UNIT 4 PSYCHOPATHOLOGY/ PSYCHIATRIC SIGN AND SYMPTOMS OF MENTAL DISORDERS

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4.0 OBJECTIVES

When you have completed this unit, you should be able to:

- define psychopathology;
- list the types of personality;
- describe the various disorders of motor behaviour, perception, thinking, affect, consciousness, orientation and memory; and
- recognise disorders which can occur in mentally ill persons while working in clinical setting.

4.1 INTRODUCTION

Usually each individual faces stress, cope-up with it and remains healthy. When the personality is subjected to anxiety producing stressors beyond the limits for adaptation, the individual suffers disorganization of personality and behaviour. Individual replaces healthy adaptive methods with neurotic and psychotic ones, i.e mental disorders. In the present unit we shall discuss the disorders of personality, motor aspects, perception, thinking, affect, orientation, memory and intelligence.

4.2 MEANING OF PSYCHOPATHOLOGY

Psychopathology is the systematic study of abnormal experience, cognition and behaviour. It involves the observation and categorization of abnormal psychic events, the internal experiences of the patient and his consequent behaviour. For example Mrs. Kumar complains that she is unhappy, in psychopathology we describe her thoughts and actions and observe her behaviour the listless sagging

of her shoulders, the tense gripping and wringing of her hands as well as her inside horrible feeling of not really existing. Psychopathology in psychiatric dictionary (Hinsic L.G. & Campbell) is defined as that branch of science which deals with morbidity or pathology of psyche or mind. Study of psychopathology includes abnormalities in terms of motor activity, thought, perception, affect, consciousness, memory and orientation and intelligence.

4.3 TYPES OF PERSONALITY

Although each individual is different than others due to his/her own particular characteristics. Certain general types of personality have been defined as disordered. In the clinical setting the nurse has to identify the type of personality organization of the patient as well as the symptomatic psychopathology which he/she has. Although these personality type are described as disordered personality it may be remembered that people having a type of personality will not necessarily develop mental disorder. So let us first have description of personality disorders.

4.3.1 Cyclothymic Personality

In Cyclothymic Personality the individual has alternating moods of cheerfulness, liveliness and sadness. It also indicates the tempo of personality i.e. vivacious or retarted. However these fluctuations of mood are not to pathological extremes. Cyclothymies are predisposed to the development of manic-depressive psychoses.

4.3.2 Hypomanic Personality

The hypomanic people are outgoing, cheerful enjoyers of life. They are free from internal inhibitions. They are energetic, confident, aggressive, optimistic, pleasure loving, unstable and easily swayed by new impressions. Some are domineering, argumentative and hypercritical. The hypomanic cannot stand frustrations and disappointments. Hypomanics are predisposed to manic episodes.

4.3.3 Melancholic Personality

These people are kindly, sympathetic, quiet and good tempered but tend to get easily depressed, express feelings of inadequacy and helplessness. They are usually meticulous preoccupied with work, perfectionistic and over conscientious. They are fearful of failure, suffer in silence and may easily cry alone. They are indecisive and feel insecure. These type of people are predisposed to depression.

4.3.4 Paranoid Personality

The paranoid person is suspicious, stubborn, lonely, insecure, unhappy, very sensitive and sarcastic. He/she is argumentative, aggressive, criticizes others and does not keep good inter-personal relationship with others though, often highly efficient. This type of people are predisposed to paranoid Schizophrenia.

4.3.5 Schizoid Personality

This personality is characterized by feeling of loneliness, isolation, timid and shyness, often good at school work, quiet and asocial. He/she reads philosophical books and expresses vague schemes for bettering humanity. They do not trust others, may have feeling of inferiority and are aloof to the opposite sex.

As their early relationship within the family is disturbed and unsatisfying, in adolescence they are disobedient, moody, ill-tempered and do not like advice or supervision.

He/she often day dreams and starts neglecting personal appearance, home and family. When these characteristics reach to maximum schizophrenic psychoses develops.

4.3.6 Obsessive Compulsive Personality

The persons with obsessive compulsive nature are those whose super-ego functions are severed. They are rigid, punctual, meticulous, in constant doubt what to do and have to go over things again and again. They cannot work under pressure, do not relax and cannot make decision. If they do make, they regret. They use rituals as defense against hostile impulses the compulsive person is hard worker too. The chronic tension of the compulsive personality with additional stress may lead to an obsessive compulsive neurosis.

4.3.7 Hysterical Personality

This personality is characterized by traits of self-centered dramatization or exhibition. Their affect is labile and prone to emotional out bursts. They show attention seeking behaviour to fulfill demanding and dependent need.

The hysterical women is very social but gets easily frustrated in reality. They are competitive against men so they are aggressive towards them as well as show dependent childish relationship. They show the symptoms of emotional immaturity in early life as enuresis, thumb-sucking and isolation.

4.3.8 Passive-Aggressive Personality

This type of personality is manifested in one of the three ways:

a) **Passive-dependent type:** This is characterized by absence of mature self-confidence and self-reliance. He/She feels indecisiveness and helplessness. He/She depends on others for decisions. There people are passive, timid and fearful.

b) **Passive-aggressive type:** This type of person is aggressive, doubtless and defensive, which is expressed by stubbornness and inefficiency. Individual usually works poorly in group.

c) **Aggressive type:** This type is personality persons have been openly hostile to their fathers in their early life. Though they have deep dependency need and aggressiveness comes in form of reaction-formation. They show continuous reaction of frustration with such immature measure such as irritability tember tantrum and even destructive behaviour. Grandiose fantasies are common. They are hostile toward authority and show "chip on the shoulder" attitude.

4.3.9 Explosive Personality

These persons are usually friendly, happy, likable and outgoing but in outbursts they show uncontrolled hostility, guilt and anxiety. They show disproportionate emotional reaction, they may shout, become destructive and assaultive when they face emotional tension. Jealously and quarrel with opposite sex and suicidal attempts in response to frustration is common.

4.3.10 Inadequate Personality

This personality is characterized by failure in emotional, economic, occupational and social adjustments. They are ineffective and unconcerned about their success in spite of being good-natured and easygoing. They lack ambition and initiative, seem to lack physical and emotional stamina. Many of the never-do-well belong in this group.

Check Your Progress 1

1) Describe characteristics of hypomanic personality.

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2) Describe paranoid personality?

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4.4 SYMPTOMS AS PSYCHOBIOLOGICAL REACTIONS

Symptoms are the result of many forces. Their origin is usually with in the patient. The symptoms may be bizarre but have a cause and meaning.

In order to understand the mental disorder you must know the current physical and emotional status of the patient.

4.5 DISORDERS OF MOTOR ASPECTS OF BEHAVIOUR

Motor disturbances is related to action or impulse toward action. It is called conation. Activities are associated with will to do (attitude) and wish to do (feeling).

The followings are the disturbances of activity.

4.5.1 Increased Activity (Over Activity)

Increased activity may be goal directed. But sometimes this goal of activity is constantly changing and no objective is achieved. It is seen in mania. Many times with increased motor activity catatonic excitement, anxietynechess obsessive compulsive disorder etc. Even the stream of thought is characterized by flight of ideas.

4.5.2 Decreased Activity

Patient takes long time to start the activity when it gets started they do it very slowly. They have to make lots of effort to do it. It is also called decreased psychomotor activity or psychomotor retardation. In extreme from, the patient is mute and motionless. It is commonly seen in depression, catatonic stupor etc.

4.5.3 Repetitious Activities

When an activity is initiated, there is a tendency to repeat it in the same manner for an indefinite period. **Stereotype activity** means persistent and constant repetition of certain activities and may be of position, movement of body or speech. Stereotype may be seen in following forms.

Stereotype Position

Catalespy: A constantly maintained immobility of position is known as catalespy. Its frequently seen in schizophrenia.

Waxy-flexibility: In this the patient's limbs may be flexed like a wax in awkward position and patient remains in that position for a long time. Catalespy and waxy flexibility are commonly seen in catatonic schizophrenia.

Stereotype Movement

Mannerisms: These are stereotyped movements commonly seen in schizophrenia e.g. grimaces repeated gestures and peculiarities of gait etc.

Stereotype Speech

Verbigeration or word salad: When words, phrase or sentence are repeated it is called verbigeration.

Clang Association: It is the repetition of rhythmic words like bat, cat, rat, sat.

4.5.4 Automatic Behaviour

In this patient follows compulsively an automatically suggestions and requests. This is seen in two forms.

a) **Echolalia:** In this the patient repeats the words or phrases which are spoken in his presence. Fro example the nurse tells the patient 'take medicine' patient repeats 'take medicine'.

b) **Echopraxia:** When the patient imitates the movement of others. Echolalia and Echopraxia are commonly seen in catatonic schizophrenia.

4.5.5 Negativism

It is a psychological defense reaction manifested by opposition and resistance to what is suggested. Patient can show this in different forms such as mutism, resfusal of food and noncompliance with requests etc. Negativism provides gratification by the acting out of hostile, revengeful feelings towards significant persons.

4.5.6 Compulsions

A morbid and often an irresistible urge to perform purposeless act repetitiously is known as a compulsion e.g. touching an object twice or doing activities in a particular sequence may take a form of ritual. Compulsion may be the result of obsessive thoughts. The acts are not meaningless. In general population many people have various obsessive compulsive habits which serve as a defense reaction for keeping anxiety and feelings of guilt at minimum. Compulsions are commonly seen in obsessive compulsive disorders and schizophrenia.

4.5.7 Violence

It is an expression of aggressiveness in the form of murders, assaults, rape, damaging self and others and suicide.

It seems there is an impairment in functioning of Super-ego. It may occur because of parental loss in early life, neglect and hatred which impairs the process of identification and internalization of values necessary to constitute super-ego control and ego ideals.

4.5.8 Suicide

It means self destruction. People with suicidal ideation have sense of lack of love and affection and deep sense of personal rejection. They also suffer from self-derogatory attitude, profound feelings of hopelessness and helplessness. The suicidal attempt is motivated by the wish for revenge or by wish-fulfilling fantasies of reunion in death.

Suicidal fantasies occur usually in periods of recovery following depression, acute schizophrenic episodes and in delirium.

4.6 DISORDERS OF PERCEPTION

As we know that our neurons give rise to a nervous impulse. On arrival in the appropriate area in the brain this impulse produces a visual, auditory or other sensory image, the interpretation and meaning of which will depend upon one's previous experiences and interpretations. This is called perception.

Disorders of perceptions are classified as illusions and Hallucinations.

4.6.1 Illusions

Illusions are mistaken or misinterpretations of sensory impressions e.g. patient perceives rope as a snake. Illusions occur due to individual's emotional state, needs and fears. In mental disorders the emotional life tends to influence perceptual experience according to the needs of the personality. Illusions can be auditory, visual olfactory, gustatory or tactile.

4.6.2 Hallucinations

Illusion is an image symbol of a real object but for psychological reasons it is misinterpreted where as hallucination is a perception without object. Hallucinations products arise from within and are not related to any external stimulus. They represent a break through of preconscious or unconscious material into consciousness in the form of sensory images in response to psychological situations and needs.

There are six types of hallucinations:

a) **Auditory Hallucinations:** These are most common form of perceptual disturbances. These are sometimes in the form of noises but commonly in clear words or complete sentences addressed to him. Often these remarks are unpleasant and derogatory or commanding which patient may follow. For example, patient says he hears voices which tell him to kill somebody.

b) **Visual Hallucinations:** These are not as common as auditory hallucinations. These occur most commonly in delirium tremens and schizophrenia in which patient sees terrifying images. It causes fear in the patient. Other conditions in which visual hallucination occurs are in acute reversible organic brain disorders of occipital cortex or temporoparietal cortex. These also occur in people who use amphetamine and atropine etc.

c) **Olfactory Hallucinations:** These are hallucination of smell, commonly seen in schizophrenic states and with lesions of temporal lobe. They are unpleasant smell and they represent feelings of guilt.

d) **Gustatory Hallucinations:** These are hallucinations of taste. They rarely occur alone but are associated with olfactory hallucinations.

e) **Tactile Hallucinations:** These are hallucinations of touch. They occur principally in toxic states e.g. delirium tremens, in cocaine addiction and, in schizophrenia also.

f) **Kinesthetic Hallucinations:** The phantom phenomenon, e.g. to feel pain in the amputated part of limb. This is the most common form of Kinesthetic hallucinatory experience.

Check Your Progress 2

Column A	Column B
i) A constantly maintained immobility of position	a) Negativism
ii) Repetition of rhythmic words	b) Hallucination
iii) Psychological defense reaction manifested by opposition and resistance of what is suggested	c) Catalepsy
	d) Compulsion
iv) A morbid and often an irresistible urge to perform purposeless act repetitiously	e) Verbigeration
v) Misinterpretations of sensory perception	f) Illusion
vi) Perception without object	

4.7 DISORDERS OF THINKING

The person joins the ideas one to another by imagining, conceiving, inferring and other processes and forms the new ideas by these processes. This function is called thinking. Thought is the most highly organized psychobiological integration and a form of implicit or internal behaviour. When dealing with psychiatric patient's a nurse should pay attention to the production of thought, the progression of thought and the content of thought.

4.7.1 Disorders in the Form of Thought

Thinking is the product of stimulus and response. As far as the mental health is concerned stimuli for thought comes from various sources e.g. unconscious and affective ones and thinking is corrected by reasoning and logic and these are realistic and in conscious awareness. In day-dreaming, thinking is directed by egocentric wishes and instinctual needs. In mental disorder e.g. in schizophrenia, thinking is directed by unconscious factors for e.g. autistic thinking or derestic thinking.

Autistic and derestic thinking is characterized by a withdrawal of a person into the self and in to the fantasy world of his or her own creation. The term is differently and interchangeable with autistic and derestic think. It may be manifested in the form of self muttering where patient keeps talking to himself or nutisum. It is a primary symptoms of schizophrenia.

4.7.2 Disorders in Progression of Thought

Usually one's thinking moves in a logical progression toward a more or less definite end. This progression of thought is known as 'stream of thought'. The followings are the disorders of progression of thought.

a) **Flight of Ideas:** The disturbance of the stream of thought in which thinking processes appear to run too quickly, yet no idea is completed is known as flight of ideas. This happens because of increased inner drive and distractibility. It is usually seen along with increased psychomotor activity it

is commonly seen in mania. Sometimes a world similar in sound but not in meaning call up the new thought and may lead to senseless rhyme, e.g. sit, sob, sigh, sorrow. This is called as **Clang association.**

b) **Retardation:** In this the initiation and movement of thought are slow, patient will speak slowly and usually in low tone. Patient will complain that he has difficulty in thinking. It usually occurs in depressive phase of affective psychoses and may also seen in schizophrenia. It is many times seen along with decreased motor activity.

c) **Thought Preservation:** In this abnormal, persistent repetition or continuance in expression of an idea is seen. It occurs in aphasia, catatonia and in senile dementia.

d) **Circumstantiality:** This is also the disturbance of flow of thought in which patient includes many unnecessary details before the goal is finally reached. The details expressed are related but not essential. It is called beating around the bush. This is seen in mania among feeble-minded, epileptics and in advanced senile mental disorders.

e) **Incoherence:** This is characterized by confusion due to repressed material highly charged affectively. In this one idea runs into another without logical sequence. It occurs in schizophrenia in which thinking is scattered.

f) **Tengantiality:** In this disorder of progression of thought patient begins to respond, follows a series of related topics but never reaches the goal finally. It is common in patients with schizophrenia.

g) **Blocking:** When patient is talking and suddenly he stops talking. It means sudden interruption in train of thought. It occurs when one feels strong affect e.g. anger or terror. After sometimes the interruption is removed and talk is continued. It is seen in schizophrenia.

4.7.3 Disorders of Content of Thought

Disorders of content of thought are discusses as over valued or over determined ideas, delusions hypochondrias, obsession and phobias.

a) Overvalued or Over Determined Ideas

When an idea has strongest feeling tones it tends to dominate and we call it over valued idea. A person tries to have observations and memories which suit to this idea and other ideas are denied admission into consciousness Over valued idea becomes most important determinant of behaviour.

b) Delusions

The delusions is defined commonly as a false belief, which is irrational, not shared by persons of same race, age and standard of education, which is held by conviction and which cannot be altered by logical arguments and which is persistent.

These appear as attempts to deal with the special problems and stresses of one's particular life situation in which fantasy is called upon to slupply what real life has denied. Delusions are of following types:

i) ***Delusions of Grandeur:*** Delusional beliefs of great power, wealth and influence e.g. he may say, he is God. This delusion arises from feelings of inadequacy, insecurity or inferiority. With the help of delusion the patient escapes from the troubles of reality which cause a threat to his emotional security. It is commonly seen in mania and paranoid schizophrenia.

ii) ***Delusion of Self-accusation:*** It arises when super-ego becomes critical because repression gets weakened and patient has vague feeling of guilt. This sense of guilt takes the form of self accusation. It is commonly seen in depression.

iii) ***Delusions of Persecution:*** Delusional beliefs of an individual that he is being deliberately interfered with, discriminated against, threatened or otherwise mistreated. He feels others are planning to harm him. These delusions permit a shifting of responsibility and otherwise serve to relieve anxiety arising from guilt. It occurs in chronic psychotic disorders.

iv) ***Ideas of Reference:*** Delusional beliefs that other people are talking about him, referring to him or that the remarks or actions of people he meets are intended to have some special significance for him. In paranoid states, ideas of reference represent a projection of the patient's own self-criticism on to the world. In depression, feeling of guilt may stimulate ideas of reference.

v) ***Thought Broadcasting:*** In this the patient believes that his thoughts are being broadcast or projected into the environment. People around him come to know about his thoughts.

vi) ***Thought Insertion:*** Patient feels that his thoughts are being implanted in his mind by other people or for

vii) ***Thought Withdrawal:*** delusion that one's thoughts are being removed from one's mind by other people or forces.

Thought broadcasting, thought insertion and thought withdrawal are commonly seen in schizophrenia.

viii) ***Delusion of Sin, Guilt, Impoverishment and illness:*** These occur mostly in depressive cases. In this unconscious hostile tendencies may be projected outward giving rise to fear of punishment. Patient feels that he has done some unpardonable sin which leads to delusion of sin and guilt and therefore depression.

Ideas of disease have similar meanings. The illness represents punishment for unacceptable and hostile drives to another person.

Ideas of poverty have the subjective sense of loss of social value. These ideas are displayed to most generally recognized symbol of value-money. In nihilistic ideas the patient feels that either he has changed or the environment he is living in has changed. He may say that he has no brain or he is no more living he is dead. These ideas have their origin in vague feelings of emotional and in a subjective feeling of unreality.

In ideas of control the patient may express the delusional belief that he is controlled or that people read his mind.

c) **Hypochondria**

In this the patient shows exaggerated concern over his own physical health. In this anxiety is displaced from unconscious mental sources to organs. It occurs in people who have shown previous tendency to evade the responsibilities of life through illness.

d) **Obsessions**

It is persistent repetition of an idea against the persons desire. Thoughts that persistently push themselves into consciousness against the desire of the patient are known as obsessions. Obsessive thoughts are strongly charged with the emotions of guilt or depression. For example patient keeps on asking why he was born. Obsessive thoughts are closely related to compulsive acts.

e) **Phobias**

Phobia is exaggerated, morbid fear, allied to obsessive thoughts the patient has fears of dirt, bacteria, cancer or of crowds. This always accompanies morbid anxiety producing component of his own personality. There are different types phobia for e.g. claustrophobia is fear of closed places, hydrophobia is fear of water.

Check Your Progress 3

1) Define delusion.

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2) Define flight of ideas.

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3) Define obsession.

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4.8 DISTURBANCES OF AFFECT

Affect is related to feeling which currently the person is having whereas mood is sustained feeling state of considerable duration. Affects serve as a warning signal to refrain from a forbidden act. Affect influence our ideas and thoughts. All affects possess an active elements. We can classify affect as follows:

4.8.1 Pleasurable Affects

These are as follows:

a) **Euphoria:** It is the feeling of emotional and physical well being. In this the patient has optimistic mental 'set' and is confident and assured in attitude. It is present in hypomanic states and in certain organic state e.g. general paresis, multiple sclerosis and in frontal lobe tumor.

b) **Elation:** Patient feels overjoyed, self-confidence radiates from him. Elation is often labile and readily shifts to irritability. It is accompanied with increased activity. It is commonly seen in mark.

c) **Exhaltation:** There is an intense elation accompanied by an attitude of grandeur.

d) **Ecstasy:** Its a feeling of extreme joy and tranquil sense of well being and

power. It can occur in dissociative epileptic, schizophrenic and affective reactions.

4.8.2 Depression

It is an affective feeling tone of sadness. It is the commonest type of complaint in psychiatric patient. It can vary from mild depressive syndrome to deeper depression. In mild depressive syndrome the patient is quiet, restrained, inhibited, unhappy, pessimistic, has feeling of inadequacy and hopelessness and the same feelings are in extreme form in deeper depression.

Grief: It is an affect of sadness due to loss of a close personal relation, may be death of a person, or loss of a significant thing.

4.8.3 Anxiety

It is a persistent feeling of dread, apprehension and impending disaster. The patient is ignorant of its source. Following are the different states of anxiety.

a) **Free-floating Anxiety:** It means anxiety is not attached to any ideational content but is felt as a morbid fear without apparent source.

   Anxiety disturbs physiological functions and finds expression in psycho physiological symptom's e.g. intestinal irritability, diarrhea, constipation, flushing and respiratory distress etc.

b) **Agitation:** When anxiety is severe and over flows in this way into the muscular system, producing gross motor restlessness, the reaction of the patient is called agitation.

c) **Tension:** In this patient feels restlessness, dissatisfaction, dread and discomfort. She/He has anxious facial expression, tremors of fingers, lack of concentration and complaints tightness in the head. Tension is accompanied by neuromuscular setting.

d) **Panic:** It is a pronounced state of anxiety which produces disorganization of ego functions. It occurs in some long standing insecurity of the personality which creates tension in threatening form. The patient may show aggressiveness and may pace about, pupils get dilated and has difficulty in thinking, appearance of bewilderment. May attempt suicide.

4.8.4 Inadequate Affect

This is emotional dulling or detachment in the form of indifference, also called apathy. Patient does not feel pleasure or pain or any other sentiments. This absence of emotional responsiveness may cause loss of touch with reality. It may appear as a protective, defensive reaction against painful perceptions. This is a primary symptom of schizophrenia.

4.8.5 Inappropriateness of Affect

It is a disharmony of affect. It is a common emotional disturbance, seen in schizophrenia e.g. patient smiles when actually the situation is sad.

4.8.6 Ambivalence

It means existence of contradictory feeling, attitudes toward the same object or person. Both of these conflicting attitudes are faces of the same coin, while only one may be visible. The other is nevertheless present e.g. feeling of love and hate towards the parents being expressed at the same time. This also is a primary symptoms of schizophrenia.

4.8.7 Depersonalization

It is an affective disorder in which feelings of unreality and a loss of one's own identity are experienced. The unreality symptoms are of two kinds; (a) feelings of changed personality. (b) a feeling that the outside world is unreal. Patient feels that he is no longer himself but he does not feel that he has become someone else. The patient feels frightening sense of strangeness and ureality. The onset may be acute following a severe emotional shock. It occurs in people who are intelligent, sensitive, affectionate, introvert type. It occurs in depression, hypochondria, obsessional states and hysteria.

Check Your Progress 4

1) List and define four forms of pleasurable affect.

   a) ....

   b) ....

   c) ....

   d) ....

2) Fill in the blanks:

   i) Elation is commonly seen in ....

   ii) Inappropriate affect is commonly seen in ....

   iii) Existence of contradictory feeling, attitudes towards the same object or person is called ....

   iv) When feeling of unreality and a loss of one's own identity are experienced it is called ....

4.9 DISTURBANCES OF ATTENTION

4.9.1 Disordered Attention

Organism examines the external world for useful data it is known as attention. It is greatly influenced by conation, affect and association. Fatigue, toxic states and organic lesions interfere and lower attention.

4.9.2 Distractibility

The inability to hold the attention for a sufficient length of time is called distractibility. In schizophrenia the degree of attention is greatly diminished.

4.10 DISORDERS OF CONSCIOUSNESS

Impairements in consciousness from least to the greatest are states of confusion, clouding of consciousness, delirium, dream and fugue states to complete stupor.

4.10.1 Confusion

It is a disturbance of consciousness characterized by bewilderment, perplexity, disorientation, disturbance of associativity and poverty of ideas. It occurs in diffuse impairement of brain tissue functions associated with toxic, infections or traumatic agents.

4.10.2 Clouding of Consciousness

It is a disturbance in which clear mindedness is not complete because of physical or chemical disturbances producing functional impairment of the associative apparatus of the cerebrum. To make patient understand a question, one has to shake him several times or to shout the question before he replies. It is seen in infectious diseases and in dissociative reactions.

4.10.3 Delirium

It is also designated as the acute brain syndrome. It consists of much more than clouding of consciousness. Delirious reactions occur in infective states, puerperial psychoses etc. It is also commonly seen with excessive use of bromides and other drugs.

4.10.4 Dream State

This is also called twilight state. There is consciousness disturbance and patient is not aware of his surrounding. Visual and auditory hallucinations occur and in response to these, patient may run away or may commit act of violence. These dream states may last from several minutes to a few days. It occurs in dissociative reactions and in epilespy.

4.10.5 Stupor

In this patient is motionless and mute but with relative preservations of conscious. Movement of eyes and respiration occur. It can occur in toxic – organic brain disease, schizophrenia intense apathy, profound depression blocking, epilespy and dissociative reaction to overpowering fear. A sudden change from stupor to activity, often impulsive or excessive occurs in psychogenic stupor only.

4.11 DISORDERS OF ORIENTATION

The process by which one understand his surrounding and locates himself in relation to it is known as orientation. If a person knows his position in reference to time, place and person, he is said to be oriented. Disorientation may occur in organic brain syndromes and in acute conflicts.

4.12 DISORDERS OF MEMORY

The function by which information is acquired and presented to consciousness and attention is stored, later same is recalled to consciousness is known as memory. It has three processes.

a) **Registration :** It means reception of the mental impression.

b) **Retention:** It means preservation of the previously acquired impression.

c) **Recall:** It means reproduction of the impression. The following are the disorders of memory.

4.12.1 Hypermnesia

Its an exaggerated degree of relation and recall. It occurs in mild manic states, paranoia and catatonia impressions with strong emotions are attached. This gets registered with more intensity.

4.12.2 Amnesia

It means loss of memory or inability to recall past experience. It can occur in

physiological disturbances of neurons through chemical alternations or trauma. In psychogenic amnesia, recall is not present for psychogenic reasons. The absence of memory is an active defense against painful experiences. The types of amnesia are:

a) **Anterograde Amnesia:** Confined to recent events and is progressive, for example a boxer who gets injury but continues the fight, later reports memory gap extending forward from the time of the injury till end of fight.

b) **Retrograde Amnesia:** Involves the past events and is not progressive. It is seen after treatment of electric shock.

4.12.3 Paramnesia

It is falsification of memory as well as distortions of memory, also serves as protection against intolerable anxiety. These are various types as follows:

a) **Confabulation:** The patient fills the gaps in his memory by fabrications a his own stories which are without any basis of fact. This is seen in senile psychoses and particularly in Korsakoff's syndrome.

b) **Retrospect Falsifications:** These are illusions of memory, created in response to affective needs. It means unconsciously we select those memories which suit our interests.

4.12.4 Deja Vu

This is an experience of seeing with the feeling that one has seen it before but does not know when and where (is a french term which can literally be translated as already seen). This is seen in schizophrenia, psychoneuroses, lesions of the temporal lobe including epilepsy and states of fatigue or intoxication.

4.13 DEMENTIA

Permanent, irreversible loss of intellectual efficiency is known as dementia. This occurs due to structural disturbances or degeneration of the higher cortical neurons such as those by prolonged toxication or malnutrition. Dementia is characterized by:

a) increasing poverty of initiative

b) restriction of interest

c) blunting of concern

d) impressions are taken in and assimilated slowly with difficulty and inexactly.

e) memory is defective

f) disorientation

g) confusion

h) judgement is defective.

It can occur in various conditions like in:

1) Atrophic changes of the brain e.g. in senile dementia.

2) Vascular disorder of the brain e.g. artrioselerotic and hypertensive encephalopathy.

3) Inflammatory disorder of the brain e.g. epidemic encephalitis.

4) Degenerative disease of the brain e.g. Alzheimer's disease, Pick's disease and huntington's chorea.

5) Deficiency diseases e.g. KOrsakoff's psychosis, Wernicke's encephalopathy, pellagra and pernicious anaemia or Vit B_{12} deficiency.

6) Neoplasm.

7) Trauma.

Check Your Progress 5

1) List five disorders of consciousness.

....

....

....

....

2) Define the following terms

a) Hypermnesia ....

b) Amnesia ....

c) Paramnesia ....

4.14 LET US SUM UP

As you have read this unit that the systematic study of cognition and behaviour is called psychopathology. For easy understanding of maladaptive behaviour, one has to know the different disorders of personality such as types of personality which each individuals. For understanding the different mental disorders in a patient you need to have knowledge of different disorders such as motor disturbances which is related to action or impulse toward action (conation), disorders of perception which includes illusion and hallucination, disorders of thought at formation, progression of thought and content level.

You have also read about disturbance of affect. Disorder of attention and disturbance of consciousness of consciousness, delirium.

It has unit emphasis is also given on disorders of orientation related to time, place or person. Wheather patient is aware of these or not. Disorder of memory is discussed by evaluating weather patient has right information and can register, retain and recall information. Dementia is discussed as permanent, irreversible loss of intellectual efficiency. This content discussed in this unit will help you to do mental status examination of the patient, make nursing diagnosis, plan the nursing care and evaluate the changes occur in the behaviour.

4.16 KEY WORDS

Amnesia : loss of memory.

Auditory hallucination : perceptible disturbances in the form of noises or unclear words.

Overactivity : increase in pressure of occupation.

4.17 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) The hypomanics are outgoing, cheerful enjoyers of life. They are free from internal inhibitions. They are energetic, aggressive, optimistic, pleasure loving and unstable.

2) Person with this personality is stubborn, does not like discipline, lonely, insecure, very sensitive and sarcastic. He is argumentative, aggressive, does not keep good inter personal relationship.

Check Your Progress 2

i) c

ii) e

iii) a

iv) d

v) f

vi) b

Check Your Progress 3

1) These are false beliefs, which are irrational, not shared by persons of same race, age and standard of education, which is held by conviction and which cannot be altered by logical arguments and which are persistent.

2) This is the disturbance of the stream of thought in which thinking process appear to run too quick yet no idea is completed is known as flight of ideas.

3) Thoughts that persistently push themselves into consciousness against the desire of the patient are known as obsessions. These are strongly charged with the emotions of guilt or depression.

Check Your Progress 4

1) a) **Euphoria:** Patient has pleasant feeling of well being and is confident and assured in attitude.

   b) **Elation:** Patient feels overjoyed, self-confidence radiated from him. It is liable and often shifts to irritability.

   c) **Exaultation:** There is an intense elation accompanied by an attitude of grandeur.

   d) **Ecstasy:** It's a feeling of extreme joy and tranquil sense of power.

2) i) mania

   ii) schizophrenia

   iii) ambivalence

   iv) depersonalization

Check Your Progress 5

1) a) Confusion

   b) Clouding of consciousness

   c) Delirium

d) Dream-state

e) Stupor

2) a) **Hypermnesia:** It means exaggerated degree of retention and recall which is found in mild manic states, paranoia and catatonia.

b) **Amnesia:** It means loss of memory or inability to recall past experiences. It can occur as defense against painful experience.

c) **Paramnesia:** It is a falsification of memory well as distortions of memory also serves as protection against intolerable anxiety.

4.18 FURTHER READING

Kapoor, Bimla (2001), *A Text Book of Psychiatric Nursing,* Vol. I & II, Kumar Publishing House, Pitampura, Delhi.