memory (recent and remote); and (4) *reduced general intelligence* or IQ (for both verbal and non-verbal tasks).

A mild global impairment of cognitive functions is called *clouding of consciousness*. This is the first slip away from full consciousness towards coma. *Delirium* is clouding of consciousness with a high output of verbal and non-verbal behaviour. *Stupor* is a state of consciousness in which the patient is inert and mute but appears none the less to be conscious of his or her surroundings (this may occur, for example, with severe psychomotor retardation in depression, or with lesions in the brain stem).

Dementia as a descriptive term means an acquired impairment of cognitive functioning of a long-term nature, which is usually progressive, and often starts with marked impairment of short-term memory. The term is also used of a group of specific diseases defined partly by particular psychopathological features and partly by particular pathological changes in the brain (see also session 3).

Insight

Insight is not a symptom as such. It is the degree of understanding that a patient has of their symptoms. Understanding is a complex matter involving, among other things, awareness that there is something wrong, and recognition of the nature of what is wrong as illness.

Insight in the former sense may be lacking with any symptom, psychological or bodily. However, insight in the second sense is typically lacking in respect of certain particular psychological symptoms, specifically with delusions, hallucinations and certain kinds of thought disorder (marked with ** in Table 3.2, or with * indicating partial insight). Symptoms of this kind are called psychotic.

The difference between non-psychotic and psychotic symptoms is well illustrated by the difference between obsessions and delusions. As described above, with an obsessional symptom, the patient, although sometimes equivocal about the need for their obsessive-compulsive rituals, ultimately regards them as something wrong with them, and hence as needing therapy. Thus Zulfikar Abbany (2001), in case 6 (p. 41), sought a therapist for his obsessions about contamination and related compulsive behaviours. With a delusion of contamination, however, the patient does not experience their belief that they are contaminated as something (medically) wrong with them. The problem, as they see it, is, simply, that they are contaminated. Similarly with guilt: obsessional guilty thoughts are 'something wrong', for which the person concerned may seek help; but with delusions of guilt, what is wrong, for the person concerned, is that they have done something wrong, and they behave accordingly—going to the police, or, more tragically, committing suicide in remorse and expatiation.

With psychotic symptoms, then, the patient is well aware that something is wrong, but fails to recognize that what is wrong is that he or she is mentally ill. Conditions in which symptoms of this kind typically occur are called psychotic conditions (see below, session 3, this chapter). Assessment of insight is important diagnostically (Session 3), and to medico-legal issues involving compulsory treatment and legal competence (see Chapter 17).

Philosophical annotations

A useful starting point for current psychiatric thinking on insight is David (1990). See also the various chapters in Amador and David (1998) and Fulford (1992), and the journal article by Lewis (1934).

The philosophical challenge (as with delusion) is to produce a definition of insight that is neither (1) circular, nor (2) narrowly medical. Aubrey Lewis' (1934) account is essentially of the latter (narrowly medical) kind, i.e. he takes it that somebody is lacking in insight they do not see things the way *the psychiatrist does*. This seems to privilege the psychiatrist's understanding of events in an unwarranted way (see Bentall, 2003, pp. 496–497). As to the former (narrowly circular) kind of definition, it is worth noting that insight is a tensed phenomenon: what one recognizes is that one *has been* psychotic. David (1990) empirically, and Fulford (1989, chapter 10) conceptually, seek to establish models of insight that are consistent with the clinical psychopathology of psychotic symptoms.

Julian Hughes, Stephen Louw and Steven Sabat (2006) have brought together an important collection of articles on philosophical and ethical issues raised by dementia.

Bodily symptoms and signs

Among the bodily symptoms and signs of particular importance in psychiatry are the following.

Autonomic symptoms

A variety of autonomic symptoms are associated with anxiety, including palpitation, tremor, sweating, blurring of vision, loose stool, and urinary frequency. Sometimes these may be the presenting symptoms of an anxiety disorder. Certain specific symptoms are recognized, e.g. 'globus hystericus' (psychogenic difficulty swallowing).

Biological symptoms of depression

As noted earlier, with major depression there may be marked 'biological' symptoms such as reduced appetite and extreme weight loss. Depressed patients may sometimes complain of these or of other bodily symptoms (e.g. pain, as below) rather than of lowered mood. As noted above, this is called 'masked depression'.

Pain

Pain is an important presenting symptom in psychiatry as well as in bodily medicine. Besides hypochondriacal conditions, it is common in both anxiety disorders and depression. In anxiety disorders, chest pain, colicky abdominal pain, and headache are common. Headache and facial pains are also common in depression (see, for example, Mr AB's case history, in Chapter 2; and Sullivan, 1995).

Dissociative symptoms

Dissociative symptoms are symptoms usually either of the primary sense and voluntary motor systems or of memory, which turn out to be due to psychological rather than to bodily pathology: examples include paralysis, blindness, and memory loss. Symptoms of this kind are traditionally called *hysterical conversion symptoms*. The term 'dissociative' is sometimes restricted to disorders of memory (memory loss and fugue states), the term 'conversion' then being used for the remainder. The theory reflected in the term 'hysterical conversion' is that an intolerable psychological conflict is 'converted' into a tolerable bodily symptom. The term 'dissociation' reflects the idea that one part of consciousness (such as a painful memory) is split off (or dissociated) from the rest. Both terms are (nowadays) used in mainstream psychiatry descriptively rather than with these aetiological implications.

Vegetative symptoms

Vegetative symptoms include disorders of *appetite*, of *sexual drive*, and of *sleep*. Specific disturbances of appetite include the reduction and loss of appetite of *anorexia* (a persistent active refusal to eat) and *bulimia* (binge eating). The sexual symptoms included under this heading are those involving drive and performance; drive may be reduced (*impotence* in men, *frigidity* in women); difficulties of performance are called 'orgasmic' difficulties, e.g. *premature* and *delayed ejaculation* in men, *vaginismus* in women. Disorders of sleep include insomnia, hypersomnia (excessive sleeping), disorders of *sleep rhythm*, and a variety of specific disorders such as *sleepwalking* and *night terrors* (attacks in which the patient wakes screaming and apparently terrified but with little or no recall the next morning).

Psychological signs

Signs of disorder are as important in psychiatry as they are in bodily medicine. Specifically psychiatric signs are limited to disturbances in the patient's appearance, behaviour, and speech. These may be as important diagnostically as simply listening to what the person concerned says. Important examples include (1) expressed affect (e.g. in depression—unsmiling and immobile face, minimal eye contact, slumped and inert posture, monotonous speech, slowed movements), and (2) dress (e.g. flamboyant in hypomania, idiosyncratic in schizophrenia, neglected in dementia).

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. What are the main groups of psychological symptoms generally recognized in psychiatry?
2. What is the most important (growing) resource for interdisciplinary work between philosophy and mental health in any of these areas of 'psychopathology'?
3. In what specific sense may 'insight' be lost in a person with a psychotic disorder.
4. Give one psychotic and one non-psychotic symptom where both have the same content, for example where the person concerned has a recurring worry that they have done something wrong. By what features would the two different symptoms (psychotic and non-psychotic) be distinguished?
5. Is psychiatry concerned at all with bodily signs and symptoms?

Session 3 Categories of mental disorder

As noted above, the two most widely used classifications of psychiatric disorders are the International Classification of Diseases (the 'ICD') published by the WHO, and the APA's *Diagnostic and Statistical Manual* (the 'DSM'). Both classifications have been developed in a series of editions over a number of years, the current versions being ICD-10 (WHO, 1992) and DSM-IV TR (for Text Revision) (APA, 2000).

The 'basic' classification

Although these classifications differ in detail, they include much the same broad categories of disorder. These are summarized in Table 3.3. An initial division is made between disorders in adults and disorders in children and adolescents. Both are then further subdivided into a variety of main kinds of mental disorder, defined mostly in terms of symptoms (as described above), personality disorders and stress-induced disorders.

Some classifications are organized in part around a number of 'axes'. Thus, the DSM has a multi-axial structure: Axis I covers clinical syndromes, Axis II personality disorders, and Axis III bodily disorders; Axis IV covers the severity of psychosocial stressors, and Axis V the level of adaptive functioning. We will be focusing here on the main categories of disorder (incorporated in Axes I and II in DSM).

Main categories of adult mental disorder

Six main categories of psychiatric disorder are generally recognized in adults.

Organic

Consistently with the predominantly descriptive basis of psychiatric classification, organic *disorders* are defined in terms of organic *symptoms*, i.e. certain specific symptoms that suggest the presence of underlying bodily pathology. (Although you will also find the term 'organic' used to mean that such pathology has actually been demonstrated.) Bodily pathology, in this context, means gross pathology of the kind with which general medicine

Table 3.3 Main categories of psychiatric disorder

Main categories of adult disorder	Organic	Acute (confusional states) Chronic (dementias—primary, secondary) Special syndromes (e.g. frontal lobe syndrome)
	Alcohol/drug related	Addiction states Complications of use/abuse Withdrawal syndromes
	Psychotic disorders other than organic and affective	Schizophrenia (simple, hebephrenic, paranoid, catatonic) Persistent delusional disorder Brief psychotic episode
	Affective disorders (happiness/sadness)	Depression—major ('psychotic'/'biological') Minor ('neurotic') Hypomania Bipolar Schizoaffective
	Anxiety and related disorders	Anxiety disorder (generalized, phobic, panic) Obsessive-compulsive Dissociative (hysteria) Somatoform (e.g. psychogenic pain, hypochondriasis)
	Disorders of vegetative function	Eating (anorexia nervosa, bulimia) Sexual function (orgasmic, drive) Sleeping (insomnia, hypersomnia, sleep terrors, etc.)
Other categories of adult disorder		Personality disorder: very long-term maladaptive personality traits Stress-induced disorders: psychiatric disorder as a reaction to extreme stress; 'psychological trauma'
Child/adolescent disorders		Learning difficulties (or mental retardation): mild, moderate, severe, profound Specific developmental delays: e.g. speech, reading, spelling, arithmetic
		'Pervasive disorders': autism; disintegrative psychosis; schizoid disorders of childhood
		Behavioural disorders: hyperkinetic syndrome; conduct disorder, socialized and unsocialized
		Disorders of physiological functions: e.g. enuresis, encopresis

is concerned, for example degenerative changes (as in dementia), brain tumours and other space-occupying lesions (such as a bleed into the brain), intoxications and infections.

The most important organic symptoms are disturbances in cognitive functioning, especially clouding of consciousness and impaired memory, as described above. However, there are other organic symptoms, for example organic hallucinations are, as it were, good quality hallucinations: they are formed (of people, etc.), often show size distortion (Lilliputian characters are typical), coloured (rather than black and white) and moving; and they are usually worse in the evenings (i.e. when it is getting dark). Organic delusions, by contrast, are poor quality delusions: reflecting the impaired cognitive functioning of organic states, organic delusions are minimally elaborated, not well sustained (they vary in content from one day to the next), and they lack the emotional charge of functional (i.e. non-organic) delusions.

There may also be warning signs of organic aetiological factors in the history, e.g. first onset of a depressive illness or anxiety state in later life in the absence of stressful life events (though the *presence* of stressful life events does not preclude organic factors: for example, in one study of brain tumours presenting with functional symptoms, 40% of subjects reported a history of stressful events associated with the onset of their symptoms (Minsky, 1933).

The complex relationship between functional symptoms and bodily causes is one reason why, as described in Chapter 2, in psychiatry it is helpful to write a *diagnostic formulation* (setting out separately the descriptively defined differential diagnoses, the aetiology, treatment and prognosis for a given case) rather than relying on brief composite diagnostic labels. It is all too easy to assume that functional symptoms equal functional causes, and indeed vice versa! This complication is further compounded by the fact that organic disorders are generally non-specific, i.e. they point to bodily pathology of *some* kind (space-occupying, cardiovascular, infections, etc.) affecting the brain, but tell us very little about the nature or precise location of the pathology.

Organic disorders, on the other hand, *are* affected by the rate at which the pathology develops. Hence they are subdivided broadly into *acute* and *chronic*. An example of the former would be a 'toxic confusional state' in which there is clouding of consciousness with disorientation, especially for time, progressing to

semi-coma and unconsciousness—getting drunk is a familiar example of this! Dementia is the most familiar example of a chronic organic disorder. Here the earliest change is usually a disturbance of memory, especially for recent events. But as with acute organic states, as the condition progresses impairment of all cognitive functions, usually with organic hallucinations and other organic symptoms, is the rule.

The term *secondary dementia* means a dementia caused by some other medical condition (e.g. myxoedema), with the implication that the condition can be arrested or reversed with treatment. Most dementias are primary. A number of specific syndromes are recognized. The most common is the eponymously named Alzheimer's disease (from which the Oxford philosopher, Iris Murdoch, suffered, as portrayed in the film 'Iris' based on the book by her husband, John Bayley, 1999) and cardiovascular dementia.

A limited number of specific organic syndromes are recognized, e.g. frontal lobe syndrome (a syndrome of disinhibition, due usually to damage to the frontal lobes of the brain—see the case history of 'Mrs Lazy' in Chapter 22, and various kinds of memory disorder such as Korsakoff's psychosis (short-term memory loss with confabulation, i.e. spontaneous filling in of lost memories with false memories: this is due to thiamine deficiency, usually secondary to long-term alcohol abuse).

Alcohol/drug-related disorders

This is the only group of psychiatric disorders in which the causal factors are sufficiently well defined to allow an aetiological rather than symptomatic basis for classification. Hence they are generally divided up partly according to the substance involved (alcohol, opioids, cocaine, hallucinogens, etc.), partly by clinical syndrome. The clinical syndromes are of three main kinds, *addiction states*, direct *complications of abuse* (e.g. Korsakoff's syndrome in alcoholism, as above), and *withdrawal syndromes* (most of which, in addition to craving, have features specific to each substance).

Psychotic disorders other than affective and organic

As we saw in Session 2, a psychotic disorder may be thought of as one in which hallucinations and/or delusions and/or certain types of thought disorder typically occur, these being the symptoms that are defined (in part) by the presence of specifically psychotic loss of insight.

In ICD-9 psychotic disorders were classed together as a separate category distinct from all non-psychotic disorders (sometimes called 'neurotic' disorders). In ICD-10 and in DSM-IV, they are included partly in the categories of organic and affective disorders, partly in a residual category for psychotic disorders of other kinds. These latter disorders include *schizophrenia* (defined by certain specific kinds of delusion, hallucination and thought disorder; and subdivided, according to the predominant symptomatology, into simple, hebephrenic, paranoid and catatonic forms—see Chapter 20 for the DSM summary box for the diagnosis of schizophrenia), *delusional disorders* (disorders in which delusions predominate, without specific symptoms of organic, schizophrenic or affective psychoses), and *brief psychotic episodes* (any psychotic disorder of acute onset, limited duration, and without serious sequelae).

The abandonment of a primary division between psychotic and non-psychotic mental disorders was motivated primarily by the difficulty of defining psychotic loss of insight, originally pointed out by Lewis (1934). Yet the concept of loss of insight continues to be widely used in psychiatry: it is important in medico-legal contexts, for example, as we will see in Chapter 17; the term psychosis, furthermore, continues to be used in both everyday medical discourse and in technical journals; and, most remarkably of all, it persists (albeit in an altered form) as a primary division in ICD and DSM, and this notwithstanding the intentions of the authors of these classifications.

Thus, in ICD-10 and DSM-IV the original primary distinction between psychotic and non-psychotic disorders has been replaced with a larger number of primary categories. But most of these new primary categories includes, explicitly or implicitly, a subdivision into psychotic and non-psychotic varieties. Hence, so far as the psychotic-non-psychotic division is concerned, our new classifications have retained the same essential structure as our traditional classifications, albeit turned 'upside down'. 'Insight', then, and 'psychotic', one of us has argued elsewhere (Fulford, 2004), should be understood as one of those high-level concepts (like 'time', see Chapter 4) that we have difficulty defining but which is none the less useful, even essential, for understanding and giving meaning to the world around us (psychotic loss of insight can in fact be partially defined in terms of the phenomenological features of our experience of illness—see Fulford, 1989, chapter 10).

Affective disorders

The most common affective disorders are depressive. Depressive disorders are subdivided into major and minor according partly to the depth of depression, and partly to the presence or absence of associated symptoms. Major depression is associated with biological symptoms as described earlier. It is in major depression also that psychotic symptoms (mainly delusions, sometimes hallucinations) occur. Major depression is for this reason sometimes called psychotic depression. Minor depression is often associated with anxiety symptoms. It is sometimes called neurotic depression. The terms reactive depression and endogenous depression are no longer used because the symptoms of depression have been shown to be the same whether or not there is an obvious external event to which the person concerned is 'reacting' (see e.g. the classic paper by Kiloh and Garside, 1963).

Hypomania (together with its more severe form mania) is the elevated mood counterpart of major depression. It is a psychotic disorder, commonly associated with hallucinations and delusions. There are often biological symptoms (e.g. reduced sleep, increased sexual appetite) and specific forms of thought disorder (e.g. pressure of speech and flight of ideas).

Bipolar affective disorder is a condition in which episodes of major depression and of hypomania alternate (the term is sometimes used of one or the other, e.g. 'bipolar disorder, depressed type'). In schizoaffective disorder schizophrenic and affective symptoms, either depressive or hypomanic, are combined.

Anxiety and related disorders

The disorders in this category are sometimes referred to as 'neurotic disorders'. These disorders cluster together; mixed forms are common; and different forms may occur at different times in the same patient. They are defined by their predominant symptomatology, as described above in session 2. The main categories are anxiety disorders (generalized, phobic, and panic), obsessive-compulsive disorders, dissociative (hysterical) states, and somatoform disorders. The latter includes conditions presenting with bodily symptoms that are not sufficiently explained by bodily pathology and in which there is also positive evidence of psychological disorder (notably other psychological symptoms).

Disorders of vegetative functions

These disorders are defined by the presence of specific vegetative symptoms as described above (session 2). The most important categories are disorders of eating (e.g. anorexia nervosa and bulimia), of sexual function (disorders of drive and of performance), and disorders of sleep (insomnia, hypersomnia, sleep terrors, etc.).

Personality disorder

Personality disorder can be thought of as a maladaptive exaggeration of a personality trait. Symptomatically, a personality disorder may appear very similar to one or other of the categories of mental disorder described above. However, where mental disorder represents a *change* from what is normal for the person concerned, a personality disorder is normally established by late adolescence and continues more or less *unchanged* into old age. Thus, in order to decide whether someone is suffering from a personality disorder or a mental disorder proper, you have to establish the longitudinal pattern of their symptoms. This is illustrated in for depressive personality disorder Box 3.1.

Stress-induced disorder

Stress-related disorders are analogous to physical trauma. Stress is of course an important aetiological factor for both bodily and psychological disorders. However, where a psychiatric condition is very clearly and manifestly a reaction to major stress, the diagnosis is of a stress-induced disorder, e.g. grief reaction, battle fatigue.

The symptoms of stress-induced disorders are very varied. Anxiety and depression are common, as are somatic complaints. But hallucinations, confusion, mania, and many other symptoms also occur.

Stress-induced disorders are generally divided into *acute* and *chronic*. The term 'post-traumatic stress disorder' (PTSD) has been introduced fairly recently to cover people who experience ongoing distress associated with nightmares, flashbacks, anxiety, depression, and a variety of other symptoms, following major trauma.

Disorders of childhood and adolescence

Many of the disorders of childhood and adolescence are different from those occurring in adults, and they are conventionally classified separately. The main groups of disorder are listed above in Table 3.3. Learning difficulties (previously called mental retardation) and specific developmental delays are separated out as distinct categories. The so-called pervasive disorders correspond approximately with adult psychotic disorders, the emotional disorders of childhood with adult anxiety related (or neurotic) disorders. The remaining groups of disorder include behavioural disorders (e.g. conduct disorder), and disorders of physiological functions (e.g. enuresis and encopresis).

Summary of psychiatric diagnosis: from symptoms to diagnostic categories

Diagnosis in adult psychiatry can be thought of as involving three main stages: (1) clarification of symptoms; (2) exclusion of drug/alcohol-related, personality and stress-induced disorders; and (3) differential diagnosis of remaining disorders according to symptomatology.

1. *Clarification of symptoms*. As it is in bodily medicine, this is the basis of diagnosis in psychiatry. Psychiatry, though, as noted earlier, is like neurology in relying *primarily* on symptoms and signs. This is why the clinical skills of history taking and mental state examination are so crucial.
2. *Exclusion of: (a) drug/alcohol-related problems; (b) personality disorder; and (c) stress-induced disorders*. Excluding drug and alcohol-related disorders depends partly on identifying any organic symptoms that may be present, partly on history, physical examination, and appropriate laboratory tests. Excluding personality disorder depends on establishing the long-term pattern of a patient's symptoms (see above and Box 3.1). Excluding stress-induced disorders involves establishing whether the patient's condition is mainly a direct reaction to some major stress factor. The latter two kinds of category should be used very sparingly and only when they are quite definitely present.
3. *Differential diagnosis of remaining disorders*. This covers all the symptomatically defined categories. Anxiety and related disorders, together with minor depression, are the most common, followed by disorders of appetite and sexual function. Psychotic disorders are the least common but also generally the most serious.

As emphasized above, it is essential to exclude bodily conditions, not only when presenting with obvious organic symptoms, but

also with any other psychiatric presentation. Major bodily pathology presenting psychiatrically (such as a brain tumour) is relatively unusual (though all the harder to diagnose for that!). But bodily illness is commonly a *complicating* factor in mental distress and disorder. Unrecognized bodily pathology, for example, is a factor in treatment-resistant depression. Again, common conditions such as anaemia and asymptomatic urinary infections, may reduce the capacity to cope with stressful events. Conversely anxiety and depression may lead to loss of sleep, failure to eat properly and other forms of self-neglect. So the bottom-line message in psychiatry, as it should be in all areas of medicine, is that a balanced 'whole person', mind plus body, approach to diagnosis is essential.

The boundary problem

Finally, it should not be forgotten that many patients presenting psychiatrically, especially in general practice, do not have anything wrong with them as such. They have life problems and difficulties with which they need help. The uncertain boundary between distress and disorder is one reason why classification and diagnosis in psychiatry are conceptually, as well as empirically, difficult.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. What are the main categories of adult mental disorder?
2. How does personality disorder differ from the main categories of adult mental disorder?
3. How does a stress-induced disorder differ from the main categories of adult mental disorder?
4. What are the main additional categories of disorders of childhood and adolescence?
5. What are the main steps in developing a differential diagnosis in psychiatry?
6. Are all distressing experiences matters for psychiatric diagnosis?

Conclusions: to diagnose or not to diagnose?

In this chapter we have focused particularly on how *psychiatrists* approach the assessment of mental distress and disorder, illustrating, in particular, the rich variety of resources available from such sources as textbooks, diagnostic manuals, psychological 'measures', research studies and narrative literature for cross-disciplinary work in this area.

Uses and misuses of psychiatric diagnosis

The psychiatric approach to diagnostic assessment is not uncontentious, of course. It reflects the 'medical' model, at least to the extent that it assumes much the same principles of diagnosis and classification as are assumed in other medical specialities, such as cardiology and rheumatology. As we saw in Chapter 2, there are competing models of mental distress and disorder—psychological, social etc.—each of which has its own approach to assessment. There are many, furthermore, particularly in the politically-active 'user movement', who reject the very idea of *medical* diagnoses of mental distress and disorder, arguing for the importance of individual understanding over general descriptive categories (Kutchins and Kirk, 1997; see also Reading Guide). Within psychiatry, too, there are other approaches. Leaving aside psychoanalysis, a whole school of twentieth century psychiatry, Adolf Meyer's 'psychobiology of the individual', was based on the belief that psychiatric assessment should take the form of a detailed understanding of an individual's experiences in the context of their particular life history and circumstances. The need for 'idiographic', alongside the currently dominant categorical diagnostic schemas, has been emphasised by recent authors (Mezzich, 2002; Mezzich *et al.*, 1996 and 2003) and is the basis for a psychiatric classification recently adopted in Spanish-speaking South America with the support of the World Psychiatric Association (see also chapter 13).

There is a danger, particularly under the growing managerial and financial pressures on clinical work, of psychiatric diagnostic categories being used in a crudely positivist way. This is a danger to which this chapter, with its necessarily descriptive and schematic format, is at risk of contributing. But such uses of psychiatric diagnosis are *misuses*. Read any authoritative account of psychiatric diagnosis and you will find a strong emphasis, first, on the need to contextualize the process by attending to the meanings of individual experiences as well as to their general form, and, second, on the nature of diagnosis itself being best understood as a form of cautious hypothesis building. Indeed Karl Jaspers, to whose foundational work on psychopathology we return in Part II, emphasized that diagnostic categories should come, if at all, *last* in the assessment of a patient, and then only after a full and in depth exploration of their individual circumstances and experiences (Jaspers, 1997, p. 20).

Difficulties of psychiatric diagnosis and classification

Much (though certainly not all) of the criticism of psychiatric diagnosis, has been criticism of a 'straw man' model of the discipline; and as we noted at the start of this chapter, part of our aim here has been to give a picture of what psychiatric assessment is really about.

All the same, psychiatric diagnosis *is* difficult. It is difficult empirically, of course: we are only at the beginning of developing scientific instruments that are up to the task of investigating the brain. But it is also difficult conceptually. The conceptual difficulties presented by psychiatric diagnosis, compared with diagnosis in bodily medicine, have been treated by those external to the subject as grounds for criticism. But the difficulties are all too evident, in substance if not in name, to those internal to the discipline. This is

vividly illustrated by the APA's 'research agenda' for the next edition of the DSM, the DSM-V (Kupfer *et al*., 2002). We return to this in detail in chapter 13. As we will see, although ostensibly concerned with enriching the 'empirical database' of the new classification (p. xv), the agenda starts with a whole chapter (called issues of 'Basic Nomenclature') on conceptual difficulties, the first of which is, as in this book, the problem of defining mental disorder itself! And many of the other conceptual items on the DSM-V agenda, either in the first or subsequent chapters, are covered by topics in this book, notably in Part III, though also in Part IV and Part V.

A (resistible?) role for philosophers

From the perspective of the traditional medical model it may seem something of a paradox, that as the scientific basis of psychiatry has become more sophisticated, with advances particulary in the neurosciences, conceptual issues in psychiatric diagnostic classification should have become, as in the APA's Research Agenda for DSM-V, more, not less, evident.

Yet this process, of conceptual issues becoming more not less evident with scientific advances, is no paradox. To the contrary, it directly reflects the wider renaissance in philosophy of psychiatry, which, as Fulford *et al*., (2003) note, directly parallels the flowering of philosophy during psychiatry's first biological phase, with Karl Jaspers' foundational work on psychopathology in the early years of the twentieth century.

If we are to respond appropriately to present challenges, then, at the very least avoiding the mistakes of the past, there may be lessons to be learned from the history of ideas of that period. We examine the philosophical history of psychopathology in the next part of the book. First, though, we return to the debate about mental illness, with detailed considerations of how it illustrates, first the methods employed in philosophical research (Chapters 4 and 5), and then the kinds of outputs or results that philosophy delivers (Chapter 6).

Reading guide

Further reading on each of the main groups of mental disorders is given in the relevant sections of this chapter. We note here only illustrative introductions and overviews.

Concepts of disorder: (2) firsthand and other narrative accounts

As indicated in this chapter, there is a growing and increasingly important literature of firsthand narrative accounts, including websites. The latter can come and go but current examples include, 'Jane's Mental Health Source Page' http://www.chinspirations.com/mhsourcepage/storybook.html and http://serendip.brynmawr.edu/sci_cult/mentalhealth/inside.html#general. An early and still useful edited collection is Bert Kaplan (ed.), (1964) *The Inner World of Mental Illness: a series of first-person accounts of what it was like*. Many examples are given in Fulford, Dickenson, and Murray's (2002) edited collection, *Healthcare Ethics and Human Values*.

In addition to the examples cited in the chapter, firsthand accounts of the experience of specific conditions include,

1. *Schizophrenia*. Morag Coate (1964) *Beyond All Reason*; Lori Schiller and Amanda Bennett (1996) *The Quiet Room: a journey out of the torment of madness*; Daniel Paul Schreber (2000) *Memoirs of My Nervous Illness*; Barbara O'Brien (1976) *Operators and Things: the inner life of a schizophrenic*; Marguerite Sechehaye's (1996a) *Autobiography of a Schizophrenic Girl: the true story of 'Renee'* (the author is in fact the psychoanalyst who interprets the material).
2. *Manic depression*. Hert and colleagues (2004) *Anything or Nothing: self guide for people with bipolar disorder*; and Kay Redfield Jamison's two books (1994) *Touched with Fire*, and (1996b) *An Unquiet Mind: a memoir of moods and madness*. As noted in the chapter, these include many extracts of firsthand narratives.
3. *Depression and grief*. Personal accounts include: William Styron (1991) *Darkness Visible: a memoir of madness* (an extract of this is given in the chapter); Stuart Sutherland (1998) *Breakdown: a personal crisis and a medical dilemma*; Louis Wolpert's (1999) *Malignant Sadness*. The American philosopher Loretta Kopelman (1994a) explores the distinction between normal and pathological grief in *Normal Grief: Good or bad? Health or disease?* with commentaries by Dominion (1994) and Wise (1994), and a response by Kopelman (1994b). A valuable edited collection is Donna Dickenson and Malcolm Johnson's (1993) *Death, Dying & Bereavement*.

Spirituality and mental health

There is a growing literature on spirituality and mental health with increasingly strong links into policy and practice in the UK. A valuable outline of the issues and initiatives is given in the NIMHE (National Institute for Mental Health in England) policy document 'Inspiring Hope' (Department of Health, 2003). A foundational publication is Swinton's (2001) *Spirituality in Mental Health Care*. Publications illustrating the practical developments in this field include two by the Mental Health Foundation (1999 and 2002), Albert Persaud's (1999) description of the importance of spirituality in cultural contexts, and the report of the *Somerset Spirituality Project Group* (2002). Recent policy guidance is given in the UK Department of Health's (forthcoming) *Meeting the Spiritual and Religious Needs of Patients and Staff*. (See also below, under 'Psychosis and Delusion'.)

Discursive approaches

The power of discursive analysis for exploring personal meanings is shown by Sabat and Harré (1997) in their article on

'The Alzheimer's disease sufferer as a semiotic subject', with commentaries by Hope (1994) and Greenberg (1994). Sabat went on to develop practical tools for improving communication with Alzheimer's disease sufferers in his (2001) *The Experience of Alzheimer's Disease: life through a tangled veil*. Gillett has worked with Harré on discursive approaches (see e.g. Harré, R. and Gillett, G. (1994) *The Discursive Mind*.) and his book, Gillett, G. (1999) *The Mind and its Discontents*. See also in *Nature and Narrative*, Gillett's (2003) *Form and Content: the role of discourse in mental disorder*; and in *Philosophy, Psychiatry, & Psychology*, Gillett's (1994) 'Insight, delusion and belief', with commentaries by David, 1994, Loizzo, 1994, and Davidson, 1994. Harré (1997a) applies a discursive approach to problems in forensic psychiatry in his 'Pathological autobiographies', with commentaries by Adshead (1997) and Norrie (1997) and a response by Harré (1997b).

The importance of narrative is also explored in a special issue of *Philosophy, Psychiatry, & Psychology* (December 2003, issue 10/4) on 'Agency, narrative, and self', edited by Melvyn Woody. Of particular relevance from this issue, in addition to Woody's (2003) 'When narrative fails', are Wells (2003) on 'Discontinuity in personal narrative', which gives a number of firsthand reports, Phillips (2003) on 'Psychopathology and the narrative self', and Thornton's (2003) commentary titled 'Psychopathology and two kinds of narrative account of the self'. (See also Reading guide to Chapter 6.)

An illustration of the value of 'embedded' case histories is Deeley's (1999a) 'Ecological understandings of mental and physical illness', with commentaries by Fabrega (1999), Harré (1999), and Littlewood (1999), and a response by Deeley (1999b). Depression and the role of insight are discussed in Martin's (1999a) 'Depression: illness, insight, and identity', with a commentary by Ghaemi (1999a) and a response by Martin (1999b). The German psychiatrist, Christoph Mundt (a successor to Jaspers as Professor at Heidelberg) gives an important discussion of the diversity of psychopathology in Mundt, 2003.

An exploration of the role of literature in improving understanding of otherwise incomprehensible experiences is Read (2003a) on 'Literature as philosophy of psychopathology: William Faulkner as Wittgenstein', with commentaries by Sass (2003), Coetzee (2003), and a response by Read (2003b).

Psychiatric symptoms

General introductions

In addition to the sources given in the chapter, note: (1) clear descriptions of all the important psychiatric symptoms together with clinical examples, in Leff, J.P. and Isaacs, A.D. (1990) *Psychiatric Examination in Clinical Practice* (3rd edn is 1990 reprinted 1992); (2) case studies in 'cognitive disorders', such as delusions (e.g. Cotard and Fregoli syndromes) and disorders of volition (such as 'alien hand' syndrome), in Halligan and Marshall's (1996) *Method in Madness: case studies in cognitive neuropsychiatry*, and Campbell's (1992) *Mental Lives: case studies in cognition*; (3) detailed clinical and neurological accounts combined with philosophical analysis in John Cutting's *Principles of Psychopathology* (1997) and *Psychopathology & Modern Philosophy* (1999); and, among modern classics; (4) Sims (1988) *Symptoms in the Mind*. Sims, Mundt, Berner, and Barocka (2000), and Mundt and Spitzer (2001) give excellent detailed overviews.

Psychosis and delusion

Psychotic experiences have received particular attention in *Philosophy, Psychiatry, & Psychology*. Thus, the first article in the first issue of PPP was on thought insertion (by Stephens and Graham, 1994a, with a commentary by Wiggins, 1994); and this was followed by Chadwick (1994, with a commentary by Stephens and Graham, 1994b).

More recently, there has been a double special issue on Schizophrenia (June/September 2001, issues 8/2 and 8/3), edited by the Warwick philosopher, Christoph Hoerl. Hoerl's (2001a) introduction on 'Understanding, explaining and intersubjectivity in schizophrenia', reflects the weaving together of analytic and Continental sources in this double issue. Thus, Eilan (2001) in her 'Meaning, truth and the self', responds both to Campbell's analytic article on 'Rationality, meaning, and the analysis of delusion', and to Parnas and Sass' (2001) more Continental approach in 'Self, solipsism, and schizophrenic delusions'. The issue also illustrates the value of looking in detail at particular symptoms. Thus, Davies *et al*. (2001) give a two-factor account of 'Monothematic delusions', with a commentary by Currie and Jureidini (2001); Roessler (2001) explores delusions of alien control; and Hoerl (2001b) explores 'Thought insertion'. Similarly, in Sass' special issue on 'The phenomenology of schizophrenia' (issue 8/4, December 2001), Gerrans (2002a) explores 'A one-stage explanation of the Cotard delusion', with commentaries by Young and de Pauw (2002) and Phillips (2002), and a response (Gerrans, 2002b). Thought insertion is also the subject of Gibbs (2000a) 'Thought insertion and the inseparability thesis', with a commentary by Stephens (2000) and a response (Gibbs, 2000b).

The border between psychotic illness and spiritual and religious experience is explored in a series of interconnected articles in the December 2002 (9/4) issue of *Philosophy, Psychiatry, & Psychology* with lead articles by Brett (2002a) on 'Psychotic and mystical states of being', and Marzanski and Bratton (2002a) on the importance of theological sources, together with a series of related articles (McGhee, 2002; Jackson and Fulford, 2002: and Sykes, 2002) and cross-commentaries (Brett, 2002b and 2002c; Marzanski and Bratton, 2002b and 2002c). (See also above, 'Spirituality and mental health').

Among particular psychotic phenomena, delusions have attracted an especially rich literature. Thus, in *Philosophy,*

Psychiatry, & Psychology, issue 11/1 (March 2004) was devoted entirely to this topic, with three target articles respectively by Bayne and Pacherie (2004a) on 'Bottom-up or top down?' (This was an article-length response to Campbell's (2001) account of monothematic delusions), Georgacha (2004a) on 'Factualization and plausibility in delusional discourse,' and Klee (2004a) on 'Why some delusions are necessarily inexplicable beliefs'. In this particular issue of *Philosophy, Psychiatry, & Psychology*, commentators were invited to respond to the group of target articles. From the clinical perspective, these included Broome (2004), Ghaemi (2004), and Harper (2004), and from a philosophical perspective, Gerrans (2004), Hohwy (2004), and Sass (2004). The authors of the target articles responded similarly to the group of commentaries (Bayne and Pachererie, 2004b; Georgaca, 2004b; Klee, 2004b).

Max Coltheart and a Martin Davies have been particularly active in this field, see their edited volume in Blackwell's 'Mind and Language' series, on *Pathologies of Belief* (2000). This is reviewed in Christoph Hoerl's Special Issue on Schizophrenia by Atkinson (2001) in 'Pathological beliefs, damaged brains'. James Phillips and James Morley's (2003) 'Imagination and its pathologies' provides a complementary collection from the perspective of Continental Philosophy.

An article that adopts a 'philosophical fieldwork' approach to delusions is Jones (1999a) 'The phenomenology of abnormal belief: a philosophical and psychiatric inquiry', with commentaries by David (1999), Ghaemi (1999b), Stephens (1999), and a response by Jones (1999b).

Psychiatric classifications of mental disorder

The two main international classifications of mental disorders (which are discussed further in Part III, chapter 13)are:

1. Chapter 8 of the World Health Organization's *International Classification of Diseases and Related Health Problems* (the ICD—current edition is ICD-10, World Health Organization, 1992) *The ICD-10 Classification of Mental and Behavioural Disorders: clinical descriptions and diagnostic guidelines.*
2. The American Psychiatric Association's *Diagnostic and Statistical Manual* (the DSM—current edition is DSM-IV, 1994; and note DSM-IV TR, for Text Revision, American Psychiatric Association, 2000).

Most of the larger psychiatric textbooks include sections on classification and diagnosis: for example chapter 1.11, by Dilling (2004), in Gelder, Lopez-Ibor and Andreasen's (2000) *New Oxford Textbook of Psychiatry*. A classic but still valuable publication covering technical and research aspects is Kendell's (1975) *The Role of Diagnosis in Psychiatry*. Christian Perring (2004) gives a philosophically nuanced account of developmental disorders of childhood and adolescence. (See also Reading guide to Chapter 13.)

Philosophy, Psychiatry, & Psychology has included articles exploring specific kinds of mental disorder. For example, a detailed discussion of false memory syndrome is Hamilton's (1998a) 'False memory syndrome and the authority of personal memory-claims: a philosophical perspective', with commentaries by Braude (1998), Eacott (1998), and Lowe (1998), and a response by Hamilton (1998b). The importance of narrative and meaning in intellectual disability (illustrated by bereavement counselling) is explored in Clegg and Landsall-Welfare (2003a) 'Death, disability, and dogma', with commentaries by Colman (2003), Casenave (2003), and Reinders (2003), with a response by the authors (Clegg and Landsall-Welfare, 2003b).

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