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Historical and conceptual aspects of motor disorders in the psychoses

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ABSTRACT

Historical epistemology is a useful method to understand the longitudinal construction of the movement disorders in psychiatry. Four periods can be identified in such a process. The first, extending from Classical times to the work of Griesinger, included disorders such as catalepsy, crocidism, epilepsy and paralysis. The second period, stretching from Griesinger to Kahlbaum, concentrated on the study of melancholia attonita, stupor and catatonia. The third period, covering the time from Kahlbaum to WWI, witnessed important conceptual shifts such as: the transformation of madness into psychoses; the redefinition of movement and motility in psychiatry; the appearance of self-contained syndromes as dyskinesias, tics, akathisia, complex disorders like the cases of encephalitis lethargica, etc.; the advent of functional and psychodynamic explanations; and the description by Wernicke, Kleist and others of the motility psychoses. The fourth period stretches from WWI to the present and since it corresponds to the views and work reported in the rest of this Special issue it has not been touched upon in this paper. In spite of an increasing methodological refinement, empirical research is yet to clarify what is the clinical meaning of the movement disorders in the context of the psychoses and to explain whether such disorders are primary (i.e. issuing directly from the brain and parallel to the rest of psychotic symptomatology) or secondary (i.e. mediated by cognitive and emotional phenomena characteristic of the psychoses).

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1. Introduction

In most of the cultures of the West, sufferers from madness (or insanity, vesanias, alienation, lunacy, psychosis, etc.) have been reported as showing disturbances of all mental faculties (Harris, 2013; Ahonen, 2014; Simon, 1978). However, problems with emotions and actions have received less study than those of intellect. This may reflect the classical Greek belief that reason (cognition) is the defining human mental faculty (Berrios, 1985; Konstan, 2006; Visvardi, 2015). With the advent of Christianity, actions (agency) started to feature prominently as a free will was needed to understand moral notions such as culpability and sin (Osborn, 1976). The Christian view of agency started to be undermined during the 17th century by the development of automaton theories (La Mettrie, 1748/2011; Ablondi, 1998; Glimcher, 2003) and in general by Cartesian dualism (Rozemond, 1998; Uttal, 2004; Schmaltz, 2005). During the 19th century, Christian 'free will' was further threatened by Darwinism and Freudianism (McGrath, 2011; Berrios and Gili, 1995; Tauber, 2010).

Such changes in the conceptual frame of the time led to redefinition (or coining) of terms involved in the description of human movement, agency and action (conation, will, volition, motor, motility, voluntary, involuntary, etc.). These changes in turn made possible the separation of neurology from psychiatry (Berrios and Marková, 2018) and the transformation of the cultural concept of madness into the medical notion of psychoses (Berrios, 1987; Beer, 1995). For example, disorders of 'motricity' were defined as 'involuntary' and incorporated into (the new discipline of) neurology; the disorders of 'motility', were placed in the ambiguous gap between the voluntary and involuntary; and the disorders of will (action) were redefined as primary and beyond the control of awareness. It became unclear whether the disorders of movement seen in the context of madness (e.g. catatonia, dementia praecox, mania, melancholia, etc.), or the severe neuroses (e.g. obsessive-compulsive disease; some forms of tics, etc.) should be classified as involuntary, primary, etc.

1.1. Issues epistemological

The confusion created by this ambiguity continues tainting 'empirical' research. Researchers rarely declare their meta-concepts: Do they consider man as an automaton? Do they differentiate between psychiatry and neurology? Do they accept a difference between voluntary and involuntary? Do they accept the existence of non-conscious sources of action?

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Failure to make such meta-concepts explicit will make interpretation and comparison of data difficult and raise questions concerning validity. Undeclared assumptions control the choice of diagnostic instruments and also the variables to be measured. For example, should a scale assessing disorders of movement focus only on their magnitude and frequency or should there be also focus on tone, pattern, rhythm and range? Should a difference be made between 'actions' considered as secondary to delusional ideas and emotional disturbance and 'actions' viewed as primary and involuntary (e.g. dyskinesias)? Should the disorders of movement associated with 'organic psychoses' (posterior fossa tumours, infections, degenerative diseases, etc.) (Assal et al., 1998) or 'secondary schizophrenia' (Sachdev, 2010) be differentiated from the ones seen in the 'functional' psychoses? If yes, why? Is it not the case that psychiatrists are currently being taught that distinctions such as organic/exogenous vs functional/endogenous are not only obsolete but also non-sensical?

Resorting to an 'operational' solution (i.e. using a 'good' scale of 'motor disorders') does not resolve this problem. There is a difference between having the 'subjective' feeling that a scale 'captures' what it purports to measure (face validity) and setting out the theoretical arguments that may legitimize the inclusion (and exclusion) of items, what can be called the 'semantic field' of a scale. For the study of motor disorders in psychiatry it might be better to define instrument 'goodness' in terms of its semantic field (a declaration of meta-concepts) than of its statistical 'validity' or 'reliability'. Unfortunately, such a declaration requires a level of awareness of the history and epistemology of psychiatry which often enough is beyond the scope of current research practice.

1.2. Issues historiographical

A popular method in the history of medicine, particularly amongst clinicians is to consider current medical views as the absolute truth ('paragon'). However, this anachronistic approach causes distortions in the historical narrative since earlier writers holding views 'similar' to the paragon (the 'pioneers') are given far more attention than the rest. This paper will make no assumptions as to the truth or otherwise of the narratives about 'motor disorders' that have been constructed in the cultures of the West.

Historical epistemology explores the ways in which a discipline has legitimized its knowledge throughout time. When applied to 'motor behaviour', it studies the manner in which 'movement' (in all its senses) has been explained and understood.

1.3. History of motor disorders

Four periods can be distinguished in the development of Western narratives on the disorders of action seen in the context of madness. The first stretches from Classical times to the work of Griesinger; the second from Griesinger to Kahlbaum; the third reaches WW I; and the fourth, goes from then to the present.

During the last two millennia, views on movement (motion) have changed from having a broad qualitative definition (as per Aristotle) which could be indistinctly applied to the physical and biological world to a narrow quantitative one (as per Galileo, Descartes and Newton) which attempted to capture an abstract physical view of 'motion' (Lange, 1886). The mechanization of motion created the need for concepts that could capture change, mutation, reactivity, etc. in the biological world; and human action and agency. In the 17th century Glisson defined reactivity as an expression of 'irritability', a function which he considered as an 'intrinsic' feature of all tissues (Verworm, 1923; Temkin, 1964; Steinke, 2005). From then on biological movement starts to be treated as a separate phenomenon and becomes one of the sources of Vitalism, a medical narrative which was to last well into the 19th century (Driesch, 1914; Normandin and Wolfe, 2013). This conceptual shift is important for, from then on, human action could be treated both as physical and as biological movement.

1.4. First period

The first period in the history of the 'disorders of movement' in their relation to madness extends from Classical Greek to Griesinger in the first half of the 19th century. Catalepsy (*catochus*, *detentio*, *oppressio*, *morbus mirabilis*, etc.), epilepsy, crocidism (carphology, fluff picking), paralysis, etc., were disorders well-known during this period. Only catalepsy, crocidism and paralysis will be touched upon in this section.

1.5. Catalepsy

Hippocrates wrote in *Prorrhetics I*, 161: "Cataleptic crises that have a convulsive turn provoke swelling beside the ear" (p. 209, Hippocrates, 1995). Since it is now known that much of the content of *Prorrhetics I* predates the Hippocratic Corpus, it can be concluded that the clinical phenomena in question are likely to have been known since before Hippocrates. By the time of Galen, catalepsy was considered as a common condition and explained as a disorder of the '*Hegemonikon*' (Kobusch, 1974) or commanding or authoritative faculty: "Next would be to go through the damages of the authoritative functions, and first those of the imagination. Of this also there is something akin to a paralysis, which is termed unconsciousness (*karos*) or catalepsy (*katalepsis*); something akin to an abnormal or defective movement, which is called delirium (*paraphrosyne*); and something akin to a deficiency or weakness, as in comas (*komata*) and lethargies (*lethargiai*)..." (p. 191, Galen, 2006). The same can be found in Soranus: "The characteristic signs of the disease in question, that is of *catalēpsis* or *catochē*, as the Greeks call it, are as follows: acute fever, loss of voice, blunting of the senses, a large, strong, full, and moist pulse, and a fixed and steady gaze. It is a swift or acute disease, even though it may supervene upon a chronic disease. And it is a serious disease and is found to occur in connection with a condition of stricture and bodily seizure (Greek *spasmos*) ... "(pp171–173, Caelius Aurelianus, 1950).

Similar views can be found in the copious literature on catalepsy written well into the 18th century. As the notions of symptom, sign, syndrome and disease begin to be redefined during this period, a debate ensued as to whether catalepsy was a syndrome or a disease (similar to the debate on catatonia during the 20th and 21st centuries) (Ungvari et al., 2010). For example, Ehlen (1753) explores the clinical and therapeutic aspects of catalepsy and reports the famous case of the Renault sisters, also written up by de la Mettrie (1737) as a shared pathology *avant la lettre*. Sagar, Linné, Vogel, and Cullen included the condition in their nosologies under the terms of catalepsy, catoche or catochus (Cullen, 1803).

Interest in catalepsy did not diminish during the 19th century as attested by major monographs by Gauvain (1814), Bourdin (1841), Puel (1856), Levasseur (1866), Gérard (1868) and Le Meitre (1895) who linked catalepsy to a variety of psychiatric disorders. At the end of the century, Tuke (1892) wrote of catalepsy: "An intermittent neurosis, characterised by the patient's inability to change the position of a limb while another person can place the muscles in a state of flexion or contraction as he will (*flexibilitas cerea*). The patient is unable to speak. Insensibility is a common, but not essential, symptom. The mental functions are to a great extent or altogether suspended in relation to the external world. In complete catalepsy the individual retains no knowledge of what occurred during the period of the disorder." (p184). In clinical and conceptual terms, catalepsy and what Kahlbaum (1874) reported as catatonia seem to overlap partially (Berrios, 1981a, 1981b).

1.6. Crocidism

Since the Classical era, crocidism or carphology have named the act of 'picking' (usually hallucinated) bits of fluff or other material from the bed covers by subjects suffering from an acute confusional state, acute brain syndrome, acute organic psychosis or delirium. These movements were defined as involuntary, spasmodic and automatic, and claimed to predict

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