Shorter Oxford Textbook of PSYCHIATRY

SEVENTH EDITION

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Preface to the seventh edition

In the 5 years since the sixth edition of this book, psychiatry has seen important advances in understanding and treatment of its disorders, as well as the publication of revised diagnostic criteria in DSM-5. These developments have been incorporated into this substantially rewritten edition, which includes a new chapter on global mental health, and division of mood disorders into separate chapters on depression and bipolar disorder.

As in previous editions, we have sought to provide information in a format, and at a level of detail, to assist those training in psychiatry. We hope the book will also continue to be useful to medical students and other health professionals, including those working in primary care, community health, and the many professions and groups contributing to multidisciplinary mental health care. More detailed information can be found in the companion reference textbook, the *New Oxford Textbook of Psychiatry*, the third edition of which is nearing completion.

We welcome Mina Fazel. Mina is the first child psychiatrist, and the first woman, to be an author of the *Shorter Oxford Textbook of Psychiatry* since its inception. We are delighted that both these unfortunate omissions have been corrected, and this edition benefits greatly from her contributions.

We thank Sarah Atkinson, Linda Carter, and Sue Woods-Gantz for secretarial assistance. We are very grateful to Charlotte Allan, Chris Bass, Christopher Fairburn, and Kate Saunders for their expert advice and helpful comments.

PH
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CHAPTER 1

Signs and symptoms of psychiatric disorders

Introduction

Psychiatrists require two distinct capacities. One is the capacity to collect clinical data objectively and accurately, and to organize and communicate the data in a systematic and balanced way. The other is the capacity for intuitive understanding of each patient as an individual. When the psychiatrist exercises the first capacity, he draws on his skills and knowledge of clinical phenomena; when he exercises the second capacity, he draws on his knowledge of human nature and his experience with former patients to gain insights into the patient he is now seeing. Both capacities can be developed by listening to patients, and by learning from more experienced psychiatrists. A textbook can provide the information and describe the procedures necessary to develop the first capacity. The focus of the chapter on the first capacity does not imply that intuitive understanding is unimportant, but simply that it cannot be learned directly or solely from a textbook.

Skill in examining patients depends on a sound knowledge of how symptoms and signs are defined. Without such knowledge, the psychiatrist is liable to misclassify phenomena and thereby make inaccurate diagnoses. For this reason, this chapter is concerned with the definition of the key symptoms and signs of psychiatric disorders. Having elicited a patient's symptoms and signs, the psychiatrist needs to decide how far these phenomena fall into a pattern that has been observed in other psychiatric patients. In other words, he decides whether the clinical features conform to a recognized syndrome. He does this by combining observations about the patient's present state with information about the history of the condition. The value of identifying a syndrome is that it helps to predict prognosis and to select an effective treatment. It does this by directing the psychiatrist to the relevant body of accumulated knowledge about the causes, treatment, and outcome in similar patients. Diagnosis and classification are discussed in the next chapter, and also in each of the chapters dealing with the various psychiatric disorders. Chapter 3 discusses how to elicit and interpret the symptoms described in this chapter, and how to integrate the information to arrive at a syndromal diagnosis, since this in turn is the basis for a rational approach to management and prognosis.

As much of the present chapter consists of definitions and descriptions of symptoms and signs, it may be less easy to read than those that follow. It is suggested that the reader might approach it in two stages. The first reading would be applied to the introductory sections and to a general understanding of the more frequently observed phenomena. The second reading would focus on details of definition and the less common symptoms and signs, and might be done best in conjunction with an opportunity to interview a patient exhibiting these.

General issues

Before individual phenomena are described, some general issues will be considered concerning the methods of studying symptoms and signs, and the terms that are used to describe them.

Psychopathology

The study of abnormal states of mind is known as *psychopathology*. The term embraces two distinct approaches to the subject—*descriptive* and *experimental*. This chapter is concerned almost exclusively with the former; the latter is introduced here but is discussed in later chapters.

Descriptive psychopathology

Descriptive psychopathology is the objective description of abnormal states of mind avoiding, as far as possible, preconceived ideas or theories, and limited to the description of conscious experiences and observable behaviour. It is sometimes also called *phenomenology* or *phenomenological psychopathology*, although the terms are not in fact synonymous, and phenomenology has additional meanings (Berrios, 1992). Likewise, descriptive psychopathology is more than just *symptomatology* (Stanghellini and Broome, 2014).

The aim of descriptive psychopathology is to elucidate the essential qualities of morbid mental experiences and to understand each patient's experience of illness. It therefore requires the ability to elicit, identify, and interpret the symptoms of psychiatric disorders, and as such is a key element of clinical practice; indeed, it has been described as 'the fundamental professional skill of the psychiatrist'.

The most important exponent of descriptive psychopathology was the German psychiatrist and philosopher, Karl Jaspers. His classic work, *Allgemeine Psychopathologie* (*General Psychopathology*), first published in 1913, still provides the most complete account of the subject, and the seventh edition is available in an English translation (Jaspers, 1963). A briefer introduction can be found in Jaspers (1968), and Oyebode (2014) has provided a highly readable contemporary text on descriptive psychopathology.

Experimental psychopathology

This approach seeks to explain abnormal mental phenomena, as well as to describe them. One of the first attempts was *psychodynamic psychopathology*, originating in Freud's psychoanalytic investigations (see p. 91). It explains the causes of abnormal mental events in terms of mental processes of which the patient is unaware (i.e. they are 'unconscious'). For example, Freud explained persecutory delusions as being evidence, in the conscious mind, of activities in the unconscious mind, including the mechanisms of repression and projection (see p. 277).

Subsequently, experimental psychopathology has focused on empirically measurable and verifiable conscious psychological processes, using experimental methods such as cognitive and behavioural psychology and functional brain imaging. For example, there are cognitive theories of the origin of delusions, panic attacks, and depression. Although experimental psychopathology is concerned with the causes of symptoms, it is usually conducted in the context of the syndromes in which the symptoms occur. Thus its findings are discussed in the chapter covering the disorder in question.

Terms and concepts used in descriptive psychopathology

Symptoms and signs

In general medicine there is a clear definition of, and separation between, a symptom and a sign. In psychiatry the situation is different. There are few 'signs' in the medical sense (apart from the motor abnormalities of catatonic schizophrenia or the physical manifestations of anorexia nervosa), with most diagnostic information coming from the history and observations of the patient's appearance and behaviour. Use of the word 'sign' in psychiatry is therefore less clear, and two different uses may be encountered. First, it may refer to a feature noted by the observer rather than something spoken by the patient (e.g. a patient who appears to be responding to a hallucination). Secondly, it may refer to a group of symptoms that the observer interprets in aggregation as a sign of a particular disorder. In practice, the phrase 'symptoms and signs' is often used interchangeably with 'symptoms' (as we have done in this chapter) to refer collectively to the phenomena of psychiatric disorders, without a clear distinction being drawn between the two words.

Subjective and objective

In general medicine, the terms *subjective* and *objective* are used as counterparts of symptoms and signs, respectively, with 'objective' being defined as something observed directly by the doctor (e.g. meningism, jaundice)—even

though, strictly speaking, it is a subjective judgement on his part as to what has been observed.

In psychiatry, the terms have broadly similar meanings as they do in medicine, although with a blurring between them, just as there is for symptoms and signs. 'Objective' refers to features observed during an interview (i.e. the patient's appearance and behaviour). The term is usually used when the psychiatrist wants to compare this with the patient's description of symptoms. For example, in evaluation of depression, complaints of low mood and tearfulness are subjective features, whereas observations of poor eye contact, psychomotor retardation, and crying are objective ones. If both are present, the psychiatrist might record 'subjective *and* objective evidence of depression', with the combination providing stronger evidence than either alone. However, if the patient's behaviour and manner in the interview appear entirely normal, he records 'not objectively depressed', despite the subjective complaints. It is then incumbent on the psychiatrist to explore the reasons for the discrepancy and to decide what diagnostic conclusions he should draw. As a rule, objective signs are accorded greater weight. Thus he may diagnose a depressive disorder if there is sufficient evidence of this kind, even if the patient denies the subjective experience of feeling depressed. Conversely, the psychiatrist may question the significance of complaints of low mood, however prominent, if there are none of the objective features associated with the diagnosis.

Form and content

When psychiatric symptoms are described, it is useful to distinguish between form and content, a distinction that is best explained by an example. If a patient says that, when he is alone, he hears voices calling him a homosexual, the *form* of the experience is an auditory hallucination (see below), whereas the *content* is the statement that he is homosexual. Another patient might hear voices saying that she is about to be killed. Again the form is an auditory hallucination, but the content is different. A third patient might experience repeated intrusive thoughts that he is homosexual, but he realizes that these are untrue. Here the content is the same as that of the first example, but the form is different.

Form is often critical when making a diagnosis. From the examples given above, the presence of a hallucination indicates (by definition) a psychosis of one kind or another, whereas the third example suggests obsessive–compulsive disorder. Content is less diagnostically useful, but can be very important in management; for example, the content of a delusion may suggest that the patient could attack a supposed persecutor. It is also the content, not the form, that is of concern to the patient, whose priority will be to discuss the persecution and its implications, and who may be irritated by what seem to be irrelevant questions about the form of the belief. The psychiatrist must be sensitive to this difference in emphasis between the two parties.

Primary and secondary

With regard to symptoms, the terms *primary* and *secondary* are often used, but unfortunately with two different meanings. The first meaning is *temporal*, simply referring to which occurred first. The second meaning is *causal*, whereby primary means 'arising directly from the pathological process', and secondary means 'arising as a reaction to a primary symptom'. The two meanings often coincide, as symptoms that arise directly from the pathological process usually appear first. However, although subsequent symptoms are often a reaction to the first symptoms, they are not always of this kind, for they too may arise directly from the pathological process. The terms primary and secondary are used more often in the temporal sense because this usage does not involve an inference about causality. However, many patients cannot say in what order their symptoms appeared. In such cases, when it seems likely that one symptom is a reaction to another—for example, that a delusion of being followed by persecutors is a reaction to hearing accusing voices—it is described as secondary (using the word in the causal sense). The terms primary and secondary are also used in descriptions of syndromes.

Understanding and explanation

Jaspers (1913) contrasted two forms of understanding when applied to symptoms. The first, called *Verstehen* ('understanding'), is the attempt to appreciate the patient's subjective experience: what does it feel like? This important skill requires intuition and empathy. The second approach, called *Erklären* ('explanation'), accounts for events in terms of external factors; for example, the patient's low mood can be 'explained' by his recent redundancy. The latter approach requires knowledge of psychiatric aetiology (Chapter 5).

The significance of individual symptoms

Psychiatric disorders are diagnosed when a defined group of symptoms (a syndrome) is present. Almost any single symptom can be experienced by a healthy person; even hallucinations, often regarded as a hallmark of severe mental disorder, are experienced by some otherwise healthy people. An exception to this is that a delusion, even if isolated, is generally considered to

be evidence of psychiatric disorder if it is unequivocal and persistent (see Chapter 11). In general, however, the finding of a single symptom is not evidence of psychiatric disorder, but an indication for a thorough and, if necessary, repeated search for other symptoms and signs of psychiatric disorder. The dangers of not adhering to this principle are exemplified by the well-known study by Rosenhan (1973). Eight 'patients' presented with the complaint that they heard the words 'empty, hollow, thud' being said out loud. All eight individuals were admitted and diagnosed with schizophrenia, despite denying all other symptoms and behaving entirely normally. This study also illustrates the importance of descriptive psychopathology, and of reliable diagnostic criteria (see Chapter 2), as fundamental aspects of psychiatry.

The patient's experience

Symptoms and signs are only part of the subject matter of psychopathology. The latter is also concerned with the patient's experience of illness, and the way in which psychiatric disorder changes his view of himself, his hopes for the future, and his view of the world (Stanghellini and Broome, 2014). This may be seen as one example of the understanding (*verstehen*) mentioned above. A depressive disorder may have a very different effect on a person who has lived a satisfying and happy life and has fulfilled his major ambitions, compared with a person who has had many previous misfortunes but has lived on hopes of future success. To understand this aspect of the patient's experience of psychiatric disorder, the psychiatrist has to understand him in the way that a biographer understands his subject. This way of understanding is sometimes called the life-story approach. It is not something that can be readily assimilated from textbooks; it is best learned by taking time to listen to patients. The psychiatrist may be helped by reading biographies or works of literature that provide insights into the ways in which experiences throughout life shape the personality, and help to explain the diverse ways in which different people respond to the same events.

Cultural variations in psychopathology

The core symptoms of most serious mental disorders are present in culturally diverse individuals. However, there are cultural differences in how these symptoms present in clinical settings and to the meanings that are attributed to them. For example, depression can present with prominent somatic symptoms in many Asian populations, such as those from India and China. The content of symptoms can also differ between cultures. For example, for sub-Saharan African populations, delusions not infrequently centre upon being cursed, a rare delusional theme in Europeans. Cultural differences also affect the person's subjective experience of illness, and therefore influence that person's understanding of it (Fabrega, 2000). In some cultures, the effects of psychiatric disorder are ascribed to witchcraft—a belief that adds to the patient's distress. In many cultures, mental illness is greatly stigmatized, and can, for example, hinder prospects of marriage. In such a culture the effect of illness on the patient's view of himself and his future will be very different from the effect on a patient living in a society that is more tolerant of mental disorder.

Descriptions of symptoms and signs

Disturbances of emotion and mood

Much of psychiatry is concerned with abnormal emotional states, particularly disturbances of mood and other emotions, especially anxiety. Before describing the main symptoms of this kind, it is worth clarifying two areas of terminology that may cause confusion, in part because their usage has changed over the years.

First, the term 'mood' can either be used as a broad term to encompass all emotions (e.g. 'anxious mood'), or in a more restricted sense to mean the emotion that runs from depression at one end to mania at the other. The former usage is now uncommon. The latter usage is emphasized by the fact that, in current diagnostic systems, 'mood disorders' are those in which depression and mania are the defining characteristics, whereas disorders defined by anxiety or other emotional disturbances are categorized separately. In this section, features common to both 'mood' and 'other emotions' are described first, before the specific features of anxiety, depression, and mania are discussed separately.

The second point concerns the term 'affect'. This is now usually used interchangeably with the term 'mood', in the more limited meaning of the latter word (e.g. 'his affect was normal', 'he has an affective disorder').

However, in the past, these words had different nuances of meaning; mood referred to a prevailing and prolonged state, whereas affect was linked to a particular aspect or object, and was more transitory.

Emotions and mood may be abnormal in three ways:

- Their nature may be altered
- They may fluctuate more or less than usual
- They may be inconsistent with the patient's thoughts or actions, or with his current circumstances.

Changes in the nature of emotions and mood

These can be towards anxiety, depression, elation, or irritability and anger. Any of these changes may be associated with events in the person's life, but they may arise without an apparent reason. They are usually accompanied by other symptoms and signs. For example, an increase in anxiety is accompanied by autonomic overactivity and increased muscle tension, and depression is accompanied by gloomy preoccupations and psychomotor slowness.

Changes in the way that emotions and mood vary

Emotions and mood vary in relation to the person's circumstances and preoccupations. In abnormal states, this variation with circumstances may continue, but the variations may be greater or less than normal. Increased variation is called *lability* of mood; extreme variation is sometimes called *emotional incontinence*.

Reduced variation is called *blunting* or *flattening*. These terms have been used with subtly different meanings, but are now usually used interchangeably. Blunting or flattening usually occurs in depression and schizophrenia. Severe flattening is sometimes called *apathy* (note the difference from the layman's meaning of the word).

Emotion can also vary in a way that is not in keeping with the person's circumstances and thoughts, and this is described as *incongruous* or *inappropriate*. For example, a patient may appear to be in high spirits and laugh when talking about the death of his mother. Such incongruity must be distinguished from the embarrassed laughter which indicates that the person is ill at ease.

Clinical associations of emotional and mood disturbances

Disturbances of emotions and mood are seen in essentially all psychiatric disorders. They are the central feature of the mood disorders and anxiety disorders. They are also common in eating disorders, substance-induced disorders, delirium, dementia, and schizophrenia.

Anxiety

Anxiety is a normal response to danger. Anxiety is abnormal when its severity is out of proportion to the threat of danger, or when it outlasts the threat. Anxious mood is closely coupled with somatic and autonomic components, and with psychological ones. All can be thought of as equivalent to the preparations for dealing with danger seen in other mammals, ready for flight from, avoidance of, or fighting with a predator. Mild-to-moderate anxiety enhances most kinds of performance, but very high levels interfere with it.

The anxiety response is considered further in Chapter 8. Here its main components can be summarized as follows.

- *Psychological*. The essential feelings of dread and apprehension are accompanied by restlessness, narrowing of attention to focus on the source of danger, worrying thoughts, increased alertness (with insomnia), and irritability (that is, a readiness to become angry).
- *Somatic*. Muscle tension and respiration increase. If these changes are not followed by physical activity, they may be experienced as muscle tension tremor, or the effects of hyperventilation (e.g. dizziness).
- *Autonomic*. Heart rate and sweating increase, the mouth becomes dry, and there may be an urge to urinate or defaecate.
- *Avoidance of danger*. A *phobia* is a persistent, irrational fear of a specific object or situation. Usually there is also a marked wish to avoid the object, although this is not always the case—for example, fear of illness (hypochondriasis). The fear is out of proportion to the objective threat, and is recognized as such by the person experiencing it. Phobias include fear of animate objects, natural phenomena, and situations. Phobic people feel anxious not only in the presence of the object or situation, but also when thinking about it (*anticipatory anxiety*). Phobias are discussed further in relation to anxiety disorders in Chapter 5.

Clinical associations

Phobias are common among healthy children, becoming less frequent in adolescence and adult life. Phobic symptoms occur in all kinds of anxiety disorder, but are the major feature in the phobic disorders.

Depression

Depression is a normal response to loss or misfortune, when it may be called grief or mourning. Depression is abnormal when it is out of proportion to the misfortune, or is unduly prolonged. Depressed mood is closely

coupled with other changes, notably a lowering of self-esteem, pessimistic or negative thinking, and a reduction in or loss of the experience of pleasure (*anhedonia*). A depressed person has a characteristic expression and appearance, with turned-down corners of the mouth, a furrowed brow, and a hunched, dejected posture. The level of arousal is reduced in some depressed patients (*psychomotor retardation*) but increased in others, with a consequent feeling of restlessness or agitation. The psychopathology of depression is discussed further in Chapter 9.

Clinical associations

Depression can occur in any psychiatric disorder. It is the defining feature of mood disorders, and commonly occurs in schizophrenia, anxiety, obsessive–compulsive disorder, eating disorders, and substance-induced disorders. It can also be a manifestation of an organic disorder.

Elation

Happy moods have been studied less than depressed mood. Elation is an extreme degree of happy mood which, like depression, is coupled with other changes, including increased feelings of self-confidence and well-being, increased activity, and increased arousal. The latter is usually experienced as pleasant, but sometimes as an unpleasant feeling of restlessness. Elation occurs most often in mania and hypomania.

Irritability and anger

Irritability is a state of increased readiness for anger. Both irritability and anger may occur in many kinds of disorder, so they are of little value in diagnosis. However, they are of great importance in risk assessment and risk management, as they may result in harm to others and self (see Chapter 3). Irritability may occur in anxiety disorders, depression, mania, dementia, and drug intoxication.

Disturbances of perception

Specific kinds of perceptual disturbance are symptoms of severe psychiatric disorders. It is therefore important to be able to identify these symptoms and to distinguish them from the other, much less significant, alterations in sensory experience which occur. We shall therefore describe perceptual phenomena in some detail.

Perception and imagery

Perception is the process of becoming aware of what is presented through the sense organs. It is not a direct awareness of data from the sense organs, because these data are acted on by cognitive processes that reassemble them and extract patterns. Perception can be attended to or ignored, but it cannot be terminated by an effort of will.

Imagery is the awareness of a percept that has been generated within the mind. Imagery can be called up and terminated by an effort of will. Images are experienced as lacking the sense of reality that characterizes perception, so that a healthy person can distinguish between images and percepts. A few people experience *eidetic imagery*, which is visual imagery so intense and detailed that it has a 'photographic' quality akin to a percept, although in other ways it differs from a percept. Imagery is generally terminated when perception starts. Occasionally, imagery persists despite the presence of percept (provided this is weak and unstructured). This sort of imagery is called *pareidolia*.

Percepts may alter in intensity and in quality. Anxious people may experience sensations as more intense than usual; for example, they may be unusually sensitive to noise. In mania, perceptions seem more vivid than usual. Depressed patients may experience perceptions as dull and lifeless.

Illusions

Illusions are misperceptions of external stimuli. They occur when the general level of sensory stimulation is reduced and when attention is not focused on the relevant sensory modality. For example, at dusk the outline of a bush may be perceived at first as that of a man, although not when attention is focused on the outline. Illusions are more likely to occur when the level of consciousness is reduced, as in delirium, or when a person is anxious. Illusions have no diagnostic significance, but need to be distinguished from hallucinations.

Hallucinations

A *hallucination* is a percept that is experienced in the absence of an external stimulus to the corresponding sense organ. It differs from an illusion in being experienced as originating in the outside world or from within the person's body (rather than as imagined). Hallucinations cannot be terminated at will.

Hallucinations are generally indications of significant psychiatric disorder, and specific types of hallucination are characteristic of different disorders, as outlined below. However, as noted above, hallucinations do occur in some otherwise healthy people. It is also common to experience them when falling asleep (*hypnagogic hallucinations*) or on waking (*hypnopompic hallucinations*). These two types of hallucination may be either visual or auditory, the latter sometimes as the experience of

hearing one's name called. Such hallucinations are common in narcolepsy (see page 327). Some recently bereaved people experience hallucinations of the dead person. Hallucinations can occur after sensory deprivation, in people with blindness or deafness of peripheral origin, occasionally in neurological disorders that affect the visual pathways, in epilepsy (see page 379), and in Charles Bonnet syndrome (see page 555).

Types of hallucination

Hallucinations can be described in terms of their complexity and their sensory modality (see Box 1.1). The term *elementary hallucination* refers to experiences such as bangs, whistles, and flashes of light, whereas the term *complex hallucination* refers to experiences such as hearing voices or music, or seeing faces and scenes.

Auditory hallucinations may be experienced as noises, music, or voices. Voices may be heard clearly or indistinctly; they may seem to speak words, phrases, or sentences. They may seem to address the patient directly (*second-person hallucinations*), or talk to one another, referring to the patient as 'he' or 'she' (*third-person hallucinations*). Sometimes patients say that the voices anticipate what they are about to think a few moments later. Sometimes the voices seem to speak the patient's thoughts as he is thinking them (*Gedankenlautwerden*), or to repeat them immediately after he has thought them (*écho de la pensée*).

Visual hallucinations may also be elementary or complex. The content may appear normal or abnormal in size; hallucinations of dwarf figures are sometimes called *lilliputian*. Occasionally, patients describe the experience of visual hallucinations located outside the field of vision, usually behind the head (*extracampine hallucinations*).

Olfactory hallucinations and *gustatory hallucinations* are frequently experienced together. The smells and tastes are often unpleasant.

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

An *autoscopic hallucination* is the experience of seeing one's own body projected into external space, usually in front of oneself, for short periods. The experience is reported occasionally by healthy people in situations of sensory deprivation, when it is called an out-of-body experience, or after a near-fatal accident or heart attack, when it has been called a near-death experience. Rarely, the experience is accompanied by the conviction that the person has a double (*Doppelganger*).

Reflex hallucination is a rare phenomenon, in which a stimulus in one sensory modality results in a hallucination in another; for example, music may provoke visual hallucinations.

Box 1.1 Description of hallucinations

According to complexity
- Elementary
- Complex

According to sensory modality
- Auditory
- Visual
- Olfactory and gustatory
- Somatic (tactile and deep)

According to special features
- Auditory
  - Second-person
  - Third-person
  - Gedankenlautwerden
  - Écho de la pensée
- Visual
  - Extracampine

Autoscopic hallucinations
- Reflex hallucinations
- Hypnagogic and hypnopompic

Clinical associations of hallucinations

Hallucinations occur in diverse disorders, notably schizophrenia, severe mood disorder, organic disorders, and dissociative states. Therefore the finding of hallucinations does not itself help much in diagnosis. However, as with delusions, there are certain kinds of hallucination which do have important implications for diagnosis of schizophrenia and other disorders.

- *Auditory hallucination*. Only clearly heard voices (not noises or music) have diagnostic significance. Third-person hallucinations (introduced above) are strongly associated with schizophrenia. Such voices may be experienced as commenting on the patient's intentions (e.g. 'He wants to make love to her') or actions (e.g. 'She is washing her face'), or may make critical comments. Second-person auditory

hallucinations (i.e. those that appear to address the patient) do not point to a particular diagnosis, but their content and the patient's reaction to them may do so. Thus voices with derogatory content (e.g. 'You are a failure, you are wicked') suggest severe depressive disorder, especially when the patient accepts them as justified. In schizophrenia, the patient more often resents such comments. Voices which anticipate, echo, or repeat the patient's thoughts also suggest schizophrenia.

- *Visual hallucinations* should always suggest the possibility of an organic disorder, although they also occur in severe affective disorders, schizophrenia, and dissociative disorder. The content of visual hallucinations is of little significance in diagnosis. Autoscopic hallucinations also raise suspicion of an organic disorder, such as temporal lobe epilepsy.
- *Hallucinations of taste and smell* are infrequent. They may occur in schizophrenia, severe depressive disorders, and temporal lobe epilepsy, and in tumours affecting the olfactory bulb or pathways.
- *Tactile and somatic hallucinations* are suggestive of schizophrenia, especially if they are bizarre in content or interpretation. The sensation of insects moving under the skin (*formication*) occurs in people who abuse cocaine.

Pseudohallucinations

This term refers to experiences that are similar to hallucinations but which do not meet all of the requirements of the definition, nor have the same implications. The word has two distinct meanings, which correspond to two of the ways in which an experience can fail to meet the criteria for a hallucination. In the first meaning, pseudohallucination is a sensory experience that differs from a hallucination in not seeming to the patient to represent external reality, being located within the mind rather than in external space. In this way pseudohallucinations resemble imagery although, unlike imagery, they cannot be dismissed by an effort of will. In the second meaning, the sensory experience appears to originate in the external world, but it seems unreal. For a more detailed discussion, see Hare (1973) and Taylor (1981).

Both definitions of pseudohallucinations are difficult to apply clinically, because patients can seldom describe their experiences in adequate detail. In any event, it is usually sufficient to decide whether a perceptual experience is a 'true' hallucination or not, since it is only the former which carries diagnostic significance. If it is not a hallucination, the experience should be described, but need not be labelled as one kind of pseudohallucination or the other.

Abnormalities in the meaning attached to percepts

A *delusional perception* is a delusion arising directly from a normal percept. This is sometimes erroneously considered to be a perceptual disturbance, but it is really a disorder of thought, and is therefore discussed in the next section.

Disturbances of thoughts

Disturbances of thoughts and thought processes are among the most diagnostically significant symptoms in psychiatry. As with disturbances of perception, therefore, this area of descriptive psychopathology merits relatively detailed description. It covers two kinds of phenomena:

- *Disturbance of thoughts* themselves—that is, a change in the *nature* of individual thoughts. The category of delusion is particularly important. Disturbances of thought are covered in this section.
- *Disturbance of the thinking process* and the linking together of different thoughts; this may affect the speed or the form of the relationship between thoughts. It can occur even if individual thoughts are unremarkable in nature. These phenomena are covered in the next section.

Delusions

A *delusion* is a belief that is firmly held on inadequate grounds, that is not affected by rational argument or evidence to the contrary, and that is not a conventional belief that the person might be expected to hold given their educational, cultural, and religious background. This definition is intended to separate delusions, which are cardinal symptoms of severe psychiatric disorder (and specifically of psychosis), from other kinds of abnormal thoughts and from strongly held beliefs found among healthy people. There are several problems with the definition, which is summarized in Box 1.2, but it suffices as a starting point for more detailed discussion of delusions.

Although not part of the definition, another characteristic feature of delusions is that they have a marked effect on the person's feeling and actions—in the same way that strongly held normal beliefs do. Since the behavioural response to the delusion may itself be out of keeping or even bizarre, it is often this that

Box 1.2 Problems with the definition of delusions

Delusions are firmly held despite evidence to the contrary

The hallmark of a delusion is that it is held with such conviction that it cannot be altered by presenting evidence to the contrary. For example, a patient who holds the delusion that there are persecutors in the adjoining house will not be convinced by evidence that the house is empty. Instead he may suggest that the persecutors left the house shortly before it was searched. The problem with this criterion for delusions is that some of the ideas of normal people are equally impervious to contrary evidence. For example, the beliefs of a convinced spiritualist are not undermined by the counterarguments of a non-believer. Strongly held non-delusional beliefs are called *overvalued ideas* (see page 14).

A further problem with this part of the definition of delusion relates to *partial delusions.* Although delusions are usually held strongly from the start, sometimes they are at first held with a degree of doubt. Also, during recovery it is not uncommon for patients to pass through a stage of increasing doubt about their delusions before finally rejecting them. The term 'partial delusion' refers to both these situations of doubt. It should be used during recovery only when it is known that the beliefs were preceded by a full delusion, and applied to the development of a delusion only when it is known in retrospect that a full delusion developed later. Partial delusions are not, in isolation, helpful in diagnosis—akin to the status of pseudohallucinations mentioned on page 8.

Delusions are held on inadequate grounds

Delusions are not arrived at by the ordinary processes of observation and logic. Some delusions appear suddenly without any previous thinking about the subject (primary delusions). Other delusions appear to be attempts to explain another abnormal experiences—for example, the delusion that hallucinated voices are those of people who are spying on the patient.

Delusions are not beliefs shared by others in the same culture

This criterion is important when the patient is a member of a culture or subculture (including a religious faith), because healthy people in such a group may hold beliefs that are not accepted outside it. Like delusions, such cultural beliefs are generally impervious to contrary evidence and reasoned argument—for example, beliefs in evil spirits. Therefore, before deciding that an idea is delusional, it is important to determine whether other members of the same culture share the belief.

Delusions as false beliefs

Some definitions of delusions indicate that they are false beliefs, but this criterion was not included in the definition given above. This omission is because, in exceptional circumstances, a delusional belief can be true or can subsequently become true. A well-recognized example relates to pathological jealousy (see page 306). It is not falsity that determines whether the belief is delusional, but the nature of the mental processes that led up to it. (The difficulty with this statement is that we cannot define these mental processes precisely.) There is a further practical problem concerning the use of falsity as a criterion for delusion. It is that if the criterion is used, it may be assumed that, because a belief is highly improbable, it is false. This is certainly not a sound assumption, because improbable stories—for example, of persecution by neighbours—sometimes turn out to be true and arrived at through sound observations and logical thought. Therefore ideas should be investigated thoroughly before they are accepted as delusions.

These issues are discussed further in Spitzer (1990) and Butler and Braff (1991). See Garety and Freeman (2013) for a cognitive account of delusions.

first brings the person to psychiatric attention, and leads to the delusion being elicited. For example, a man with the delusion that he was being irradiated by sonic waves covered his windows with silver foil and barricaded his door. Occasionally, however, a delusion has little influence on feelings and actions. For example, a patient may believe that he is a member of the royal family while living contentedly in a group home. This separation is called *double orientation*, and usually occurs in chronic schizophrenia.