

2. Talk

The decision regarding which aspects of the mental state examination get a separate heading is arbitrary. Talk justifies a separate category as it occurs in all interviews and some straightforward observations can be made (on rare occasions when the patient does not talk, we make a useful observation). The word talk is chosen rather than 'speech', because speech and thought are sometimes used interchangeably (i.e., pressure of speech is sometimes referred to as pressure of thought). Nevertheless, the term pressure of speech is defined in this section. Under 'Talk', we deal with some of the mechanical aspects of verbal communication: articulation, volume, speed and pitch.

Articulation

Articulation refers to the clarity with which words are spoken. Poor articulation suggests mechanical problems - pathology may exist as upper-motor (cortical) or lower-motor (cranial nerve) lesions. A wide range of neurological disorders (i.e., Huntington's disease, multiple sclerosis), and also fatigue and intoxication need to be excluded.

Psychiatric/medical drugs may lead to articulation problems, through for example, Parkinsonism, TD, and dry mouth.

Many people with chronic schizophrenia have poor articulation. Important factors may include (as mentioned), drug induced Parkinsonism and TD. However, this disorder subtle neurological deficits (Bachman et al, 2005; Bombin et al, 2005) and the connections between the frontal lobes (executive functions) and many other regions, including the cerebellum (coordination) are frequently abnormal (Harrison, 1999). Other contributing factors may include reduced volition and lack of practice. Finally, people with schizophrenia have reduced 'theory of mind' (Pentarakis et al, 2012) meaning a reduced ability to grasp of the thinking of others. Theoretically, this reduced ability could result in failure to monitor whether or not listeners are hearing/understanding what is being said, leading in turn to a lack of appreciation of the need to speak more clearly.

Volume

Loud talk may occur in anger, or as a characteristic of an individual who wishes to make a strong impression, as in the case of some individuals with histrionic traits. More commonly in psychiatric practice loud talk occurs as a feature of mania, in which case it is a manifestation of increased energy. Finally, it may occur as a

feature of individuals who have lost the ability to monitor their social performance, as in schizophrenia and dementia.

Quiet talk may be a feature of depressive disorder, Parkinsons disease, cerebellar lesions (some but not all cases), and as a characteristic of the unassertive individual.

Rate

Rapid talk may be a feature of mania (Figure 14), anxiety and stimulant use.

Slow talk may be a feature of depression, sedation, Parkinsons disease or intoxication.

Cerebellar lesions produce two forms of rate disturbance, one, simple slowing, the other (“scanning dysarthria”) is slow with interruptions and syllables uttered with variable force.

Pressure of speech/thought/talk can be placed under different headings, and will be mentioned again in the section on ‘Thought’ under the heading of ‘flight of ideas’. There are three features:

- increase in speed of talk
- the talk is loud
- the patient is difficult to interrupted. The patient will simply ‘talk over’ (speak louder) when the interviewer is talking.

Where there is much pressure, the patient may talk when there is no one else present. He/she may be heard talking when alone in his/her room – the question may be raised as to whether he/she is talking “to voices”. Sentences may be left uncompleted, the patient passing on to different topics (flight of ideas, see later) and rhyming or punning speech.

Pressure of speech/thought/talk is characteristic of mania, but stimulant intoxication must be excluded.

Dr Sax

Re Rat Theory Swim
My view: Rats aren't
meant to swim if they
were there'd be a
Plague of rodents
running around. Its
sink or swim. &
sadly that's just
Nature.

Figure 14.

Dr Sax

Re Rat Theory Swim

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This letter was written by a middle-aged man who was suffering mania. He attended a lecture given by the author at which the Porsolt Swim Test was mentioned (a laboratory test of the time rats can swim, under different circumstances).

It is of interest from a number of points of view, including the disordered thought which makes the argument nonsensical. Another is the rushed form of writing, which increases as the letter continues – the same rush (increased rate) was present in his speech.

Pitch

High-pitched talk may be the result of fear, anxiety or excitement. Constant low-pitched talk may be the result of depression or hypothyroidism.

Dysprosody is the loss of the normal melody of talk. This occurs by definition with the constant low-pitched talk of depression. However, the term is usually applied where the lack of fluctuation in pitch is a feature of chronic schizophrenia and prefrontal-mesocortical damage.

In schizophrenia, dysprosody is often associated with disorder of affect. Where dysprosody is a feature of depression, it is expected to resolve with the remission of the episode. Where dysprosody it is a feature of chronic schizophrenia, it is unlikely to resolve (as current treatments have minimal effect).

3. Mood

Mood has been defined (Kaplan and Saddock, 1991) as a pervasive and sustained emotion, subjectively experienced and reported by the patient, as well as observed by others. There are four important elements in this definition.

- mood is “sustained” - for the healthy individual mood is usually measured in the order of hours (although environmental stimulus such as good or bad news may result in a sudden change). In mood disorder the mood is frequently sustained for months.
- mood is “pervasive” – extending influence throughout the mental life, modifying thinking and behavior. For the healthy individual, happiness is associated with optimism and energy. However, when there is pathologically depressed mood, thoughts may be preoccupied with sad events (i.e., the reawakening of grief over a deceased person) or become delusional (usually in the form of delusions of guilt, and behavior may include suicide.
- mood is “subjectively experienced” by the patient. To be certain on this point the interviewer must ask about the patient’s mood. (This part of the mental state examination, in which the patient gives verbal information, as in psychiatric history taking).
- evidence of mood is observable by others.

While many moods are described in literature, psychology and daily life, those of chief interest in psychiatry are sustained depression, elation, irritability and anxiety. Mention should also be made here of the distress experienced by sustained hallucinations, delusions and other psychotic phenomena.

As mood has a subjective component, it is necessary to enquire. Questions like ‘How have you been feeling in yourself/your spirits?’ begin to tap into mood. The response, should be clarified and recorded. It should be followed by a comment as to whether the response is consistent with the observable features. Some patients complain of depression but do not look or sound depressed, while others deny mood problems yet are outwardly depressed or elevated; inconsistency is an important finding.

Depression

Subjective experience

A variety of words may be used to describe depressed mood, including ‘sad’, ‘low’, ‘down’, ‘blue’, ‘no good’, ‘not much good’ and ‘like shit’.

Some patients deny the presence of depressed mood, even when, to the observer, it is clearly present. This may arise through a conscious decision to hide the emotion, or in some instances the patient may not be aware of depressed mood. In such cases a prominent feature/complaint may be the inability to experience pleasure or unexplained physical pain (and terms such as smiling depression or masked depression have been used in the past – but not presently).

Objective findings

Objective evidence includes slow movements, monotonous talk, sad face, immobile face, downcast eyes slumped posture and crying.

In addition to the various depressive disorders (major depressive disorder, cyclothymia, dysthymia and adjustment with depressed mood), consider common disappointment.

People suffering the negative symptoms of schizophrenia may appear depressed. In the presence of negative symptoms, making an accurate diagnosis of depression may be difficult. When there is doubt, there is little harm giving a trial of antidepressant treatment, to determine whether such treatment provides benefit.

People with personality disorder experience frequent conflicts and disappointments. They are frequently sad and claim depression. In these circumstances, it may be difficult to confirm a diagnosis of a depressive disorder, but a trial of antidepressant treatment may be beneficial.

Physical conditions to be excluded include hypothyroidism and Parkinsonism (idiopathic and drug included).

Elation

Subjective experience

Patients may admit to feeling ‘high’, ‘racing/racy’ and ‘wonderful’. They may feel they have great personal assets. (Figure 15.)

Patients may deny any mood symptoms because,

- they are not aware that their elation is pathological: “I feel fine, great, actually”, or “At last I have my old confidence back”

- they enjoy the elation and wish to avoid treatment which will reduce their 'high'.

" WHO I AM
I am a happy
person.

I love life.

I am a strong
person

I am a funny girl

I make my friends
+ family laugh

I am forgiving "

Figure 15. This was written by a young woman suffering mania. She lists her assets. When one feels so positive, it must be difficult to accept that one has a mental health problem which needs treatment.

Objective findings

The clinician should observe and record evidence of loud, rapid, continuous talk, continuous smiling, informality, colorful dress, overt sexual behavior, uninhibited talk of sex, pressure of speech, exaggerated claims of beauty, skills and competence, and grandiose plans based on those claimed assets.

Elation suggest mania or schizoaffective disorder. Exclude stimulant use and organic mood disorder (in particular, supraspinal multiple sclerosis, pseudobulbar palsy and frontal lobe syndrome). (Figure 16.)

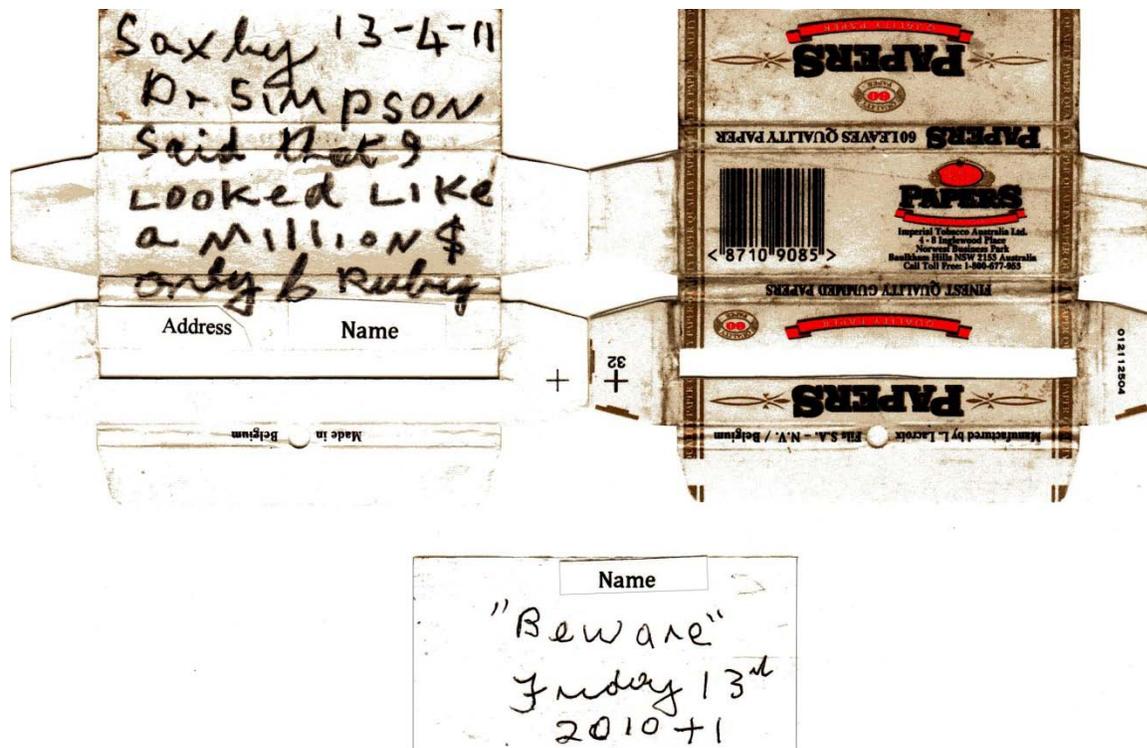


Figure 16. These two letters/notes were written by a middle aged man with mania. Many signs are illustrated. He talked continuously, he also wrote continuously. On this occasion (a Friday 13th in 2011) he had used all available paper (and paper was made freely available to him), and for a further writing surface he wrote on the inside of a cigarette paper packet. The outside of the packet is also shown. He also wrote on both sides of his last cigarette paper.

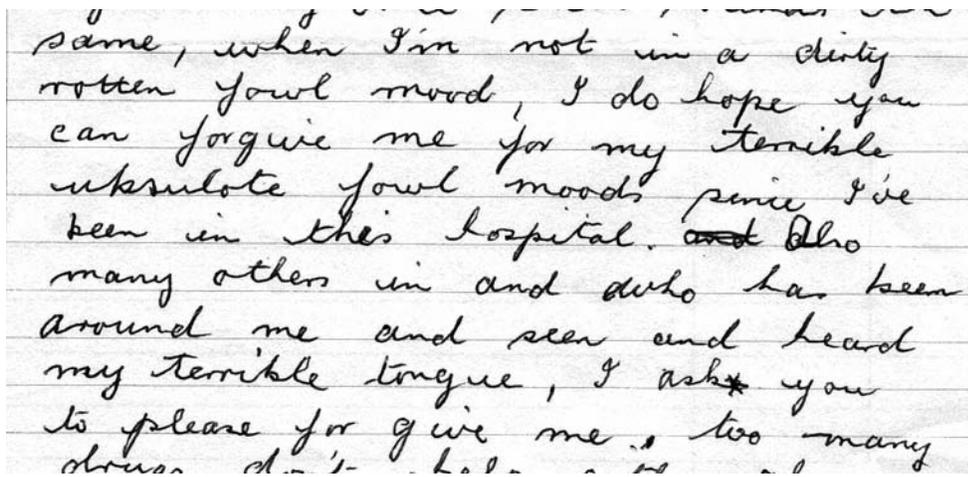
On the packet (using a blunt pencil) he commenced with the current authors given name (demonstrating informality) and doctor had said that he “looked like a million dollars” – while this conveys something of the grandiosity and elation of his mental state, he was also arguing that he was well and did not need treatment (lack of insight). The second last line (before identifying features, which have been covered), he wrote, “Only C Ruby”. Champion Ruby is the brand name of a relatively mild tobacco for rolling cigarettes. Here he was conveying that while he was a smoker, he had only ever used a mild tobacco (and this practice had not damaged his health).

On the cigarette paper, on one side he wrote “Beware Friday 13th 2010 + 1”. This was not a serious warning, but a joke (a common feature of elation). On the other side he wrote the name of a new business venture he intended to establish (a common thought during elation) – that side is not presented as it reveals his identity. Because cigarette papers are so thin, what is written on one side can be seen through and makes difficult, reading of the writing on the other side. Thus, some correction fluid was applied on the side presented.

Irritability

Subjective experience

Some irritable people will admit to feeling ‘crabby’, ‘snappy’, ‘angry’, ‘out of sorts’ and ‘hard to get along with’; most of these people will describe irritability as an unpleasant experience. (Figure 17.)



same, when I'm not in a dirty rotten foul mood, I do hope you can forgive me for my terrible absolute foul moods since I've been in this hospital. ~~and~~ Who many others in and who has been around me and seen and heard my terrible tongue, I ask* you to please for give me, too many

Figure 17. This is an abstract from one of three romantic letters written by a late middle aged woman to the author over a period of five years. Her case had never been managed by him, but they knew each other through contact on a psychiatric ward. She suffered chronic mania. Here she apologizes for episodes of irritability, “I do hope you can forgive me for my terrible absolute foul moods” and “my terrible tongue, I ask you to please forgive me.”

It is common, however, for irritable people to deny irritability and to justify the evidence of irritability on the grounds that any normal person would be annoyed by the interviewer’s persistent and stupid questions. (Figure 18.)

Tis The Season

Tis the season to be manic
Kick up your heels + have a frolic
Forget your pills + make a date
Stick the Lithium Carbonate
Midnight bathing in the pool
Down the pan with Haloperidol
Run Round + Round the pine
~~But~~ I don't take Carbamazepine
I haven't slept for days + days
I feel great and on a high
Now in Hospital I ~~to~~ lie
All full of pills + ECT.
like everychristmas,
Some Bastards signed me in here,
Still not to worry Theres always next year.

Figure 18. This was written by a young woman suffering a manic episode. Mood elevation led to light hearted poetry. This is rhyming verse, rather than clang associations (discussed under Thought) as there is an effort to get a rhythm into the lines and the rhymes have been worked out rather than have occurred automatically. The content includes the rejection of many of the known treatments (lithium, carbamazepine, haloperidol and ECT), over-activity and sleeplessness. The patient describes mood elation—"I feel great and on a high". There is a suggestion of irritability, when she refers to those who caused her compulsory detention as "Bastards". But this is immediately followed by the euphoric "Still not to worry Theres always next year".

Objective findings

Irritability is revealed by cursing or critical comments. The voice may be raised, the eyes wide or darting and there may be sighing and hissing. (Figure 19.)

Alternatively, there may be refusal to speak or enter into conversation. There may be breaking of things and in the extreme, to physical assault. More commonly the irritable patient simply looks tense and is easily startled and annoyed.

We don't even have a Tasmanian Association for Autistic Children. Do you know how "slack" this is inclined to make you? I would at least like to see a Patient Name Centre For Autistic Children so I can start doing something! And you might as well do it - That is, bet your Bottom dollar that the center is of Psychic origin or nature
Name

Figure 19. This letter was written to the author when he was in an administrative position, from a female patient of another psychiatrist. It was known that this person was the patient of another psychiatrist because she mentioned the fact in another letter. No other information is available, except the hand writing is of a style taught in schools in the 1950s, and does not seem to have "matured" much. The message does not flow well, full stops have been omitted and the word 'psychic' is used where the word 'psychiatric' would have been more appropriate. As the language and educational back ground of the correspondent is unknown, it is impossible to judge whether there is superimposed thought disorder. It is assumed the correspondent was suffering a manic episode. There is grandiosity in that she is recommending the opening of a facility to be named in her honor. There is an abrupt opening and ending, with neither the usual introductory remarks nor wishes for further discussion. Finally, there is irritability, the correspondent being unreasonably critical of the author.

The presence of irritability suggests a range of psychiatric disorders including mania, depression, paranoid psychosis and attention deficit disorder.

Also exclude stimulant use, drug withdrawal, delirium of other causes and common irritable, difficult personality.

Anxiety

Subjective experience

Anxious patients describe feeling 'churned up', 'butterflies in the stomach', 'worried', 'frightened', 'tense' and 'upset'. (Figure 20.)

Objective findings

The anxious patient is often pale, looking frightened and restless. The hands are often sweating and tremulous, clenched or touching the face or hair and straightening the clothes. There may be much clearing of the throat and difficulty with articulation due to dryness of the mouth. There may be frequent micturition.

The symptom of anxiety is present in the various anxiety disorders, depressive disorders, schizophrenia and drug withdrawal. Being interviewed about emotional matters may be sufficient to produce some anxiety in some people.

One view of agitated depression is that it represents the co-existence of anxiety and depression.

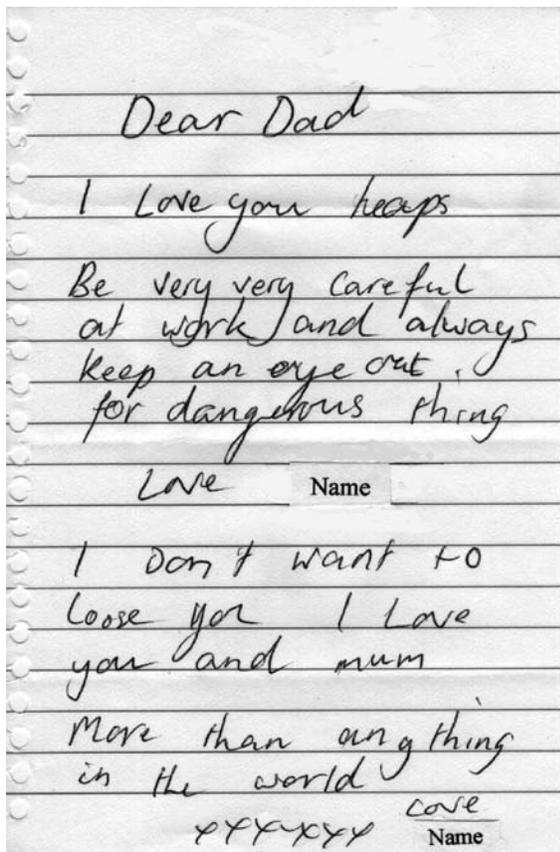


Figure 20. This letter was written by a pubescent male to his father. He (the boy) was refusing to go to school; this was damaging his education and hence, his

future prospects. This letter was initially (incorrectly) read as suggesting a paranoid state.

The boy was not afraid for his own safety, but for that of his father. School refusal is often not because the child is afraid of bullies etc (although, of course, this can be the case), but because he/she is afraid something might happen to his/her parents in his/her absence. In such cases (as in this one) the term “separation anxiety” is appropriate.

Generalized anxiety disorder is a condition of excessive anxiety and worry, without additional features.

Panic attack deserves special mention, they are a feature of most agoraphobia and other phobias, or may exist as a separate entity. Individuals who are distressed often report they have had a panic attack. However, such assertions should be examined.

Panic attacks are terrifying and have both mental/thought and physical/physiological components. They are of sudden onset, usually build up in seconds or tens of seconds, last less than half an hour, and have a distinct ending. Some patients report panic attacks which last hours with an imperceptible ending. This is probably not physiologically possible; such reports may reflect lingering fear of the panic attack, rather than persistence of the attack.

The mental/thought component is terror, with various accompanying thoughts. The most common is that the individual is about to die, usually that they will/are having a heart attack – this is suggested by palpitations, shortness of breath, sweating etc. Less commonly, individuals fear they may lose consciousness/have a seizure, or disgrace themselves by losing control of bladder or bowels, or attack others or property. Ask something like, “And, when you were having this attack, what were you thinking was going to happen?”, “What was going through your mind at the time?” Unless there is a discrete episode of mental/thought symptoms, a diagnosis is unlikely.

The experiences of derealization and depersonalization are mental experiences which occur in a range of aroused/anxious states – but are distinct from the terror discussed above. Derealization is an alteration in the perception of the world – the individual feels that the environment is different (“Everything seems unreal”) – sometimes the experience is that the world has become only two dimensional, or like a stage. Depersonalization is similar, there is the sense of strangeness about

one's body – the individual may feel like a puppet, that their body is alien or changed in size.

The physical/physiological symptoms include:

- palpitations (feeling the heart beat). As mentioned, the heart may beat so fast and forcefully that individuals may fear their heart will break. Naturally, many will consult a cardiologist and not be reassured that all is well cardiologically.
- shortness of breath. Even at rest, the individual may have 'air hunger', breathing deeply at a rapid rate, but still feeling the need for more air. This too is very frightening. (Some researchers have suggested the existence of a suffocation reflex, and that components of panic attack may be due to over-activity of an as yet undescribed suffocation center.)
- 'pins and needles' in the hands, and rarely, feet. This is a result of the over breathing liberating excessive CO₂, thus altering the chemistry of the blood and causing stimulation of long (thin) nerve cells.
- dizziness, light-headedness, unsteadiness on the legs, the feeling of being about to faint (probably a similar mechanism as described above, plus autonomic nervous system over-activity).
- increased sweating of the palms of the hands and forehead (the result of increased sympathetic nervous system activity).
- nausea, 'butterflies in the stomach', feeling of being about to vomit.
- trembling of the hands (also the result of increased sympathetic nervous system activity and probably increased circulation of adrenal released adrenalin)
- tightness of the chest, even chest pain and a feelings of choking, due to increased voluntary and involuntary muscle activity.
- chills or hot flushes. It is difficult to explain how these diametrically different experiences occur – perhaps they reflect a lability of the autonomic nervous system.

Agoraphobia (fear of leaving the home, more correctly, fear of exposed places) may present with and without panic disorder. **Social phobia** is the anxiety which arises in social situations, and **specific phobias** involve unrealistic fears about specific situations (such as lifts), or possible exposure to a feared object or circumstances (e.g., snakes, spiders). Phobias often involve panic attacks – patients are quick to tell of things/events which trigger panic.

4. Affect

The term affect is defined differently in different areas of science and even by different authorities within the same field. Influential textbooks of the mid-20th Century (Freedman & Kaplan, 1967; Kolb, 1977) made no clear distinction between affect and mood, and the recent “New Oxford Textbook of Psychiatry” (Gelder et al, 2000) does not list affect in the index.

Current opinion is, however, that affect and mood are distinct facets of the emotional state, a key element of the mental state examination (Kaplan & Sadock, 1998; Serby, 2003).

These facets of emotion are described using two dimensions; essentially time and place. With respect to time, consideration is given to spontaneous moment to moment events and sustained (at least the length of an interview, and in pathological states, as long as months) events. With respect to place, consideration is given to subjective/internal experiences and objective/external observations.

Affect is the external/objective evidence of the moment to moment emotional experience of the individual. The healthy individual experiences a flow or change of emotions with changes in topic of conversation and circumstances. From the external observations we infer moment to moment changes in the emotional experience of the individual. Components of the mental state examination such as appearance, behavior, talk, and rapport, and elements of the personality assessment in are used in the observation process. The healthy individual will provide different external information when talking of a recently deceased parent and a new grandchild. The healthy individual will display a capacity for a range of emotions (love, hate, anger, regret, hope, expectation), and to some extent, show interest and engage in the interview, and display some regard and non-possessive warmth for the interviewer.

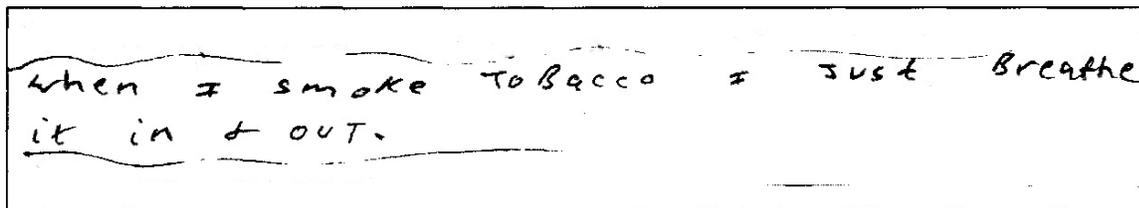
Mood, by comparison, is a sustained subjective emotional experience.

An early version of the Diagnostic and Statistical Manual (discarded from the author’s library, and thus impossible to reference) stated that affect is to mood what weather is to climate.

It is frequently necessary to assess the affect of people with depressive disorders or schizophrenia. In depressive disorders there is sustained low mood. As we all

know from personal experience, when we have suffered a significant loss, it can be difficult/impossible to be 'cheered up' (by ourselves or others). In pathologically low mood, being 'cheered up' and experiencing normal emotional responses is even more difficult/impossible. Thus, low mood puts a clamp on affect, in depressive disorder the affect may be noticeably restricted or abnormal. With remission of the disorder, however, there is restoration of affect.

Schizophrenia is characterized by positive symptoms (i.e., hallucinations, delusions) and negative symptoms (i.e., loss of the ability to experience emotions, social withdrawal, self-neglect). Damage to emotional mechanisms is intrinsic to the disorder and is reflected not only in the loss of the ability to experience pleasure, but also in abnormal affect. Such patients because of immobile face and lack of tonal variation in speech may "look depressed" but may deny depression. Often they will complain of the absence of emotions. (Figure 21.) (Of course, people with schizophrenia may have a superimposed depressive disorder, a possibility which must not be overlooked.) Unfortunately, the abnormal affect of schizophrenia is unresponsive to treatment.



When I smoke Tobacco I just Breathe
it in & out.

Figure 21. This note was written by a young man suffering schizophrenia who complained bitterly about loss of the ability to experience pleasure. He often gave as an example that he no longer derived pleasure from smoking. (People smoke, among other reasons, because nicotine causes dopamine release in pleasure center.) Here he states, "I just breathe in and out". It may be argued that many chronic smokers claim to no longer enjoy smoking, and that this is nothing unique. Having clinical experience of the patient this note is submitted as a rare written report of loss of the ability to experience pleasure as a symptom of schizophrenia.

Many labels has been coined for the classification of affect. Too many choices makes life difficult. The following trim list is recommended.

Flat affect

When the affect is flat, there is little if any change in the quality and quantity of affect with the introduction of different topics or circumstances.

Restricted and blunted affect been used as alternatives to flat affect, however, Kaplan & Saddock (1991) arranged all three in order of degree. The current author recommend using only one term: flat. The first task is to determine whether flat affect is present or not, and if it is, a comment on whether it is mild, moderate or severe may be attempted.

Occasionally the term ‘depressed’ affect is used. This is not recommended, as it presupposes a diagnosis. It is errant to use the term ‘depressed’ affect when describing a person with schizophrenia.

In addition to schizophrenia and depressive disorders, flat affect (or similar) may be found in Parkinson’s disease (idiopathic and drug induced), hypothyroidism and certain neurological conditions (e.g., dystrophia myotonica).

Inappropriate affect

Inappropriate affect indicates a set of moment to moment observed markers of emotion which is not culturally consistent with the conversation or circumstances. (Figure 22.)

Theoretically, this term could be applied where there is flat affect, but inappropriate affect is usually reserved for peculiar displays such as inappropriate mirth or anger. Obvious examples include when a patient is discussing a sad event, but displays apparent pleasure (laughter while discussing being sacked or the death of a loved person).

Caution is required with laughter, however, as it may arise high arousal. An individual embarrassed by a certain event (spilling coffee at a meeting) or discussing a painful topic may defend against distress with a laugh. (In some cultures, laughter is the appropriate funereal behavior.)

It is necessary to have some access to the content of thought before confidently identifying affect as inappropriate. For example, if an individual has a long and deep dislike for a parent, laughter at the mention of their death may be appropriate rather than inappropriate. Inability to access to the content of thought of psychotic individuals can make the use of this term problematic.

Inappropriate affect is observed in disorganized (hebephrenic) schizophrenia. There may be giggling and failure to respond with appropriate behavior to serious situations.

Rarely, patients with other forms of schizophrenia may become suddenly and unnecessarily violent. Subsequently, in discussions, such patients may show lack of remorse or distress when faced with the consequences of their actions. Appearing unconcerned, in such circumstances, may be considered inappropriate affect.

The individual with antisocial personality will display a callous disregard for the consequences of action, as may the individual with severely limited intelligence.

“Instead I fumbled along, failing miserably in an under-staffed bank, with, double the work load that I could do in one day. I was sacked. Most of the time I was in a daze and I never knew if I had served any customers accurately or not, anyway after I got my notice I was working in a Commonwealth sub-branch in Highton. For the day I was \$50 out, earlier at Corio Village I was \$500 short in the balancing of the money at the end of the day. I got determined as we were on our way to the bank headquarters, I mad up my mind that I was going to do better. As I was deciding this for a while, getting more and more determined suddenly Heaven opened and I looked up and felt and heard God laugh. It was a happy, benevolent, empathetic laughter that immediately made me feel better. I saw the laughter stream down from Heaven to me. The last thing on earth I wanted to do was laugh. I was so, so serious and I was a bit annoyed that God didn’t share my concern. Perhaps He knew something that I didn’t. Anyway getting out of the car I saw Brian Furbisher, my best friend from church. He was sitting down in the gutter underneath a sign (I think it was a stop sign).Well, when he saw me, Brian stood up and was walking across the footpath staring at me with a big smile and laughter in his eye. I said hello and looked at him staring at me until I was about ten yards past him. I think it was the most evenly contested staring match seen in Bendigo that year...”

Figure 22. This document was written by a man suffering schizophrenia who was sacked from his job in a bank because of repeated inability to balance his till at the end of the day (loss of bank money).

He writes that he was “in a daze” unsure whether he had done his work properly. This probably reflects the experience of trying to do exacting work while floridly psychotic.

He writes that he heard, saw and felt God’s laughter streaming down to him from Heaven. This is a multi-modal hallucinatory experience which is difficult to simply classify.

He is aware that he has lost money that is not his own, and that this is a serious matter. However, he does not convey that he felt significant emotional distress. The last sentence “I think it was the most evenly contested staring match seen in Bendigo that year” may appear to be a clever piece of humorous writing. Probably the correct interpretation is that it reflects mild thought disorder and the inappropriate emotional experience characteristic of disorganized schizophrenia.

Labile affect

In labile affect there are sudden and frequent changes in affect, which are culturally excessive in the given environment.

The shifts of affect are often from one emotion type to a very different emotion type. These changes may occur in response to minimal stimuli. Thus, a patient may respond to mention of a distant, moderately unhappy event with tears and great distress, and subsequently be moved by an encouraging remark to hilarity and happiness. Left alone, such a patient may display a range of affects, presumably associated with spontaneous thoughts. Labile affect is commonly described as being subjectively unpleasant.

As with inappropriate affect, labile affect may result in sudden, unnecessary violence.

Labile affect may be observed in schizophrenia, mania, mixed mood disorder (symptoms of mania and depression occurring simultaneously) and attention deficit disorder. It is also reported in the aftermath of severe psychological trauma, intoxication, substance withdrawal, dementia, and hypoxia and other causes of delirium.