Pseudo-obsessive symptoms in the endogenous psychoses:

psychopathology and differential diagnosis according to the Kleist-Leonhard-School

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Basic diagnostic differences between ICD 10/DSM IV and Leonhard's classification

DSM IV / ICD 10

Diagnosis is made by the appearance of a

minimum number of symptoms from a given symptom-catalogue which have to exist over a

given period of time.

Leonhard's classification

Diagnosis is made by the evidence of **characteristic symptom constellations (specific symptoms** form **characteristic syndromes),** which run a **typical course (prognosis).**

descriptive psychopathology

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symptom connections
(„Symptomverbindungen")
cardinal symptoms / core disturbances
facultative symptoms

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clinical entities
(„Krankheitsgruppierungen")

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nosology of mental diseases
differentiated aetiology

The Triadic System in clinical psychiatry

German tradition of psychiatry (Birnbaum, Jaspers, Kraepelin, Schneider, Leonhard)	ICD 10
organic („exogenous") psychoses primary brain disease brain dysfunction due to somatic diease	organic (symptomatic) mental disorders F0 mental and behavioural disorders due to substance use F1
endogenous psychoses manic-depression: monopolar depressions and euphorias; manic-depressive illness; cycloid psychoses schizophrenia: group of schizophrenias (unsystematic/systematic)	schizophrenia, schizotypal and delusional disorders F2 mood (affective) disorders F3
variation of human nature/personality personality disorders neurotic disorders addiction disorders sexual deviation mental retardation	neurotic, stress-related and somatoform disorders F4 behavioural syndromes associated with physiological disturbances and physical factors F5 disorders of adult personality and behaviour F6 mental retardation F7

Obsessions and compulsions: Definitions

ICD 10	DSM IV
Obsessional thoughts: distressing ideas, images, or impulses that enter a person's mind repeatedly. Often violent, obscene, or perceived to be senseless, the person finds these ideas difficult to resist.	Obsessions: persistent ideas, thoughts, impulses, or images that are experienced as inappropriate or intrusive and that cause anxiety and distress. The content of the obsession is often perceived as alien and not under the person's control.
Compulsive acts or rituals: stereotyped behaviours that are not enjoyable, that are repeated over and over and are perceived to prevent an unlikely event that is in reality unlikely to occur. The person often recognises that the behaviour is ineffectual and makes attempts to resist it, but is unable to.	Compulsions: repetitive behaviours or mental acts that are carried out to reduce or prevent anxiety or distress and are perceived to prevent a dreaded event or situation.

adopted from: PubMed Health

„Obsessive and compulsive“ phenomena in organic brain disorders

historically: organic obsessive-compulsive disorder (not included in ICD/DSM)

sequelae of
- head trauma (postconcussional syndrome F07.2)
- encephalitis (postencephalitic syndrome F07.1)
- brain infarction
- temporal lobe epilepsy

pathological laughter/crying („Zwangslachen/-weinen“): affective incontinence following brain injury

symptoms mainly part of organic personality disorder (F07): particularly in coincidence with slow thinking in a uniform way and/or circumstantiality

Tourette‘s syndrome

rare genetic disorders (neuronal Ceroid-Lipofuscinosis, Kufs disease)
Vit B12 deficiency

Obsessive-compulsive disorder: diagnostic criteria

ICD 10	DSM IV
Obsessional symptoms or compulsive acts or both must be present on most days for at least 2 successive weeks and be a source of distress or interference with activities.	Either obsessions or compulsions (or both) are present on most days for a period of at least 2 weeks. The obsessions or compulsions cause distress or interfere with the patient's social or individual functioning, usually by wasting time.
Obsessional symptoms should have the following characteristics: a. they must be recognised as the individual's own thoughts or impulses. b. there must be at least one thought or act that is still resisted unsuccessfully, even though others may be present which the individual no longer resists. c. the thought of carrying out the act must not in itself be pleasurable (simple relief of tension or anxiety is not regarded as pleasure in this sense). d. the thoughts, images, or impulses must be unpleasantly repetitive.	Obsessions (thoughts, ideas, or images) and compulsions (acts) share the following features, all of which must be present: a. they are acknowledged as originating in the mind of the patient, and are not imposed by outside persons or influences. b. they are repetitive and unpleasant, and at least one obsession or compulsion that is acknowledged as excessive or unreasonable must be present. c. the patient tries to resist them (but resistance to very long-standing obsessions or compulsions may be minimal). At least one obsession or compulsion that is unsuccessfully resisted must be present. d. experiencing the obsessive thought or carrying out the compulsive act is not in itself pleasurable. (This should be distinguished from the temporary relief of tensions or anxiety.)

Anankastic personality disorder, obsessive-compulsive personality disorder (F60.5)

A. The general criteria of personality disorder (F60) must be met.

B. At least four of the following must be present:

1) Feelings of excessive doubt and caution.

2) Preoccupation with details, rules, lists, order, organization or schedule.

3) Perfectionism that interferes with task completion.

4) Excessive conscientiousness and scrupulousness.

5) Undue preoccupation with productivity to the exclusion of pleasure and interpersonal relationships.

6) Excessive pedantry and adherence to social conventions.

7) Rigidity and stubbornness.

8) Unreasonable insistence that others submit to exactly his or her way of doing things, or unreasonable reluctance to allow others to do things.

Obsessive and compulsive symptoms
according to K. Leonhard I

Definition:

obsessive idea (alias: compulsive idea, obsession; „Zwangsvorstellung"): disorder of thought content

Intruding ideas and thoughts which are recognized as being without cause or unsubstantiated, even as absurd.
Against one's better jugdement these ideas compell the person's will to act in a specific manner.
<u>If the person resists, marked anxiety or distress appears</u> that urges the person to concede.

Obsessions usually enforce compulsive acts („Zwangshandlung") or omissions („Unterlassung"). Other activities are left undone.

Obsessive and compulsive symptoms
according to K. Leonhard II

theoretical background:

fearful thoughts are not brought to a conclusion

there remains a very last possibility, a last risk, no matter how improbable

individuals with obsessions do not ignore, but struggle with these possibilities as soon as they become aware of it

no automatism in reasoning

Classification of the endogenous psychoses

	favourable prognosis			unfavourable prognosis	
Kraepelin	manic-depressive insanity			dementia praecox	
Bleuler	manic-depressive illness	group of schizophrenias			
DSM-IV ICD 10	affective disorders	schizoaffective disorders		schizophrenia	
Leonhard	monopolar affective psychoses	manic-depressive disease	cycloid psychoses	unsystematic schizophrenias	systematic schizophrenias

Differentiated Psychopathology: essential psychopathological levels

affectivity	- „mood“ (elevated/depressed)	
	- „quality of affect“ (e.g. blunting of affect)	
thought	- formal	-- stream of thought
		-- coherence of thought/speech
	- thought content	
(psycho)-motility	- quantitative (hyper-/akinetic)	
	- qualitative	-- simple movement pattern
		-- complex motor pattern

Classification of the Endogenous Psychoses in Leonhard's Differentiated Psychopathology

monopolar affective psychoses manic-depressive disease cycloid psychoses anxiety-happiness psychosis confusion psychosis motility psychosis	**favourable prognosis**
unsystematic schizophrenias affect-laden paraphrenia cataphasia periodic catatonia systematic schizophrenias systematic paraphrenias hebephrenias systematic catatonias	**unfavourable prognosis**

Obsessive and compulsive phenomena in phasic psychoses

thought and psychomotor inhibition lead to indecision which secondary leads to anancastic tendencies:

- obsessive brooding, ruminations on various depressive ideas („Grübelzwang")
- compulsive acts („Zwangshandeln")

occurrence in:

- melancholia
- depressive episode in manic-depression
- anxious pole of anxiety-happiness psychosis

(see ideas/delusions of guilt: continous ruminating that as he did not believe in God, somebody will be killed, and acts with excessive cleansing rituals to avoid punishment)

with/without anankastic personality (disorder)

Psychoses of the psychomotor sphere

quantitative disturbances	qualitative disturbances „true" catatonias
⇩	⇩
hyperkinetic-akinetic motility psychosis	periodic catatonia systematic catatonias

Quantitative and qualitative changes in psychomotor behaviour

psychomotor hyperkinesia

increase of reactive and expressive movements

simple movement patterns	complex
harmonious with natural grace	distorted, lacking natural grace;
diversified	monotonous: iteration, stereotypy, mannerism

psychomotor akinesia

severe inhibition and loss of expressive facial movements

motor inhibition with depressed mood	reduced reactive or spontanous movements with stiffness
pure akinesia	akinesia followed by negativistic behaviour („Gegenhalten“) or isolated hyperkinetic traits

Psychomotor behaviour / Psychomotility

spontaneous movements	volitional impulse („Willensimpuls“)
reactive movements	immediate motoric response to external stimuli with quick volitional impulse (e.g. greeting, nodding, waving or other motor activity of visual attention)
expressive movements („Ausdrucksbewegungen“)	involuntary movements, which directly express affective mental states („Gefühlszustände) via facial expression and gestures

Disturbances of psychomotor behaviour I

Iteration
simply composed, repetitive movements repeated in the same way, without goal-oriented behaviour or expressive character

Stereotypy
recurrent, not goal-directed, limited movements carried out in a uniform way

Mannerism
complex motor patterns triggered by external stimuli
rituals and habits involving certain sequences of movements
resembling obsessive and compulsive phenomena but lacking fearful worries (affective link)
recurrent, static, unvaried, un-changing motor behaviour in a stiff way
movement mannerisms („Bewegungsmanieren")
movement omissions („Unterlassungsmanieren")

Disturbances of psychomotor behaviour II

Parakinesia / Grimacing
distorted, disharmonious reactive and expressive movements
absence of fluidity or loss of harmonious merging into each other of gestures and facial expression
jerky, galvanic mid-term movements;
stiff or choppy movements, abrupt movements in a stiff motion sequence

Psychomotor negativism
active resistance with characteristic opposite trend (ambitendency), e.g. alternating between desire and aversion;
e.g. head looks in another direction than would be expected from the body's stance
motiveless, appearence not related to anxiety or delusions

Proskinesis
abnormal tendency to turn towards the examiner and to begin with automatic movements as a result of external stimuli („Anstoßautomatie", „Gegengreifen", „Mitgehen")

Disturbances of (psycho-)motor behaviour III

Tardive dyskinesia
involuntary movements of tongue, jaw, trunk or extremities
spasmodic with subjective impairment (in relation to antipsychotic medication); different patterns:

- **choreiform (rapid, jerky, nonrepetitive)**
- **athetoid (slow, sinuous, continual)**
- **rhythmic (stereotypes)**

Tics
brief, sudden, simple composed, repetitive movements
spasmodic motor movements
temporarily suppressible and preceded by a premonitory urge

Diagnostic Criteria for Schizophrenia, Catatonic Type (DSM-IV 295.20; ICD 10 F20.2)

Presence of characteristic psychotic symptoms in the active phase for at least 1 week:

A (1) delusions/prominent hallucinations/incoherence/catatonic behavior/flat or inappropriate affect; (2) bizarre delusions; (3) prominent hallucinations

B functioning is markedly below the highest level achieved

Catatonia: The clinical picture is dominated by any of the following:

1. Motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor

2. Excessive motor activity (that is apparently purposeless and not influenced by external stimuli)

3. Extreme negativism (an apparently motiveless resistance to all instructions or maintenance of rigid posture against attempts to be moved) or mutism

4. Peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures), stereotyped movements, prominent mannerisms*, or prominent grimacing*

5. Echolalia* or echopraxia*

* not included in ICD10

not included in DSM IV: verbal perseveration, automatic obedience

Systematic schizophrenias: general criteria

typically: onset is often gradually and turns to a chronic course without stable remissions

(no phasic or periodic course)

in the beginning often appear unspecific, so-called accessoric symptoms (epiphenomena), e.g. depressive or euphoric mood swings, short-time delusional symptoms or hallucinations, which disappear and are replaced by the developing characteristic residual syndrome

clinically sharply distinguished symptom constellations: not only a combination of symptoms, but distinct and autonomous syndromes

development of sharply defined, stable and irreversible residual syndromes („Defektsyndrome"), which can be reliably demonstrated in each examination in their specific symptom constellation

refractory to antipsychotic treatment

specific disturbances of affectivity, thought, psychomotor behaviour as well as perception as breakdown of higher psychic systems

==> systematic schizophrenias

Clinical symptomatology of diseases of the psychomotor sphere

motility psychosis	periodic catatonia	systematic catatonias
bipolar phasic	**bipolar with residual syndrome**	**chronic progressive**
hyperkinesia: restlessness with increase in expressive and reactive movements	hyperkinesia with akinetic traits: parakinesia, restlessness with stiff motor activity, stereotypies, grimacing	**distinct subtypes involvement of discrete functional psychic units „Symptomenkomplexe"**
akinesia: rigid posture and rigid facial expression disappearance of reactive movements	akinesia with hyperkinetic traits: uniform movements, iterations, stereotypies, bizarre postures, perseveration stupor with negativism	Parakinetic Manneristic Proskinetic Catatonia Negativistic Speech-prompt Sluggish, speech-inactive
accessoric symptoms: incoherent speech/mutism hallucinations/delusions full remission after each episode	periodic onset;episodes of worsening in the course apathy, stiff movements, isolated stereotypes, or grimacing; residual state of varying severity	gradual beginning chronic progressive course without remission, refractory to treatment

Periodic catatonia

central syndrome
qualitative psychomotor disturbances

hyperkinetic pole — **mixed states** — **akinetic pole**

- hyperkinesia with akinetic traits
- psychomotor excitement and restlessness with iterations, stereotypies
- parakinesia, facial grimacing
- distorted movements
- impulsive actions

- akinesia with hyperkinetic traits
- stupor with negativism
- stiff motor activity
- bizarre, stereotype postures
- uniform movements
- perseveration

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intermittent, bipolar course with accessoric hallucinations and delusions

characteristic catatonic residual syndrome with psychomotor weakness of expressive movements, isolated stereotypies, grimacing facial movements, disharmoniously stiff or parakinetic movements and diminished incentive

Systematic Catatonias

qualitative psychomotor disturbances

Clinical subtype	Characteristic syndrome
Parakinetic Catatonia	parakinesis, bizarre expressive and reactive movements, agrammatical sentences, jumpiness of thought
Manneristic Catatonia	mannerisms within complex movements and/or omissions, progressive stiffness of psychomotor activity
Proskinetic Catatonia	proskinesis ("Mitgehen, Gegengreifen"), murmuring with verbigeration
Negativistic Catatonia	psychomotor negativism, ambitendency
Speech-prompt Catatonia	empty, meaningless facial expression, autism, short-circuiting of speech, talking-past-the-point ("Vorbeireden")
Sluggish Catatonia	extremely extinguished initiative with sluggish verbalizations, continuous hallucinations with distracted facial expression

Proskinetic Catatonia

- proskinesis: abnormal tendency to turn towards the examiner and to begin with automatic movements as a result of external stimuli

- impulse-automatism („Anstoßautomatie")
  going with reactions („Mitgehen")
  responsive grasping („Gegengreifen")

- when being addressed the patient begins to speak in an undertone and further stimulation causes murmering with verbigerations of isolated words or phrases

- stiff movements, lack of initiative

Manneristic Catatonia I

Initial course:
mannerisms resemble obsessions, compulsive actions and/or phobias, but fearful worries and thoughts disappear quickly

acceptance of the obsessions and compulsions
yielding to compulsions rather than resisting

mannerisms are more prominent than motor rigidity
increase of stereotyped attitudes
stereotyped behaviour in more or less all areas of life

affective mood swings, short-time delusions

Manneristic Catatonia II

Complete picture:
stiff and „wooden“ psychomotility (gait and facial expression)

movement mannerisms:
stereotyped kneeling, touching the floor, touching objects or other patients, turning the body before passing through a door, pushing rocks and papers off the side walk
pecularities when eating: holding a spoon in an odd manner, putting the fork down after every bite
pecularities when visiting the toilet / washing room: repetitive tooth brushing, scrubbing up, towelling himself (frequently procedure takes hours)

movement omissions:
refusing certain food, refusing all food intake, mutism, refusing body hygiene, standing on a fixed place

Manneristic Catatonia III

involuntary movements are more and more reduced
motor activity becomes stereotyped and being carried out in a fixed manneristic way; they stand stiffly and walk with choppy steps; movements are somehow unflowing, tight, and „wooden“, finer psychomotor adjustments in the flow of movements are missing

mannerisms continue as long as the rigidity has not progressed too far
whole day becomes a rigid mannerism

with motor impoverishment, movement mannerisms become replaced by mannerisms of omission

Opposition (Gegenhalten), „psychological pillow“, maintainance of given postures („Haltungsverharren“) or bizarre posturing in rest position has been seen only in severe, untreated cases

Manneristic Catatonia: Conclusion

characteristic symptoms and treatment options

acceptance of the obsessions and compulsions, increasing impoverishment of involuntary movements, rigidity of posture and movements

movement mannerisms, omission mannierisms
stiff positions and stiff facial expression
relatively preserved affectivity
no prominent thought disorder; alogical thinking

treatment of choice: modified behaviour therapy,

continuous training of activity to reduce mannerisms and to avoid omissions (prompting!)

work therapy and occupational therapy

remissions do not occur

Diagnostic representation of Manneristic Catatonia in DSM and ICD

obsessive-compulsive disorder with low insight / poor prognosis (DSM)

(schizotypal) personality disorder

schizophrenia, catatonic type

major depresssion

Eccentric Hebephrenia

severe affective blunting with gradual onset (in the beginning with compulsive features and resembling depressive syndromes)

morose, joyless affect, with querulous attitudes (not really depressive), occasionally dysphoric resentments

uniform, monotonous, and affectless speaking with complaints and demands, which are repeated in a querulous tone with no appropriate affect

complaints on hypochondriacal alienation,

monotonous wishes and grievance time and time again (e.g. for dismissal) irrespective of the listener's attidude (similar to compulsive ideas)

impoverished stream of thought, severely reduced initiative and activity

ethical blunting

eccentric affectations, monotonous habits (e.g. collecting rubbish of all kinds) and compulsive symptoms which may develop to mannerisms, but remain modifiable, susceptible of change over time;

motor activity preserved

Medical treatment of pseudo-obsessive and manneristic symptoms in subtypes of schizophrenia

in general: there exist no type-specific treatments

acute treatment

- along to the psychopathological syndrome individual treatment with antidepressant and/or anxiolytic and/or antipsychotic drugs and/or ECT

maintenance treatment

- treatment of **dysphoric resentments** with antidepressant and/or anxiolytic and/or antipsychotic drugs

- **work therapy and occupational therapy**