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In the handout are represented the man parts of the general psychopathology and specific psychiatry according to the international classification of diseases (ICD-10) and new approaches in psychopharmacotherapy.

It will be useful for foreign students of medical high schools.

PROLOGUE
THE SUBJECT AND PROBLEMS OF PSYCHIATRY

Translated literally from Greek, 'psychiatry' means the science of treating the soul (psyche - soul, iatrea - I treat). Psychiatry studies clinical, pathological, social and biological aspects of mental diseases, means of treatment and prevention of mental disorders, a system of organization of psychiatric aid, questions of expert examination (military, forensic, labor, pedagogical) as well as the social and legal situations of patients.

The development of psychiatry leads to separation of the following branches – child, forensic, military psychiatry, labor expert examination, psychohygiene, psychopharmacology.

The psychiatry course is divided into two areas, studied in order - general and specific psychiatry.

**General Psychiatry** includes the following areas - general psychopathology, a study of the etiology and pathogenesis of mental diseases, classification of mental diseases, general principles of treatment and prevention.

General psychopathology studies the basic concepts of mental disorders. It includes general topics of diagnostics, studies causes and conditions of onset, tendencies in the course of mental diseases, symptoms and syndromes of psychoses and borderline states, their structure and systematism.

**Specific Psychiatry** studies separate (specific) nosological forms, their etiology and pathogenesis, diagnostics and differential diagnostics, treatment, questions of labor, military and forensic expert examination.

Any time the disease affects the whole body, so every doctor, particularly general practitioners whom often applied patients or their relatives, in general examination should pay attention to the patient’s mental condition. So only in case of psychiatric knowledge mental disorders can be timely diagnosed and treated.
CHAPTER 1

History of Psychiatry

Mental diseases have been with Man ever since he had the ability to reason. The attitude of society towards mentally ill people has been different in various countries and in different times. On the basis of studying the social organization of aid to the mentally ill as well as the scientific and ideological bases in psychiatric theory, it is possible to conditionally distinguish the following periods in the development of psychiatry.

Since ancient times, before schools of medicine were established in Greece (hellenic medicine), people would explain the behavior of the mentally ill using primitive theological approaches, which ruled out the possibility of offering the person any help.

Hippocrates, who lived in the V and IV centuries B.C. was the first scientist to propose that mental disease depends on disturbances in the functioning of the brain. Instead of lighting incense to the gods he suggested concrete interventions involving the patients themselves, e.g. rest, diet, baths, cold water, light motion, gymnastics, emetic and laxative drugs.

In European countries, a religious and mystical attitude rose towards patients with mental disorders, which led to mass persecution and their burning at the stake during the Catholic Inquisition. Along with this there was the organized social isolation of the mentally ill (obligatory in nature).

The XVIII Century is called the epoch of Pinel in France (1745-1826), who removed the iron chains from the mentally ill. This, along with the general progress in society and science, allowed the provision of medical aid to the mentally ill as well as a scientific study of mental diseases. Esquirol worked towards developing Pinel's ideas, and he set up the first colonies for the mentally ill, and wrote exceptional scientific works on the classification of mental disorders, about monomanias and pathologies of perception.

In the 19-th century English doctor Conolly and German psychiatrist Grisinger managed to arrange the qualitative improvement of many of psychiatric institutions, which helped the scientists to systematize the knowledge and experience that had accumulated, propose scientific classification of mental disorders and organize teaching of mental diseases.
During the XIX Century the forms and methods of providing psychiatric aid improved, and the network of psychiatric institutions, hospitals and clinics broadened; there were departments of psychiatry set up to teach doctors, prepare scientific research, monographs and textbooks. As a result of this process, the nosological direction of thought formed the theoretical basis of clinical psychiatry, and it was largely due to the work of German psychiatrist Kraepelin.

During this period in the field of psychiatry started the formation of different branches of psychology by the head of Freud (1856-1939). He gave the theory of the structure of psyche and founded psychoanalytic psychology. In the future Adler and Yung developed his theory.

 Constitutional-genetic branch was founded by Crechmer, who confirmed hereditary of diseases. During XIX-XX centuries Russian psychiatric school by the leadership of Korsakoff formed psychoprofilactic, psychohygenic branches. The studies of Sechenov, Pavlov, Orbeli and others contributed future researches of the mechanisms of functioning of the brain and development of physiology into psychiatry.
CHAPTER 2

General Psychopathology

2.1 Disorders of perception.

Sensation is the first stage of cognition, which reflects the separate sides, characteristics, qualities of objects and occurrences, which directly stimulate the sensory organs. Perception integrates reflection of characteristics of objects and occurrences as whole. With the help of perception a man can feel, see, hear the surrounding world and can recognize it. Disorders of perception are divided into three groups – illusions, hallucinations and psychosensory disorders.

**Illusions** - is distorted perception of real existing objects and occurrences. Due to physical rules Illusions can be physical, for example crooked spoon in the cup of water.

*Affective illusions* are influence of affects – the fear, anxiety. For example, in darkness a man under the affect of fear can perceive a stone as an animal or, hanging clothes as one’s image. Affective illusions may appear during maniacal or depressed conditions, when patients perceive the faces of surrounding people as happy and smily or sad and melancholic.

*Verbal illusion* is a wrong interpretation of the meaning of words, speech of other people. Patient may hear threats, curses as if referring to him, while the speech is neutral for patient.

*Pareydolical illusions* occur as disorders of consciousness, when the actual images are perceived as different, usually as strange-fantastic shapes. For example, the design on wallpaper is perceived as moving animals.

Illusions can be classified according to the sensory organs (visual, audial, olfactory, taste, tactile).

**Hallucinations.**

It is a disorder of perception without a really existing object. These hallucinatory feelings are real for the patient. Patient has no critical attitude to his condition.

Hallucinations are divided in accordance with the organs of sensation (auditory, visual, olfactory, tasting, tactile, visceral, kinesthetical). According to the level of complexity there are *simple* and *complex* (combined) types of hallucinations. During simple hallucination only one analyzer is in-
involved in the process. The example of simple hallucinations are elementary photopsies (sparks, flame) and acousmas (whistle, crack, noise). During complex hallucination the patient hears formed phrases, sees visual images (several analyzers are involved in it).

All hallucinations are divided into true and false (pseudo hallucinations). During the true hallucinations, patients perceive the hallucinatory forms from the surrounding world. They hear voices from outside, they see horrorful images, animals, feel bad smell and patients are sure about reality of these feelings. They think that others also perceive the hallucinatory images.

In case of pseudohallucinations the hallucinatory feelings are coming from inside the patients body. For example, patients hear “voices” from the head, from the abdomen. In case of pseudohallucinations patient feels, that this feelings have “maden” character, with special meaning, from outside forces. Patient says, that this feelings have artificial character, but they don`t have critical attitude to this condition.

Verbal hallucinations often express as pathological perception of some words, speeches, talks by patient.

Antagonistic – patient hears speech with opposite context, for example, through one ear he hears an order to do something and with the other – not to do, or one voice suggests eating the food, the other says “don’t eat, it’s poisoned”.

Imperative hallucinations – are distinguished by command tone. Sometimes voices order to commit actions which are dangerous for patient and others. In such cases patient can have aggressive behavior, because he has no incite.

Commenting hallucinations – are commented the patients’ behavior.

Functional hallucinations are expressed when one of analyzers is stimulated. Then turning on the ventilator, the patient hears talking in its noise, when turns it off, he stops hearing voices.

Visceral hallucinations – feeling of different types of animals, subjects in the body.

Hypnagogic visual and auditory hallucinations are rising during falling asleep in transitional period from awaken to dreaming.

Hypnapompic hallucinations are rising during waking up period.

Extracampine hallucinations are out of “sensory field” of the given receptor. So, for example, visual hallucinatory images are out of the patient’s visual sphere, they are often in the backside of patient.
Tactile hallucinations - patients feel as if insects are crawling under the skin, which is often accompanied with itching and burning. Sharl-Bonne’s hallucinations are the result of damage to one of analyzers. For example, deaf person has auditory hallucinations, blind - has visual hallucinations. Hallucinations can be suggested (for example, in hypnotic sleep). Types of suggested hallucinations are Lipman’s and Reyhard’s symptom (visual hallucinations), Ashaphenburg’s symptom (auditory hallucinations).

Psychosensory disorders.
Cenesthopathy is an unpleasant sensation in different parts of the body which is not connected with somatic disorders. Metamorphopsia – is disorder of perception of object’s shapes and size, expressed in macropsia (increasing of size) and micropsia (decreasing of size) shapes. Dismegalopsia – surrounding objects perceive prolonged, wide, convulted around their axis. Poropsy – is disorder of perception, which is expressed by changing of perception of distance from the object to the patient. Derealization – is psychopathological condition and characterized by hard feeling of losing reality of the surrounding world. During derealization the surrounding objects are perceived as changed, strange, lifeless. Buildings, trees are moving, faces of people change the shapes, everything is dark and unlike. Symptoms of de`ja vu (have already seen) and jamais vu (never have seen) refer to derealization. Depersonalization – is characterized by losing of feeling of own personality, splitting of personality. Patient feels, that his personality is changed, there are two personalities, one is working as usual and the other one is looking after the first one. Usually it is accompanied with disorder of body scheme. Autometamorphopsia – is distorted perception of shape or dimension of own body. For example, it seems to the patient, that his head becomes huge or small, that extremities have different length, the body is deformed (dismorphopsyp), turned around its axis(dismegalopsy). Sometimes there can be feeling of absent part of body (phantom feeling) and in severe cases pain of this part.

Hallucinoses
The condition characterized by plenty of hallucinations within one of analyzer and it is not accompanied with disorder of consciousness. Mainly
these are auditory hallucinations – monologues, dialogues, sometimes they can have commanding character.
CHECKING TESTS
1. Illusions may occur in
   a) ill people
   b) healthy people
   c) children
   d) all mentioned above
2. All mentioned are illusions, except
   1) affective
   2) real
   3) false
   4) verbal
   5) pareidolical
   a) 1,2,3  b) 3,4  c) 2,3  d) 1,4,5
3. Affective illusions may occur
   a) in state of indifference
   b) in affective condition
   c) after sleep
   d) none of mentioned
4. Verbal illusions may occur
   a) in dark place
   b) in case of isolation
   c) in case of disorientation
   d) in case of real speech
5. Pareidolical illusions occur
   a) in case of consciousness disorder
   b) in case of memory disorder
   c) both of mentioned
   d) none of mentioned
6. Hallucinations are characterized by
   a) distorted perception of really existing objects and occurrences.
   b) perception of none existing objects and occurrences
   c) occur only in elder people
   d) none of mentioned
7. Pseudohallucinations are characterized by
   1) madden character
   2) situated in inner organs or in the head
   3) occur in clear consciousness
   4) occur in case of disorder of consciousness
   a) 1,2,3  b) 1,2  c) 1,2,4  d) 2,3
8. Type of suggested hallucinations is
   a) Sharl-Bonne’s hallucinations
   b) Reyhard’s symptom
   c) extracampine hallucinations
d) functional hallucinations
e) acoasms
9. All mentioned are psychosensory disorders, except
a) cenesthopathies
b) photopsia
c) metamorfopsia
d) disorder of body image
10. All the following characterize derealization, except
a) unreal character of surrounding world
b) déjà vu
c) jamais vu
d) feeling of changeness of own personality
11. Cenesthopathies are characterized by
a) distorted perception of own body’s shape and size
b) unpleasant sensation in inner organs and whole body
c) hyperesthesia or hypoesthesis
d) all mentioned

Answers: 1. d, 2. c, 3. b, 4. d, 5. a, 6. b, 7. a, 8. b, 9. b, 10. d, 11. b

2.2 Disorders of Memory

Memory is the reflection of life experience in consciousness, and is characterized by perception, fixation and reproduction (call to mind) of information. The strength of memory is connected with concentration of attention, interest of information and from somatic condition.

There are also distinguished mechanical, visual, auditory, emotional and logical memories. Mechanical memory is based on frequent repeating of the same facts, emotional memory is based on the storing of information related to intense emotional experience.

There are distinguished short memory (information retains from seconds to an hour) and long-term memory (information stored in memory for many years), which is source of knowledge, experience and skills for person.

Disorders of memory are:

**Dismnesia** – these are different types of hypomnesias – difficulties of perception, fixation and reproduction of information.

**Amnesia** is partial or complete loss of memory.

The following types of amnesia are described:

**Retrograde amnesia** – events which precede disease slip out of memory.
**Anterograde amnesia** – is losing memory of events, which is immediately followed after the onset of disease, for example after craniocerebral trauma.

**Fixated amnesia** – loss of ability to fix information.

**Progressive amnesia** – is constantly increasing loss of memory, when current events slip out of memory first, long term events store longer relatively or slip out of memory in later. This is called “Ribo’s law” or “law of regress of memory”.

**Retarded amnesia** – information is kept after the event, but sometime after it forgets.

**Regressive amnesia** – in this case forgotten information is re-called in memory.

**Katathym amnesia** – expressed by amnesia, that is connected with strong emotional feelings.

**Amnestic aphasia** - is disorder of memory, when patients forget the names of objects, but remember their purpose and how to use them.

**Amnestic disorientation** – due to rough disorders of memory, patients lose orientation in place, time, and situation.

**Paramnesia** – is wrong, false memories. The following forms of paramnesia are distinguished:

**Pseudoreminisence** – is filling of defect of memory by past events.

**Confabulations** - is filling of lack of memory by made up events, which have fantastic character and have never taken place in patient’s life.

**Kryptomneses** – is disorder of memory, patient cannot distinguish facts and events, which really have taken place, from the events, which patient heard or read before, or saw in dream.

**Pseudologia fantastica** – it is false memory, patient is making memories (which didn’t happen), in order to attract attention of surrounding people. This condition is typical for hysterical personality.

**Korsakoff’s syndrome.**

This syndrome is described with fixation amnesia, confabulations, pseudoreminisence, retrograde amnesia.

Korsakoff’s (amnestic) syndrome is typical of alcoholic psychosis, organic disorder of the brain (tumors, senile psychoses, infections, intoxication psychoses).

**CHECKING TESTS**

1. Retrograde amnesia is
a) Impossibility to remember current events
b) impossibility to remember events after out coming from unconscious condition
c) impossibility to remember events before out coming from unconscious condition
d) all mentioned
2. All mentioned are disorders of memory, except
a) dismnesia
b) confabulation
c) déjà vu
d) kriptomesia
e) anekforia
3. Which one is false memory
a) retrograde amnesia
b) confabulation
c) jamais vu
d) retarded amnesia
4. All mentioned are paramnesias, except
1) pseudoremnesence
2) kriptomesia
3) confabulation
4) dismnesia
5) amnesia
a) 1,2,3   b) 2,3  c) 4,5 d) 2,4,5
5. Which one is hypomnesia
a) paramnesia
b) dismnesia
c) pseudologia
d) amnesia
6. All mentioned are included in Korsakoff’s syndrome, except
a) confabulation
b) fixated amnesia
c) retarded amnesia
d) pseudoremnesence

Answers: 1. c, 2. c, 3. b, 4. c, 5. b, 6. c

2.3 Disorders of intellect.

Intellect and mind are man’s cognitive activities, they include knowledge, gained experience and ability for their further acquisition and usage in practice.
Intellect is not an independent function, it summarizes cognitive processes: abilities, intellectual (ability) efficiency, memory, attention, and thinking. Social factor plays an important part. The abilities of a man play a great role in helping him to get knowledge and acquirements faster and easier. Combination of different abilities characterizes man’s endowments (for example, man has outstanding natural gifts for mathematics, languages and music). The main condition in the development of the intellect is the intellectual efficiency. It’s well-known that most talented and genius people have a great capacity for work.

Disorders of intellect may be congenital (ICD-10, mental retardation, ICD-9 oligophrenia) and acquired (dementia).

**Mental retardation** is a condition of impaired or incomplete development of mentality (mind). It is characterized by disorders (disturbances) of cognitive, speech, motor and social capabilities which supply intelligence and their disturbances give rise to disorder of adaptive behavior.

There are a lot of reasons for mental deficiency. Cerebral affection of the fetus as a result of severe pregnancy toxemia, chromosomal abnormality, metabolic disorders of pyruvic acid (phenylketonuria, phenylpyruvic oligophrenia), German measles, Rhesus factor, parents’ severe infectious disease, parents’ acute alcoholism etc. Severe infection, intoxication, brain injury in childhood can also cause retardation of the mental development.

There are 3 types of mental retardation - slight mental deficiency (moronism), moderate mental deficiency (imbecility), strong mental deficiency (idiocy).

**Slight mental retardation** (moronism). In presence of slight mental deficiency the development delay of the speech habits takes place, but most of these children have an opportunity to use their speech in different conditions of life, to take part in clinical discussions, look after themselves (washing, dressing, food intake etc.), and helping in the house.

As a rule, such children have poor progress in studies, especially while learning reading and writing. They often attend specialized institutions with the aim of developing different skills (habits) and compensatory abilities. In most cases it is possible to place them in a job in which the practical or manual part is more important such as non qualified or semi qualified manual work. During emotional and social immaturity their place in social life becomes limited. For instance, they are not able to deal with family life and upbringing in general they are often confronted with difficulties getting used to the cultural standards and traditions. Such kind of people have restricted stock of words (their vocabulary is about 2000-
3000 words), the memory is mechanical and it is difficult for them to calculate (it is easier for them to deal with additions and subtractions), their thinking is concrete, it’s difficult for them to draw conclusions and generalizations, figurative meaning of proverbs is not always clear, they cannot distinguish the main sense from the secondary one. They are suggestible, quick-tempered, quick to take offense, unforgiving, they may be aggressive but at the same time they work hard which helps them to adapt to life (social adaptation).

Moderate mental retardation (imbecility). The stock of words of the imbeciles is poor (200-300 words), pronunciation is wrong, they cannot count, distinguish colors, they are not able to attend any kind of school. It is also difficult for them to do common work/labor. Imbeciles need care; they are strongly attached to their parents and to their carer. Their attitude towards such people is positive but with others they can be malicious and aggressive.

Strong mental retardation (idiocy) is often accompanied by anomaly. There is a lack of speech in this case. Patients emit inarticulate sounds. They only satisfy their biological needs (they cry when they are hungry or need care, bite their fingers, scratch the face).

Idiots may be torpid and lethargic (for the most part they sleep) or they always cry and shout, extremely restless in bed.

Dementia (from Latin de – prefix, which means lowering, moving down + mens – mind, intellect) – is acquired dementia. Dementia is expressed by steady weakening of mental abilities, intellect. It is developed with disease of Alzheimer, Pick, progressing paralysis (paralytic dementia), epilepsy (epileptic dementia), malignant forms of schizophrenia (schizophrenic dementia), brain injury (traumatic dementia), senile psychoses (senile dementia), frequently with atherosclerosis and hypertonic diseases. Dementia can be total and lacunars (partial). Total dementia is characterized with steady weakening of all intellectual functions, weakness of judgements, conclusions, complete absence of critical evaluation of self condition, disorders of acquiring and learning ability, rough disorders of memory, ethical norms, moral. Such kind of patients are hypersexual, voracious and euphoric. Total dementia is observed with progressive paralysis, senile psychoses.

Lacunar dementia expresses with disorders of memory and attention. The other intellectual functions suffer in second turn. Such kind of patients lose the ability of counting, remembering dates, names, current events, active attention quickly becomes weak, irritative. Patients retain the critical
attitude to their condition, they cannot learn the new information, but the old one, especially professional, they retain for a long time. Lacunar dementia is specific for cerebral arterioscleroses, hypertonic diseases, tumors, syphilis of brain.

Today we use the calculation of the intellect quotient (IQ) to determine its level. The formula is

\[
\text{Psychological (al) age} \times 100 \\
\text{Passport age}
\]

According to Izenk, in 200 examined children it was found that the IQ of one of them turned out to be more than 140 and the IQ of another one was less than 60 (mental deficiency). The IQ of the rest of the children turned out to be within 90-110.

**CHECKING TESTS**
1. All are etiological factors of oligophrenia, except
   a) alcoholism of parents
   b) infection disease during pregnancy
   c) chromosomal abnormalities
   d) young age
2. Dementia is characterized by all mentioned symptoms, except
   a) decrease of intellectual abilities connected with different illnesses
   b) lost of knowledge and skills
   c) clinical features change in case of different disease
   d) treatment is possible by using antipsychotics
3. Epileptic dementia is characterized by all mentioned, except
   a) memory disorder
   b) circumstantiality of thinking
   c) emotional weakness
   d) decrease of vocabulary
   e) slowness of movements
4. Dementia in Alzheimer’s disease is characterized by all mentioned, except
   1) amnesia
   2) aphasia
   3) ambivalence
   4) apraxia
   5) amentia
   a) 2.3 b) 3.4 c) 4.5 d) 1.3.5 e) 3.5
5. Partial dementia is typical of
   a) schizophrenia
   b) epilepsy
c) atherosclerosis of brain vessels  
d) senile psychosis

**Answers:** 1.d, 2. d, 3. c, 4. e, 5. c

### 2.4 Thinking Disorders

Thinking is the highest form of reflecting reality. It is the mental function which realizes analytical and comparative activity and enables a person to reveal similarities and differences between objects and phenomena (events), to differentiate primary and secondary properties of a phenomenon, to summarize and concretize, to formulate statements reflecting the significant features of objects and phenomena (events) as well as to come to certain conclusions. In fact, thinking is an analytical and creative activity. Thinking can be exact and subjective or abstract and logical. The main means of externally expressing thought is through speech.

Thinking disorders can be divided into 2 groups:

1. Associative process disorders
2. Contextual disturbances of thinking (also called disorders of content and conclusions)

**Associative process disorders.** Associate process disorders are - disorders of the rate (or speed) of thinking, which is manifested as acceleration and inhibition of associative process. *Inhibition of associative process* – notions and ideas become poor, associates reduce in speed and slacken. Patients do anything requiring mental work with difficulty. They understand the meaning of anything said to them very slowly. They answer questions late and slowly, using very few words (often only 'yes' or 'no'). Such disorders can be seen in depressive states.

*Acceleration of thinking* – there is the stimulation of thinking and an abundance of thoughts and ideas. Patients are talkative; their speech is rapid and hurried. They start to reason superficially. The patient's attention is diminished and he is distracted – everything that exists around him at that point attracts his attention and is reflected in his thoughts and speech. Thus, a condition – called flight of thoughts “fuga idearum” – can develop when the patient speaks about something and then moves on to another topic without finishing the previous thoughts and then again about something else, so that it becomes impossible to follow his thoughts and understand
him. This disturbance is typical of manic states (accompanied with an elevated mood).

Splitting of thinking (schizophasia) – In this case there is no logical link between two thoughts, although the thoughts themselves may be correct. The sentence is grammatically correct in its construction, e.g. "I feel bad as the weather is good" or "I am ill because I used to read a lot in my childhood" etc. In such cases the patient has clear consciousness.

Arrest of thoughts (sperung) – The patient states that "at this very moment, it is as if his head was emptied of thoughts or his thoughts seem to have come to a barrier and it is impossible to continue."

Autistic thinking – The patient is isolated from reality. He lives with imagined thoughts, ideas and feelings. This is a new and specific form of thinking. In this disorder, the patient can be self-absorbed and indifferent to reality. Contact with them is very difficult. In some cases, even if they manage to be contacted and talk to the doctor, it is impossible to find out their thoughts and feelings, which remain a part of their inner world. They give some vague answers and avoid the question. They hide their inner feelings. This is a characteristic symptom for schizophrenia.

Symbolic thinking – The patient sees sense in things and events known only to him. For example, the number of buttons on the doctor's white coat shows the patient how many days he has remaining to live or the green color (or some other color) speaks about some tragedy or danger that is expected. Symbolism may also be expressed in the patient's written speech.

Perseveration – This is the repetition of something which has already been said – words, phrases or sentences. Such patients are able to correctly answer only the first question that is asked, after which they repeat the same answer (sometimes for a very long time). For example, a patient is asked: "How are you?" "I'm well" he replies. "How long have you been in hospital?" "I'm well" and so on.

Philosophical thinking (reasoning) – The patient's thinking seems to be logical, but in its context it is commonplace and plain (empty or meaningless). This thinking is not purposeful, not exact and not productive. For example, the patient wants to express his opinion about an important topic and uses many terms and formulas (within the limits of his intellectual capabilities) but is unable to come to a certain conclusion to express his basic thoughts. The patient can philosophize very plainly about a topic which is clear to everyone and does not need any new explanation. The patient can also philosophize about a complicated topic that may be important, even if he does not have the most basic knowledge in that field. Unable to prove his super-
ficial ideas with facts, the patient complements his speech with many words.

*Mentism* (flow of thoughts) – This is a flow of ideas which seems strange to the patient. The patient says that thoughts come into his head independent of his own will and have an obligatory character. That patient is unable to regulate them. This disorder is part of the Kandinskiy-Clerambault syndrome.

*Incoherent thinking* – In this case, both the logical and grammatical structures are impaired in the patient's speech. The speech is composed of words which aren't connected logically and grammatically e.g. "patient, table, it's fine weather, sleep" etc. In such cases the patient's consciousness is impaired. This is typical of amnesia, which is a serious impairment of consciousness. Such a group of words is called a word jumble (word salad).

*Pathological circumstantial thinking* – Thinking becomes adhesive or viscous and associative processes are slow. The patient has difficulty expressing his thoughts. He moves from one thought to another with difficulty because it is not easy for him to create new associations. A very characteristic feature of this state is that patients do not differentiate primary ideas from secondary ones or the main features of objects and phenomena from secondary ones. In other words, the patient's speech is needlessly detailed, making thinking unproductive. This disorder occurs in organic pathologies and epilepsy.

**Disturbances of Thinking Content.** Delusional ideas, obsessive-compulsive disorders and overvalued ideas belong to disorders of thinking content.

**Delusions** are wrong conclusions made on a pathological basis, which do not undergo any correction through speech, i.e. one cannot persuade a patient that the ideas he has are wrong. The patient lacks a critical opinion (or insight) towards his thoughts and the patient is sure of his unhealthy conclusions and denies any proof or fact that contradicts his thoughts. The delusions are so real and stable for the patient that they completely control his behavior and activity. Delusions are always pathological symptoms and can never be present in a healthy individual. Delusions can be primary and secondary. The basis of the primary delusions are facts, events, which interpreted in a wrong way, these delusions are progressing and becoming systematized. Primary can be delusional ideas of jealousy, love, hypochondria, high origin, reform, persecution.
Secondary delusions are formed on hallucinations, psychosensory disorders and emotions. These ideas are not systematized; they are changeable due to hallucination or other disorders. According to their content, delusions may be:

**Delusions of relation** – The patient is sure that everything going on in his surrounding (events, other people's behavior, speech etc.) concerns him and is directed against him. Everywhere he sees and hears remarks, threats and signs addressed to him. For example, if there are two men at a bus-stop he is sure they are there for him and are talking about him. If anybody asks him a question, he thinks they are teasing him. Such people stop going to public places and do not use public transport as they are sure of being followed – as soon as they appear somewhere, they think that everyone looks at them in a different way (suspiciously, thinking bad things about them).

**Delusion of persecution** – The patient is sure that some apparent enemies are always following him and aiming to harm him or destroy him physically. These enemies can be separate people (known and unknown organizations, state organs etc.). For example, the patient is certain that the police or national security service are pursuing him. Such patients are always alert and tense, trying to protect themselves by all possible means. Sometimes they themselves begin to persecute the people whom they suspect. The patient can even say that the "persecutors" can rush into the hospital through different means, e.g. by pretending to be ill, and can harm him there as well.

**Delusions of influence** – The patient thinks that he is affected by "a magnetic field, cosmic rays, electric current" etc. This influence, according to him, is realized by special equipment and devices. He can state that he is always under this influence, that in this way both his physical and mental states are being affected. He may think that others are trying to take away his thoughts or control him. The patient can also state that others are trying to influence him using hypnosis and causing unpleasant feelings in him.

**Delusion of poisoning** – The patient is pathologically certain that someone is trying to poison them through any means, e.g. by adding poison to his food, by poisoning his medicine, by filling his house with poisonous gases etc. Such patients refuse to take food and prepare everything themselves. They become extremely cautious in everything. Sometimes they stop buying food in the shop where they always did, thinking that their enemies can poison the food items there.

**Delusions of jealousy** – The patient is sure that their partner is committing adultery. He gives a delusional interpretation of neutral facts and events.
which is baseless. He displays unhealthy behavior, all the time looking for proof of adultery. He is also capable of acting very aggressively e.g. the patient says, "My wife goes out to the balcony very often, supposedly to water our flowers, but I know that she is giving a secret signal to her lover about when they should meet" or "The door mat is not in its usual position so it's obvious that someone was in our house during my absence and I know that it was my wife's lover."

Hypochondric delusion – The patient is sure that he suffers from a severe and incurable disease. They go to different specialists, undergo many laboratory and instrumental tests, but their negative results don't please them. They start to think that the doctors do not understand anything and cannot detect their disease. They start to work out their own methods of treatment – for example, a special diet or regimen which should be helpful in their opinion. The patient can be sure that he has a specific disease – cancer, syphilis, AIDS, indigestion etc. – or the patient may note that certain functions have been impaired – "urinary bladder is affected, because of which urine has accumulated" or "heart function is disturbed as scars have appeared in the heart muscle and any grave, incurable disease can be caused."

Delusions of denial or nihilistic delusions – The patient denies the existence of his inner organs or their function. For example, patients may say "my heart has stopped", "blood doesn't flow through my veins any more", "Doctor, how can I eat? I don't have a stomach anymore and my intestines are completely necrotic." Sometimes the denial can reach global issues and world events and the patient may say "The sun doesn't provide light anymore", "Everything is gone, there is no life", "The world is completely destroyed" or other such thoughts.

Dismorfophobia and dismorfomania – delusion of having physical abnormality. Patients are sure that their nose, extremities are changed, they are extremely ugly. They go to surgeons and ask help.

Delusions of self-condemnation or self-blame – The patients pathologically blame themselves for seemingly bad things, without any facts to support their guilt. They blame themselves even for disasters that happen in other parts of the world. They think that because of their mistakes, their relatives' future is ruined, that they have to be responsible for others' mistakes. They can even announce, "There is no punishment bad enough to correspond to their mistakes."

Delusion of grandeur – This can be a very senseless delusion, often called megalomanic delusions. E.g. the patient announces that he gave birth to all the children in the world or he has written all the books in the world, etc.
Residual delusion after severe psychosis some symptoms preserved, but during the time all this pathological symptoms reverse. Suggested delusion is formed in healthy people, who are having relationship with a patient in a long time (ill relative). This delusion may occur to those, whose intellect is not high, and they don’t have critical evaluation of the situation, for example children.

Mechanisms of formation of delusional ideas.

1. Katathym mechanism – delusion is formed on unreal aspiration and desires.
2. Holothym mechanism – delusions are connected with emotional state (delusion of grandeur, self-blame, etc)
3. Kataesthetic mechanism – delusion based on hallucinations (delusion of poisoning, persecution, etc)
4. Senestopathic mechanism – delusions form under the influence of senestopathies (hypochondrical delusion, influence etc).

Obsessive-compulsive disorders include irresistible fears, thoughts, actions, memories, etc. Patients have critical attitude to themselves, they try to get rid of these disturbing conditions.

Obsessive thoughts – are absurd in their content, constantly and irresistibly conscious of patient.

Obsessive fears (phobias) – are claustrophobia – fear of close spaces, agoraphobia- fear of wide spaces, antrophophobia – fear of human beings, cancerophobia – fear of having cancer, etc. Sometime rituals are expressed at obsessive fears and thoughts, i.e. obsessive movements and actions, which have protective nature for preventing seeming danger. Doing the rituals (patient makes 5 circles around his house before going to work, 3 times changes his transport, etc.) makes the condition of patient easier.

Obsessive actions – is irresistible need to do something. If the action is not committed, the tense feeling of undone rises.

Overvalued Ideas. Overvalued thoughts are excessively emotional thoughts, based on a real fact. But they are excessive, i.e. the patient gives too much meaning to them, which does not correspond to reality. These ideas are characterized by great emotional saturation and stability. These ideas have a dominant place in the patient's behavior. The patient does his best to prove the idea’s correctness. The patient ignores all the facts which contradict his point of view. In other words, overvalued thoughts can be characterized as a subjective and one-sided interpretation of the situation. Overvalued thoughts often occur in psychopathic people, especially in paranoid psychopaths.
Paranoial syndrome

This syndrome consists exclusively of primary delusions. Most often these may be delusions of jealousy, invention, persecution and so on. There are no hallucinations or ideas of automatism. The delusional ideas are monothematic and systematized. Consciousness is unimpaired in such patients.

Paranoid syndrome

This may consist of primary and secondary delusions, with hallucinations playing an important part in the clinical presentation. Delusions may be polythematic and non-systematized. Under the influence of delusions patients are scared, tensioned and have anxiety. Type of hallucinatory-delusional syndrome is Kandinsky-Clerambault syndrome or syndrome of mental automatism.

Kandinsky-Clerambault syndrome (syndrome of mental automatism)

This is the collection of the following interrelated symptoms - pseudohallucinations, mentism, delusions of persecution and influence, feelings of domination and openness. For this syndrome is typical alienation of all mental functions, everything is controlled from outside (actions, thoughts, etc).

The syndrome may manifest differently and the following three types are distinguished -

Ideatory or associative automatism - patients complain of ideas that are forced into their heads, thinking that is against their will. They speak of "openness" of thought, saying that others can hear their thoughts and that they can read others' minds.

Senesthopathic automatism - presents various unpleasant sensations such as heat, cold, pricking, pressure and so on, of which patients complain. Hallucinations of taste and smell may also form part of this syndrome.

Motor automatism - patients complain that they are being "forced to do things" and that their actions are not their own, they are being controlled from without. Such movements may be varied, such as swinging the arms, turning one's head or even speaking.

Cotard's syndrome

In this case hypochondriac-nihilistic delirious ideas rise against the background of anxious-depressed spirit, they have megalomaniac character. Patient perceives himself as alive body; they express ideas of world break.
Paraphrenic syndrome
This is a combination of various delusional ideas and may see ideas of persecution and influence simultaneous with delusions of grandeur and power. Patients speak of how they are the Lord of the Universe, speak many languages, are supremely powerful and so on. They narrate about their trips to other planets and their meetings with alien beings. Such ideas are always absurd in nature.
**Syndrome of dismorfophobia-dismorfomania**

It is characterized by Korkina’s triad – delusion of having physical abnormality, depression, delusion of reference. It seems to patient, that their body or parts of the body are changed and ugly. They think that other people also note these changes and they are in the middle of attention. They insist to have surgical intervention.

**CHECKING TESTS**

1. All the followings are disorder of associative process, except
   1) autism
   2) schizophrenia
   3) delusion
   4) oligophasia
   5) reasoning (philosophizing)
   a) 1.3.5  b) 2.3  c) 3.4  d) 2.4.5

2. All mentioned belong to obsessive conditions, except
   a) obsessive thoughts
   b) phobias
   c) loudness of thoughts
   d) compulsions

3. In case of obsessive thoughts
   a) critical attitude is preserved
   b) patients hide these obsessions
   c) obsessive thoughts have character of loudness
   d) all mentioned
   e) none of mentioned

4. Cotard’s syndrome includes all mentioned, except
   a) delusional ideas of self-abuse
   b) hypochondrical delusion
   c) dysphoria
   d) nihilistic delusion
   e) depression

5. Residual delusion arises
   a) after epileptic psychosis
   b) after alcoholic delirium
   c) infection disease with consciousness disorder
   d) all mentioned
   e) none of mentioned

6. All mentioned refer to delusional ideas, except
   1) impossible to correct
   2) psychotherapeutic correction is possible
3) Critical attitude is absent
4) occur on pathological base
5) insight is preserved
a) 2,5 b) 3,4,5 c) 1,3,5 d) 3,4
7. Paranoid syndrome includes all mentioned, except
a) delusional idea of poisoning
b) delusional idea of persecution
c) delusional idea of self-blame
d) delusional idea of influence
e) hallucinations
8. Paranoial syndrome includes all mentioned, except
a) delusional idea of reference
b) delusional idea of persecution
c) hallucinations
d) delusional idea of grandeur
9. Syndrome of mental automatism is characterized by
a) delusional idea of influence
b) verbal-kynesthetic hallucinations
c) pseudohallucinations
d) all mentioned
e) none of mentioned

**Answers:** 1.c, 2.c, 3.e, 4.b, 5.d, 6.a, 7.c, 8.c, 9.d

### 2.5 Disorders of emotions

Emotions are a special type of human reaction to external and internal stimuli which express the attitude of an individual towards various aspects of life.

There are positive and negative emotions. The former are desirous to a person, he works towards having such emotions, while the latter are unpleasant - a person avoids them. This immediately reveals the motivational role of emotions.

Emotions are directly related to the activation of an organism. The objective signs of emotions are their bodily manifestations - facial expression, pose and expressive movements. Emotions are accompanied by various changes in the activity of respiratory, digestive, cardiovascular and endocrine organs, skeletal and smooth muscles as well as other metabolic changes. These include pallor, hyperemia of skin and mucous membranes, fluctuation of blood pressure, pulse and breathing frequency, thermoregulation, midriasis, increased peristaltic movement, pilomotor...
reactions and much more. These changes lead to many of the subjective feelings accompanying affective reactions and expressive movements. There are several types of emotions – the lowest (biological) ones related to the satisfaction or dissatisfaction of the basic needs (instincts) – hunger, sexual desire, thrust - and the highest ones related to the satisfaction or dissatisfaction of spiritual needs (social, cognitive, moral).

Emotional states primarily include the **mood** of a person. Mood is a stable and mildly expressed emotional state. Mood can be steady (ethymic), aroused (hyperthymic), depressed (hypothymic), anxious etc.

**Affect** is a short-term expressively lasting positive or negative feeling, during which person’s vegetative and motional manifestations are objected. Affects can be physiological and pathological.

**Physiological affect** is a short-term emotional arousal under the influence of external irritators. It proceeds against the background of clear consciousness without amnesia and disorders of motor-volitional sphere. The force of affect is dependent on the magnitude of irritants. Healthy person also can experience affect. Persons involved in criminal events under physiological affect are considered responsible.

**Pathological affect** is a short-term psychosis, lasting with the narrowing of consciousness, disorders of orientation, hallucinatory delusional feelings, which are accompanied by motor agitation and aggressive behavior. It can be observed in persons with impaired neural system. In this case even a small irritation can cause intense emotional reaction.

Pathological affect lasts from few seconds to an hour; it ends by a patient’s falling deeply asleep, complete or partial amnesia. A man involved in some criminal events under the pathological affect is considered irresponsible.

**Hyperthymia (elevated mood)**. This is a happy, festive, elevated, cheerful mood with an increase of alertness, initiative, optimism, when nothing spoils the present good mood. Negative emotions are absent, or instable and pass quickly. Patients feel happy, full of energy, everything around them seems interesting; they are aware of everything happening around them and are active. They constantly smile, move about, speak continuously, and make witty jokes.

**Euphoria** - this is elevated mood without the activation of intellectual processes and a tendency towards movement.

**Hypothymia (lowered mood)** is characterized by low melancholic mood, sorrow, grief, feeling of deep unhappy. Patients feel pressure in the chest and heart region, in all body, decrease in desires. The whole world becomes sad, grey, nothing can give pleasure. Only bad things are expected.
**Dysphoria.** This is gloominess, irritability, hostility, a sullen mood with peevishness, dissatisfaction, negative attitude towards surroundings, bursts of irritation, anger, wrath with aggression and destructive actions. During dysphoria, destructive reactions of dissatisfaction may start up due to unimportant reasons, sometimes with no particular cause at all, simply inherently from the patient himself. Duration is several days. There is type of dysphoria, which leads to drunkenness (dypsomania). It has paroxismal character.

*Emotional weakness* – is instability, labile of mood with the sharp fluctuation from the higher moods to the low. Such fluctuations can be provoked by insignificant facts. In some cases because of an insignificant reason a patient becomes upset, cries (for example, during watching movies or reading a book).

*Ambivalence.* The coexistence of two opposite emotions towards one and the same object. Ambivalence is a sign of splitting in mental processes, which is characteristic of schizophrenia. The ability to choose one emotion is lost, and patients cannot come to one conclusion about something, and therefore cannot decide on one action (ambitendency).

*Parathymia.* Emotional inversion, when emotional reactions are opposite to what would seem suitable in a given situation.

*Affective flattening* is poverty of emotional manifestations, emotional coldness, indifference towards relatives. A patient loses interest to himself. *Apathy* is characterized by complete absence of emotional manifestations, lifelessness, indifference towards relatives and all happening around, absence of desires. Nothing can arise interest, emotional response (“death with opened eyes”).

**Syndromes**

*Manic syndrome* is characterized by the following triad: elevated mood (hyperthymia), acceleration of thinking, and motor excitation. In this condition patients are laughing, making jokes, singing, feel themselves happy and careless. Associations go fast, and can reach to flight of thoughts «fuga idearum». They can express ideas of grandeur, overvalue their own abilities. They are extremely active, motor agitation is observed, which is described by purposefullness. All desires are elevated, attention is destructed.

*Depressive syndrome* is characterized by lowered mood, slow thinking and motor inhibition (depressive triad). Motor inhibition can be expressed, up to stupor – complete motionlessness. Sometimes, agitation, which is accompanied with anxiety, fear (agitated depression), may be observed
against the background of low mood. Patients speak of a pain in the soul or a weight on the soul, or in their chest (anietas precordialis). Depressive syndrome can also be expressed through apathy, loss of love for relatives, emotional reactions to surrounding – morbid psychic anesthesia (anesthesia dolorosa psychical). In some cases an unexpected burst of severe melancholy may be observed. A patient cries, hurts himself, tries to commit a suicide (raptus melancholicus).

CHECKING TESTS
1. Elevating of associations are typical
   a) Euforia
   b) Manic syndrome
   c) Apathy
   d) Depressive syndrome
2. Opposite emotional states in the same time are called
   a) Parathymia
   b) Emotional weakness
   c) Euforia
   d) Ambivalence
3. Pathological affect is characterized by:
   a) Narrowed consciousness
   b) Inadequate response to external stimuli
   c) Amnesia
   d) All mentioned
4. Psychomotor inhibition is typical
   a) Depressive syndrome
   b) Manic syndrome
   c) Dysforia
   d) None of mentioned
5. All mentioned symptoms are typical for manic excitement, except
   1) Chaotic movements
   2) Distracted attention
   3) Stereotypical movements
   4) High appetite
   5) Ideas of self-overestimation
   a) 1,2,3  b) 2,3  c) 1,3  d)1,3,5
6. For depressive syndrome is typical
   a) Decreased mood
   b) Inhibition of associations
   c) Motor inhibition
   d) All mentioned
   e) None of mentioned
7. Dysforia is typical of
2.6 Disturbance of volitional activity

Will (also called volition) is the ability towards planned, organized activity, aimed at the achievement of conscious objectives. Human behavior is regulated mainly through a mechanism of reasoning. Instincts have retained some significance in humans, but do not control or direct the effectiveness of human behavior. Volitional activity is regulated by motives, i.e. conscious objectives of behavior and a rational program for their achievement. Man has both biological and human necessities, and the latter usually dominate.
Volitional disorders that are seen in clinical practice include disorders of attention, inclination and movement.

Motor Disorders. Motor disorders are common during psychotic states. It is disorders of movement and of behavior in general that often cause people to notice the patient's condition. They are expressed as motor excitation and stupor.
Motor excitation is always accompanied with other mental function disorders and is usually called psychomotor excitation. It can arise in different mental disorders, for example manic, hebephrenic, catatonic, delirious, amentive excitations.

Catatonic excitation – is expressed as chaotic excitement, impulsivities and aggression. Accompanied by stereotypic and purposeless activity. Schizophrenia and symptoms of echo-reactions are specific: echolalia – is stereotype repeating of heard words, echopraxia – is repeating of movement of the surrounding people, echomimia – is the mimic repeating of interlocutor. Hebephrenic excitation – is characterized by foolish behavior, motor and associative agitation is accompanied with absurd poses, schizophrenia and neologism (creation of new words).
Catatonic stupor – is characterized by absence of movements and mutism (refusal to talk), which is sometimes expressed by waxy flexibility, the patient can be given any posture, in which he may stay for a long time. Sometimes the symptom of air pillow of Dupree is expressed: patient lies in bed with head hanging in the air. Snout reflex can also be (stretch forward lips) and symptom of hood (pulling cloth on the head), symptom of negativism – passive (patients follow instructions) or active (counteract), embryonic pose.

Catatonic stupor can rise both as with clear consciences (lucid catatonia) so as with disorder of consciences (oneiroid catatonia). Fragmental delusion ideas and hallucinations can rise.

Psychogenic stupor is seen in the clinical manifestation of acute affective and shock reactions. Such states are seen as reactions to very grave and sudden events, causing great psychological trauma and shock. Stupor may be total or partial, its duration may be minutes till hours. The depth, duration and future dynamics of the state depend on the character of the causal event. During total psychogenic stupor the facial expression of the patient reflects the nature of his reaction to the psychogenic event - fear, horror, confusion. Vegetative symptoms are often present. The consciousness is affectively narrowed (affective twilight) and after coming out of the state there is partial or total amnesia regarding the experience.

Disorders of inclination may express as hyperbulia, hypobulia, abulia and parabulia.

An increase in all inclinations or hyperbulia. Patients are gluttonous, sexual, and cynical, women are coquettish. Patients have expanded interests, they start various tasks, often starting a number of them at once, but due to distractibility of attention, rarely finish any of them. They easily establish ties with other people and make new acquaintances, allowing casual sexual contact.

Weakening of inclinations or hypobulia is characterized by decrease of activity, weakness and indifference. Patients are limited in contact with surrounding people. They are passive, don’t show imitativeness, they talk less. All instincts are decreased.

Abulia is complete loss of will power. It is characterized by inactivity, indifference towards surrounding, relatives and self, all happening around, absence of plans for future, no desire for cognitive activity. Instincts are absent.

Perversion of inclinations or parabulia. Parabulias are met in psychiatric practice frequently. Types of parabulia are kleptomania - the inclination to
steal but not for profit, pyromania is the inclination to set things afire without intending to cause damage to life and property, dromomania is the inclination to wander, coprolalia, polyphagia, onichophagia, automutilation, sexual perversions.

**Disorders of attention.** Disorders of attention include some of the most common symptoms in mental illnesses. Attention, which is the ability to concentrate on surrounding objects, may be either active or passive. Passive attention, which is based on unconditional reflexes, is very stable towards external pathological factors. Active attention, which is linked to conscious human activity and is specific to human mental activity, is easily disturbed during mental disorders. The most common forms of attention disorders are exhaustion, distractibility and pathological fixation.

*Exhaustion of attention* is very common in asthenic states. Such patients get tired quickly during conversations or while performing any mental activity, they lose the direction of the conversation, the quality of their replies worsens, and levels of mental productivity fall.

*Distractibility of attention* is common in manic patients. The attention of such patients continuously switches from one topic to another, registering the minutest of details, but without a possibility of concentration on one object for a long time.

*Pathological fixation* of attention to a specific set of objects is seen in depression. The patient cannot divert his attention from painful experiences, cannot read, watch television, and constantly thinks about one and the same thing - about the negative situation he considers himself in, which seemingly has no escape.

**CHECKING TESTS**

1. Disorders of volitional sphere are expressed by
   a) Disorders of attention
   b) Disorders of inclination
   c) Motor disorders
   d) All mentioned
   e) None of mentioned

2. Which is true for hyperbulia
   a) Elevated mood
   b) Decreased mood
   c) Decrease of inclinations
   d) Increase of inclinations

3. Foolish behavior is typical for
   a) Catatonic excitement
b) Hebephrenic excitement
c) Manic excitement
d) None of mentioned

4. All symptoms are typical for psychogen stupor, except
   a) Absence of speech (mutism)
   b) Narrowed consciousness
   c) «air pillow» symptom
   d) Connection with psychogenic factor
   e) Facial expression is connected with situation

5. For catatonic stupor is not typical
   1) Amimic facial expression
   2) Expressed depressive affect
   3) Echo-reactions
   4) Long preservation of the same pose
   5) Absence of speech, negativism
      a) 2,4,5  b) 2,3,5  c) 2,3  d) 3,4

6. All mentioned are disorders of volitional activity, except
   a) Disorders of attention
   b) Disorders of behavior
   c) Memory disorders
   d) Disorders of inclinations
   Answers: 1.d, 2.d, 3.b, 4.c, 5.c, 6.c

### 2.7 Disorders of Consciousness

Consciousness is the quality of the highest organized substance, brain’s ability to reflect integrative material world, to integrate different forms of objective world’s reflections: feelings, perception, memory, thinking, but it is not equal to the most complex of them – abstract thinking.

According to Jaspers, disorders of consciousness have the following common points -

1. Detachment from the real world, seen as the distorted perception of surroundings, difficulty in fixation or total impossibility to perceive - sometimes reality may be perceived as separate, disconnected fragments.
2. Disorientation with regard to time, place, the surrounding people and situation.
3. Disorders of the thought process in the form of disconnection, judgements are disturbed.
4. Difficulty in remembering occurring events and subjective pathological phenomena.
A disorder of consciousness is only characterized if all these four components are present. Disorders of consciousness are expressed by the following syndromes.

**Deafening.** There are the following degrees.
The lightest form – is *obnubilation*. Consciousness as if becomes clouded. Patients answer the questions slowly, cannot comprehend the situation quickly, they are flabby, sluggish.
At more expressed condition of deafening the threshold of out irritators’ perception rises. Patients don’t give any reaction to the questions, asked in the quiet tone of voice. The loud speech they perceive slowly. The thinking process becomes rather difficult, the ideas becomes poor. They don’t understand the meaning of difficult tasks, the simple ones they solve with difficulty and slow pace. The poverty of mimics, indifference, silentness, inhibition down of movement are expressed. The patient’s face expresses indifference, flattening. The reaction to the painful irritator is decreased. This condition is called *somnolence*.

**Sopor** is a more severe case of pathological process. Patients move less, speech contact is impossible. Their reaction to strong irritators (for example painful irritators) occurs as weak elementary movements. Pupils and corneal reflections, and swallowing movements are intact.
The hardest degree is *coma*. Unconditioned reflex is absent at all. Disorder of breathing, decline of cardiovascular activity, disorders of functions of other vital organs with rise of psychomotor irritation, epileptic seizures.

**Delirium** is characterized by the expressive disorders of perception. Often these are true visual hallucinations. Patients disorientate in place, time, but save orientation in own personality. Patients are extremely irritated, save themselves from the hallucinatory occurrences by escaping, hiding, attack the seeming followers. Fear, tearfulness, irritation are expressed. Their verbal expressions are inconsistent, sight is disfocused. Micropsy, macropsy, zoopsy are specific. Delirious condition of consciousness increases to the evening, night. Conscience can be clear during the day, patients answer the question correctly, have critical attitude to their disease facts. Memory is saved partially at the time of delirium.
Delirious syndrome can be expressed in two atypical forms:

*Mussitated* – patient’s activity is within the bed, patients are constantly whispering some words, make meaningless monotonous, stereotype movements, take off the dust from themselves, pull off the blanket, etc.
professional delirium - is marked by the flow of hallucinative occurrences, which reflect the professional habits of the patients. Psychomotor excitement is expressed in making as automatic professional acts. The patients accompany these actions with some words which point its reference to the profession. Delirium is typical for intoxications, alcoholic psychoses, symptomatic psychoses, etc.

Amentia – is the condition of sharp confusion of consciousness. The main symptom of this form of consciousness’ disorder is disorder of synthetic activity which is expressed in incoherence of speech. The perception of the surrounding situation is also fragmentary. The mimic expresses confusion, surprise. All types of orientations are disturbed. Monotone motor arouses within the bed can be observed. Episodically fragmentary hallucinations and delirious occurrences can be arising. Emotional state is unstable. Duration is long – weeks, months. Deep amnesia and long asthenia follows amentia. It is observed during hard somatic and infectious diseases.

Oneiroid – is characterized by the flow of dream-like fantastic hallucinations. Patients seem to be in a state of double orientation - realizing that they are in a hospital and talking to a doctor, while at the same time being the direct participant of their hallucinatory experiences. These hallucinations are of great fantasy in nature with patients seeing other planets, great historic wars, flying from one city to another and so on. They are usually pleasant for the patient and one may often see a blissful smile on their faces as they narrate their experiences. There can be delusional ideas, which have fantastic character. Patients give special meaning to the surrounding events and people. Positive and negative twins symptom, when the patient recognizes strangers but cannot relatives. Fregoly’s symptom – patient thinks that one person can have different masks. Duration can be weeks. After the oneiroid state patients have memories about the sick feelings. Oneiroid is observed in schizophrenia, epilepsy, organic pathology of the brain.

Twilight condition of consciousness. It begins and ends suddenly. It is accompanied with the fragmentary perception of the surrounding situation and amnesia at the time of disease. The consciousness of the patient is narrowed, his feelings are connected to the certain situation, persons, thoughts. It is accompanied with the tense affects of anger, fear. Psychomotor excitement rises with the fragmentary delusional ideas, hallucinations. Due to anxious-malicious mood and delirious interpretation of the surrounding patients are disposed to aggressive actions. Duration is minutes, hours, sometimes days. It ends with complete amnesia.
Twilight condition can be of two types:
- With hallucinations, delusions, disphoria, psychomotor excitement, aggressive behavior. In this case hallucinations are true, colorful and have aggressive content.
- With ambulatory automatisms – when patients do actions (simple or complex) in unconscious condition. Complete amnesia is seen. There are the following types of ambulatory automatisms:
  *Fugue* is a short state of ambulatory automatism. Patients may unconsciously start to run, or spin around continuously for a couple of minutes. When their consciousness is restored, patients may continue doing what they were doing before, or may be surprised at the attention they seem to have attracted of the people around them, without understanding the reason. *Trance* – in this condition patient does more complex actions – he can go out of the house, wander, travel from one city to another and their behavior seems to be normal, but only from outside. After this condition patient has complete amnesia.
  *Somnambulism* – in the night patient wakes up and does some actions, then turns to his bed or sleeps anywhere he is.
Syndrome of twilight disturbance of consciousness is more often met in epilepsy, organic damage of the brain, hysterical psychoses.

**CHECKING TESTS**

1. Somnolence condition is described by all mentioned, except
   a) Semi-sleep condition
   b) Absence of spontane speech
   c) Confabulation
   d) External stimulants can improve pathological condition for a time

2. All mentioned are typical for delirium, except
   a) Pareidolical illusions
   b) Visual hallucinations
   c) Symtoms of mental automatism
   d) Affective disorders
   e) Motor excitement

3. Musitated delirium is characterized by all mentioned, except
   a) Expressed motor activation: patiens escape, shout, hide, etc
   b) Motor activation in the limits of bed
   c) Patients mumble
   d) Patient is lying and doing uncoordinated movements

4. All pathological states are typical for delirium, except
   1) Double orientation
   2) Visual true hallucinations
3) Pareidolical illusions  
4) Motor excitement  
5) Waxy flaxibility  
   a) 1,2,4  b) 1,3  c) 1,5  d) 3,5  
5. Deafening is characterized by all mentioned, except  
   a) Decrease of clearance of consciousness till complete lose  
   b) Expressed hallucinations and delusions  
   c) Slowness of thinking  
   d) Motor inhibition  
6. Syndromes of consciousness disorder are characterized by all mentioned, except  
   a) Difficulty in reflection of external world  
   b) Detouchment from envieroment  
   c) Incoherence of thinking, complete or partial amnesia during consciousness disorder  
   d) Artifital, made character of condition  
7. Double orientation is typical of  
   a) Delirium  
   b) Oneiroid  
   c) Both of them  
   d) None of them  
8. Incoherence of thinking is typical of  
   a) Delirium  
   b) Oneiroid  
   c) Amentia  
   d) Twilight condition  
9. Patients behavior is determined by visual hallucinations  
   a) Delirium  
   b) Oneiroid  
   c) Both of them  
   d) None of them  
10. Paroxismal character has  
   a) Delirium  
   b) Amentia  
   c) Twilight condition  
   d) None of mentioned  
11. Which symptom is not included in Korkina`s triad  
   a) Sureness of having phisical defect  
   b) Depression  
   c) Ideas of reference  
   d) Fixated amnesia  
12. Walter-Buel`s triad is typical of  
   a) Psycho-organic syndrome  
   b) Mental automatism syndrome
c) Twilight condition of consciousness
   d) None of mentioned

13. It seems to patient, that his movements are regulated from outside
   a) Mentism
   b) Kynesthetic automatism
   c) Cenesthopathic automatism
   d) Ambulator automatism

**Answers:** 1.a, 2.c, 3.a, 4.c, 5.b, 6.d, 7.a, 8.c, 9.a, 10.c, 11.d, 12.a, 13.b
CHAPTER 3

METHODS OF EXAMINATION IN PSYCHIATRY AND BASES OF TREATMENT

The observation of mentally ill patients is complex (interview with patient, anamnesis, objective examination and paraclinical examinations).

The interview is purposeful to do alone with patient, in order to have full confidence. Doctor must attentively observe patient`s behavior and listen to complaints. Some patients can have no complaints or, opposite, many complaints, which have no connection to their illness.

Mental status is formed during several days, when patient is fully examined (behavior, actions, speech, etc) and must include description of all mental functions. During the interview patient`s appearance, facial expression (indifference, amimia, suspiciousness, etc), expression of eyes (active, anxious, melancholic, cruel), movements (fast, free, impulsive, chaotic, steady, artificial, slow, etc) are important. The tone of the voice, pronunciation, (high, low, slow, fast, etc), emotional conditions, decrease of vocabulary, circumstantialities, perseveration etc must be considered.

Paraclinical examination includes general laboratory examination, experimental-psychological investigation, methods of EEG, CT, etc.

Psychopharmacology

Psychopharmacological treatment method was introduced in the 20th century, 50-ies by Deley and Deniker, when was chlorpromazine (amisinalin) synthesed and offered for treatment. Now are produced large psychopharmacological materials, the usage of which contributes to the patients mental state and behavior normalization, reduces patent’s treatment time, “open door” hospitals and units are organized.

All this eases mental patients’ social adaptation opportunities. Psychiatric hospitals’ structure is changed, where treatment of patients with borderline disorders start.

Classification of psychotropic medications. Due to clinical influence psychotropic medications are classified:
1. Neuroleptics (antipsychotics) – these are main methods of treatment of active psychoses. They reduce psychomotor excitation, pacify agitated patient, affect on hallucinations, delusions, catatonia and other pathological states. Neuroleptics have neurotrop effect, which expresses as extrapyramidal and neuro-vegetative disorders. The followings belong to the group of neuroleptics:
   - Aminasin, tisercin, triftasin, haloperidol, leponex, olanzapine, rispolept, serocvel, etc.

2. Tranquilizers – these medications have weak antipsychotic effect, decrease emotional tension, anxiety, also have myorelaxation and anticonvulsive effect.
   - Elenium, seduxen, nitrazepam, lorazepam, noxiron, midocalm, etc.

3. Antidepressants
   - Tricycle antidepressants (melipramin, anafranil, amitriptylin, nortriptilin)
   - Selective inhibitors of serotonin re-uptake (fluoxetin, zoloft, fluvoxamin, rexetin)

4. Normothymics (carbamazepin, salts of lithium), which normalize affective conditions, and have preventive action during affective psychoses.

5. Nootrops – which stimulate metabolism of the cells (aminalon, encefabol, nootropil, pantogam)

6. Psychostimulators - elevate level of emotions, remove tiredness (fenamin, pervitin, centedrin).


**Electroconvulsive therapy**

Electroconvulsive therapy was offered for treatment of mental disorders in 1938 by Italian scientists Cherleti and Bini. For this purpose special electroconvulsive apparatus was worked out, which has electrodes, voltameter and time misurer.

There are many contraindications. This therapy is used only if there are no somatic disorders.
During electroconvulsive therapy epileptoform seizures appear. After the attack patient has complete amnesia. For treatment is needed 6-10 attacks, with intervals of 2-3 days. On average after 3-7 attacks therapeutic productivity is seen. According to wide usage of psychotrop medications this method is used rarely. Indications for electroconvulsive therapy are «drugresisted» types of depressions, especially in the limits of schizophrenia and bipolar psychoses, involution depression, also catatonic form of schizophrenia.

**Psychotherapy**

Psychotherapy is a therapeutic method, when through word the doctor influences the patient’s mental world. Its purpose is to remove symptoms of disease, to change the patient’s attitude to his person, morbid condition and surrounding people. Therapeutic outcome of psychotherapy depends not only on peculiarities of individual’s character, type and course of the disease, but also on doctor’s experience and skills, ethical, hygienic, deontological principles of hospital. 

**Suggestion.** Influence on patient’s mental world through speech, which is accepted by the patient without any critical attitude. Suggestion can be held as awaken condition, as well as in hypnosis and narcohypnosis states.

**Rational psychotherapy.** Doctor explains the meaning of the disease, the etiology, development of symptoms and suggests self-confidence to patinet to overcome fear, subjective unpleasant feelings, incorrect judgements. In fact the doctor changes the patient’s thinking, helps differently look at the situation, not to give up.

**Autotraining.** This method was offered by German doctor Schulz in 1923. Autotraining relaxes, and then fully removes anxiety, irritability, and tiredness through activation of psychoregulation mechanisms. It is widely used both in treatment of neuroses, as well as in different diseases of inner organs, that accompanied by neurotic disorders, for example, after cardio-ischemia, there can be anxious mood, fear of relapse.

**Hypnosis** – is a Greek word, which means sleep. This term was suggested by English surgeon G. Braid in 1843. Before treatment the patient is explained about this method. The doctor understandably explains, that hypnosis concentrate hidden forces of the organism, thus creating condition for rapid recovery. The patient should know that hypnotherapy is a scientifically justified, effective therapeutic method, which increases the results of treatment.
CHAPTER 4

SPECIFIC PSYCHIATRY

PSYCHOSOMATIC DISORDERS

This group of mental disorders include: symptomatic psychosis and psychosomatic disorders in narrow meaning.

Psychosomatic disorders, refer to those conditions where the underlying cause is mainly in the mental sphere. The symptoms in these cases will very often be only physical or somatic in nature. Somatopsychic disorders cover those conditions where the root cause is somatic. But in these cases, the manifesting symptoms will be mainly mental in nature. Thus, these two groups of diseases cover those conditions where the cause and the clinical presentation are a cross-over between the physical and the mental spheres of the human being.

Symptomatic psychosis
(somatopsychic disorders)

This group of conditions cover physical conditions which directly affect mental functions through biochemical and pathophysiological changes occurring in the organism. Somatic illnesses may be infectious or non-infectious, acute or chronic.

Until the 19th century, there was a general opinion that each somatic illness was characterized by a specific mental disorder, i.e. the clinical picture of psychosis depended on the underlying somatic illness. However, a German psychiatrist named Bonhoeffr helped change that perception. Bonhoeffr observed similarities in psychiatric symptoms (clouding of consciousness, delirium, amentia etc.) during various infections, intoxications and other somatic illnesses and came up with his concept of “reactions of the exogenic type.” This states that the mental symptoms do not depend on the somatic illness, but rather on the person who has contracted that illness and the reaction of his/her brain (which he called the “reaction of the exogenic type”) to that condition. He stated that the brain
produced certain biochemicals (which he called the “intermediate link”), which then led to the development of those symptoms.

Bonhoeffler’s theory has strong and weak points. He was largely right in saying that the somatic illness itself does not usually lead to a specific mental condition. But he was too dismissive of the role of that exogenic factor, and the “intermediate link” that he spoke about was never biochemically isolated. Today, it is largely believed that the pathogenesis of somatogenic reactions depends on the interaction between the micro- and macro-organisms as well as the patient’s specific personality and character.

**Prevalence of symptomatic psychoses.** The morbidity of symptomatic psychoses is 5-8%.

**Acute symptomatic psychoses**

Usually before acute symptomatic psychoses there is prodromal period, when headaches, weakness, irritability, emotional and sleep disorders, hyperaesthesia are seen. Originally, five conditions were considered to be the main psychiatric symptoms of *acute* somatic illnesses – torpor, delirium, amentia, twilight narrowing of consciousness, acute hallucinosis.

**Delirious syndrome** - it occurs in case of acute infection and somatic diseases with a high temperature. This condition is characterized by bright illusional-hallucinatory feelings on the background of consciousness disorder and connected with this psychomotor excitement. Duration is 1-2 days, ends with recovery. Depending on premorbid personality features, expression of infection disease and psychoses, amentia can develop.

**Amentive syndrome.** Orientation in place, time, situation and self-orientation is distorted. Thinking process is also distorted and incoherence is typical. Psychomotor excitement is in the limits of the bed. Sleep disorders appear, fragmentar delusional ideas, episodic hallucinations rise. Duration is from several days till weeks. Syndrome ends with prolonged asthenia and amnesia. In severe cases psycho-organic syndrome can be seen.

**Twilight condition** of consciousness starts suddenly and is characterized by deep disorder of consciousness and orientation. Under the influence of horrified visual, auditory hallucinations and delusional ideas, patient becomes aggressive, attacks, escapes, is dangerous for surrounding people. Disorder lasts 2-3 hours, ends with complete amnesia.
Acute verbal hallucinosis is characterized by sudden onset of auditory hallucinations, which have commented character. Patients hear different voices, mainly dialogues. Sometimes voices talk about the patient (third person hallucination), they can have imperative character. Influenced by these voices patients become (especially in the evening) excited, anxious. Connected with voices there can be delusional ideas. Consciousness is not distorted.

Torpor is a common mental disorder during infection and somatic diseases, hard intoxications. It is expressed by different levels – from somnolent condition till sopor and even coma.

Chronic symptomatic psychoses

Prolonged course of somatic illness can occur in chronic symptomatic psychoses, duration is about 2-3 months. This psychosis ends with hard asthenia, sometimes with psycho-organic syndrome, which is characterized by Walter-Buel’s triad: decrease of memory and judgements, affective liability. The following types of psycho-organic syndrome exist:

Asthenic: expressed by mental and physical weakness, tiredness, exhaustion of attention, hypomnesia, low efficiency.

Explosive: In this case most expressed symptom is emotional liability. Patients can be angry, dysphoric and aggressive.

Euforic: In this case patients are careless, happy, without critical attitude to their condition.

Apathic: patients are indifferent to themselves and to other people.

Chronic somatic conditions may lead to manic, depressive or schizophreniform symptoms.

MENTAL DISTURBANCES DURING SYPHILITIC DAMAGE TO THE BRAIN

Syphilitic infection can damage all organs and tissues including the brain. Depending on the character of the damage to the brain tissues, the time period in which this occurs and the specific mental disturbances that occur, two kinds of disease are distinguished – 1) syphilis of the brain and 2) progressive paralysis.

Syphilis of the Brain
Syphilis of the brain is characterized by a highly polymorphic psychopathological clinical picture. Mental disturbances in this case are caused by syphilitic damage to the blood vessels and brain meninges. The mildest form of syphilis of the brain is *syphilitic neurasthenia*. Its symptoms include weakness, malaise, and decreased ability to work, mental and physical exhaustion, sleep disorders and appetite loss, irritability, memory loss, bad mood as well as meningeal symptoms and symptoms specific to the cranial nerve damage (strabismus, anisocoria, trigeminitis and inflammation of the facial nerve), aphasia and apraxia.

As the disease progresses, more malignant forms of syphilitic psychoses develop. *Apoplectic type* of syphilis is the result of syphilitic endarteritis. In such cases, frequent strokes are seen with subsequent paralysis and focal damage, irritation, emotional lability and lowering of intellect. There may be episodic cases of consciousness disorders. As the number of hemorrhages in the brain increases, focal signs grow more prominently and dementia develops. Any of the strokes may end in the patient’s death.

*Epileptiform syphilis* is characterized by convulsive seizures, episodic disorders of consciousness and dysphoric mood. Gradually, the memory weakens and the intellect is lowered.

*Hallucinatory-paranoid form* is characterized by disorders of perception and delusional ideas with one of them prevailing and this dominance shifting to the other from time to time. Of the delusional ideas, the most common are delusions of persecution, while rarer ones include hypochondric delusions, delusions of grandeur, self-blame and so on. The delusional ideas are usually simple and connected to the surroundings of the patient, they are devoid of symbolism. Patients insist that their neighbors “turn on the radio very loudly on purpose” to make them angry, that the “nurse gave them the wrong injection”, that “doctors let his illness progress.” Anisocoria and a lazy reaction of the pupils to light are common.

*Syphilitic gummas* are seen much rarer than the other forms. There can be solitary or multiple small gummas. Depending on their location and size, varying neurological symptoms may develop. Usually, gummas do not reach a size large enough to put pressure on surrounding tissues, although in some cases this may happen. These cases are similar to brain tumor patients in clinical manifestation – intracranial pressure is increased, there is vomiting, severe headaches, adynamia and sometimes clouding of consciousness and convulsive states.

*Congenital syphilis* is the result of trans-placental infection of the embryo from the ill mother. Congenital syphilis is characterized by meningitis, me-
Meningoencephalitis and vascular problems. Hydrocephaly may develop. Characteristic clinical symptoms include meningoencephalitis, seizures and oligophrenia (mental retardation). Parenchymatous keratitis is a common symptom of congenital syphilis, damage to the inner ear and deformation of the front teeth (Hetchinson’s triad) as well as epileptiform seizures.

**Treatment** of mental disturbances in brain syphilis begins with the application of combined specific therapy – antibiotics (penicillin, erythromycin) and bismuth drugs, iodine, mercury, arsenic. Psychotropic treatment depends on which symptoms dominate.

**Progressive Paralysis**

Synonyms include progressive paralysis of the insane, Bayle’s disease, Bayarjet’s progressive paralytic dementia. The disease was first described by French psychiatrist Bayle in 1822. The syphilitic nature of the disease was proven in 1914 after Japanese scientist Nogushi isolated the spirochete from the brain tissue.

The classic picture of progressive paralysis includes three stages – 1) initial or neurasthenic, 2) explosion of the disease, 3) malignant or marasmatic stage. Each of these stages is characterized by specific mental, neurological and somatic disturbances, which keep growing more severe.

**Initial or neurasthenic stage** is characterized by the occurrence of neurotic-type symptoms such as headaches increasing in intensity, growing fatigue, mental and physical exhaustion, irritability, lowering of ability to work, sleep disorders. Besides neurasthenic symptoms, signs more characteristic of syphilis are also seen, which can be characterized as a loss of ethical norms. Patients have decreased interest in their families, stop caring for their relatives, and often lose their sense of shame. Patients become uninhibited, untidy, crud and tactless. People around them notice a cynicism that the patient did not have earlier and their use of abusive language.

**Stage of disease explosion** is characterized by an increasing loss of memory, weakness of thought processes and judgements, a complete loss of critical attitude (insight) towards their disease as well as crude sexual uninhibition with complete loss of shame. Talkativeness and a tendency to praise oneself are common. The emotional sphere of the patients also changes dramatically. There is marked emotional lability, episodes of irritation and anger occur, but they are overcome quickly (unlike epilepsy). Such patients quickly go from tears to laughter and vice versa. There is euphoria although in some cases there may be depression with suicidal
tendencies. Often, delusional ideas develop such as delusions of grandeur and one of its subtypes – delusions of wealth.

The third stage, marasmus, is characterized by profound dementia and a state of complete mental and physical degradation.

**Neurological disturbances** – the most common neurological symptom and one of the first to appear is Argyle-Robertson’s symptom – the absence of a reaction to light, while convergence and accommodation are maintained. There may often also be anisocoria, severe miosis, sometimes up to the size of a pinhead and deformation of the pupils in other cases. In cases of progressive paralysis there may often be a smoothening of the nasolabial grooves, ptosis, a mask-like face and a sliding of the tongue to one side. Often dysarthria develops early on and there are also symptoms like logoclonia, stressed speech and rhinolalia. The most crude neurological symptoms are most characteristic of the marasmatic stage – apoplectiform seizures, leaving focal damage behind in the form of paralysis and palsy, aphasia, apraxia and so on.

**Somatic disturbances** – Besides specific damage to the liver, lungs, skin and mucous membranes, the most common symptoms include metabolic disturbances, trophic skin ulcers, increasing traumatization of the bones, hair loss, edema, progressive exhaustion and suppurative processes.

**Treatment** of mental disturbances in syphilis of the brain begins with the application of combined specific therapy. Psychotropic treatment depends on which symptoms dominate.

**Mental disorders expressed by somatic symptoms**

*(psychosomatic disorders)*

In the 19th century the opinion that psychological factors may have an important role in the etiology of somatic disorders was widely spread. These ideas laid the foundation for psychosomatic medicine and its supporters were convinced that emotional changes were accompanied by physiological changes in the body. If these changes last long, or are too frequent, then there are pathological somatic changes as a result. Part of this theory was the opinion that these emotional conflicts, which arise on the subconscious level, may lead to specific somatic pathology – coronary heart disease (CHD), essential primary hypertension, bronchial asthma, peptic ulcers, thyreotoxicosis, diabetes mellitus and neurodermatitis. This is one theory.
According to another theory, non-specific mental stressors (behavioral, hormonal) lead to behavioral changes which may cause pathological processes in organs, e.g. smoking, alcohol abuse. Mental disorders expressed by somatic disorders are – conversion hysteria, hypochondria, dismorophobia, anxiety disorder, somatoform pain disorder, disorders of adaptation, somatization.

Doctors who have specialized in virtually any field can come across patients with such disorders, because – even though the etiology of the disease is mental – virtually any physical symptom can be present in the clinical picture of the illness, with absolutely nothing to suggest any psychiatric problems in the patient.

This process of transfer of mental symptoms to the physical sphere is called *somatization*. Medicine has as yet been unable to determine the biochemical or pathophysiological mechanisms that are involved in this process, but the abundance of clinical experience with such patients has left no doubts that such a process exists.

Somatization can be met in different mental disorders, but it is more typical for adaptation, anxiety disorders, depression.

**Prevalence** of psychosomatic disorders. The morbidity is 15-50%.

### Somatoform disorders

*Somatization* – Main feature is various somatic complaints, that are expressed before 30 years old.

This disorder usually is seen in women. Somatization is difficult to cure. *Conversion disorders*. Conversion disorders – amnesia, sensor disorders, difficulties of walking, etc, which are described in conversion neuroses. With such diagnosis hospital applicants is 1%.

*Somatoform pain disorders*. Characterized by chronical pains, which are not connected with somatic disease and last more than six months.

*Hypochondria*. The patient is sure that he suffers from a severe and incurable disease. They go to different specialists, undergo many laboratory and instrumental tests, but their negative results don't please them. They start to think that the doctors do not understand anything and cannot detect their disease. Hypochondria diagnosis is made if this sureness lasts about 6 months.

*Dismorophobia*. It seems to patient, that their body or parts of the body are changed and ugly. They live with this ideas and think that other people also note these changes and they are in the centre of attention.
The treatment is difficult. Cosmetic intervention is contraindicated, if there is no real defect. They insist to have surgical intervention.

**Treatment.** Supporters of psychosomatic theory think, that treatment of this disorders is psychological. However, several psychological disorders, which occur connected with somatic diseases, need treatment with psychotropic medications – neuroleptics, antidepressants, tranquilizers and psychotherapy.
CHECKING TESTS
1. Which is symptomatic psychosis
   a) involution psychoses
   b) epilepsy
   c) brain syphilis
   d) all mentioned
   e) none of mentioned

2. All mentioned are acute exogenous reaction, except
   a) delirium
   b) psycho-organic syndrome
   c) amentive syndrome
   d) twilight condition of consciousness

3. Chronic symptomatic psychoses are characterized by all mentioned, except
   a) Asthenic syndrome
   b) Paranoid syndrome
   c) Manic syndrome
   d) Delirious syndrome

4. All the followings are clinical types of syphilis, except
   a) Asthenic
   b) Paranoid
   c) Hebephrenic
   d) Depressive

5. All mentioned are psychosomatic disorders, except
   a) Conversion hysteria
   b) Dismorfophobia
   c) OCD
   d) Hypochondria
   e) Somatoform pain disorder

6. Initial symptom of progressive paralyzes is
   a) Disartry
   b) Argayl-Robertson`s symptom
   c) Ptos
   d) Anizocoria

7. The duration of acute symptomatic psychosis is
   a) 2-3 hours
   b) 2-3 days
   c) 2-3 weeks
   d) All are right
   e) All are wrong

Answers: 1.c, 2.b, 3.d, 4.c, 5.c, 6.b, 7.b
CHAPTER 5

Alcoholism, alcoholic psychosis

Unitary use of alcohol (ethyl spirit) can cause acute intoxication, and continuous using of alcohol leads to alcoholism.

Alcohol intoxication
Alcohol intoxication is a symptom complex of mental, vegetative and neurological disorders conditioned by psychotropic action of alcoholism. Clinical revealing of alcohol intoxication is divided to the following types: simple and pathological. Simple intoxication has the following stages:

Light alcohol intoxication is characterized by feeling of physical and psychic comfort. Mood is increased, feeling of satisfaction. Person is filled with pleasant thoughts and associations, he becomes very talkative, his mimic and moving is filled with high expressiveness. Speech becomes loud and fast. Thinking is fastened, shallow associations appear. Critical attention towards his state and towards his duties are lowered. Vegetative symptoms are expressed by hyperemia and more rare by paleness of face, and by pulse fastening.

Middle stage of alcohol intoxication is characterized by inhibition of mental functions high mood is changed to depression, activity is gradually decreasing, coordination is distorted and gait is unsteady. Dysarthria is typical.

Deep stage of alcohol intoxication – expressed by different types of consciousness. Sometimes there can be epileptic seizures, involuntarily defecating and urinating. In severe cases this condition can be a reason of death.

Pathological intoxication. In this case the quantity of used alcohol is not important, pathological condition can arise, because of incompleteness of neural system.

Pathological intoxication is an acute short mental disorder with sudden onset, twilight condition of consciousness arises, all types of orientation are distorted. It can express with psychomotor excitation and aggression. Patient is frightened, anxious, because of horrorfull hallucinations. In this condition patient is dangerous for himself and surrounding people. Their actions are well coordinated. It is unsuccessful to contact to them. The face is pale, the pupils are dilated. The duration is short (half an hour till 1-2 hour). Everything ends by deep sleep. Amnesia is being full.
**Clinics of Alcoholism**

Alcoholism is a chronic disease, characterized by pathological addiction to alcohol drinks (psychic and physical dependence), development of dysfunctional state, abstinence syndrome, by stable somatoform disorders and mental degradation.

**Prevalence of alcoholism.** 120 million in the world suffer from alcoholism, morbidity is 2%.

Alcoholism develops gradually. There are three stages in the clinic of alcoholism.

*First stage* (the stage of psychic dependence). Alcoholism is becoming the mean which is constantly needed to increase the mood, make easy the contact with people. Tolerance to alcoholism becomes higher. Patients lose vomiting reflex. After becoming sober patients do not remember some episodes (perforation amnesia). The duration of the first stage on average is 3-5 years.

*Second stage* (the stage of physical dependence). The main feature is physical dependence. The absence of alcohol causes syndrome of abstinence. It is expressed by psychical, neurological and somatic disorders – patient has fear, anxiety, surrounding events interpret in delusional way, irritability, anxiousness, low mood is expressed. Sleep disorders arise, hypnagogic hallucinations can be seen. All mentioned symptoms are accompanied with weakness, headaches and vegetative disorders (excessive sweating, tremor of tongue and body, diarrhea, etc). There can be cardio-vascular disorders (tachycardia, elevation of blood pressure), disorders of gastro-intestinal system. Habitus of the patient is specific: face becomes edematous and cyanotic, eyes are bloody, and expressed tremor. Epileptic seizures also can arise. In this stage personality changes start. Intellectual work is difficult to do, patients lose their workplaces and all the money they spend to buy alcohol. Alcoholic psychosis is seen in this stage.

*Third stage* (the stage of alcoholic degradation). The main mean is intolerance to alcohol – intoxication can be even from drinking a small glass. The alcoholic degradation of personality develops. The rough cynicism is accompanied with “alcoholic” humor, dysphories and aggression. The sick men live like parasite. Cirrhosis, alcoholic cardiomyopathy, pancreatitis, gastritis, lowness of sexual potency with increasing the feeling of jealous to wife are characterized for patients. This condition is evaluated as toxic encephalopathy.
Alcoholism in women

Alcoholism in women is developed in the middle age. Reasons are different: family conflict, low educational level to special workplaces (work in the bars, pubs, etc). Stages of alcoholism rise fast and unmentioned, because women frequently hide this abusement. And alcoholism is diagnosed in late stages. In women alcoholism develops 3-4 times faster than in men. Beside abctenent syndrome, with its typical symptomes, usually there can be dysphoric states and other affective disorders.

Treatment

Treatment of alcoholism is carried out both in dispensary and stationary conditions. For treatment in dispensary condition it is very important whether patient wants to be cured or not. In more difficult cases treatment takes place in alcohol clinics, where there are better conditions for treatment. Productivity of treatment depends on its duration and must be organized timely. The sooner treatment begins, longer it continues, the more productive it will be.

Treatment of alcoholism, as a rule, must be fulfilled in a complex way and psychotherapy must play main part in it. In the first period of treatment patients’ organism must be disintoxicated and strengthened. The main point of treatment is holding of reflector therapy during which are used vomiting drugs (apamorphin, emethy and so on), due to which arouses disgust and vomiting reflex towards alcohol. Treatment arousing hypersensitiveness by means of teturam is very widely spread, after using it patient is feared of consequences of using alcohol, this treatment is used for reducing alcohol addiction. But this treatment must be carried out with care, because teturam has different side effects.

Dipsomania

Dipsomania (the real hard drinking) – is a special form of alcoholism, which develops on the background of dysphoria with the anxious and irrepressible desire to press his condition in alcohol. Hard drinking is lasts several days. Then during several weeks or months patients keep themselves from drinking at all till the next affective phases.

Alcohol psychoses

Alcohol delirium (delirium tremens). Among mental disorders having alcohol origin delirium tremens plays the leading role. Psychoses can develop either while using much alcohol or after ceasing to use it. Psychoses
can develop due to additional factors (inflectional diseases, high temperature, brain defeats, operation, and exhaustion).

Psychoses can develop by chance, in an acute form, especially if there are some additional causes. Though very often days before some signs appear, dream disorder becomes very unstable, mood lowers being assisted by fear and alarm, trembling of hands becomes more expressed, especially in the evening hypogogic hallucinations appear.

Disease begins with dullness of consciousness, disorder of time, situation, orientation, expert disorder of self which is not destroyed. One the background of the consciousness disorder bright, multiple, visual mares take place. Person can see constantly moving insects, little animals (rats, mouse, small devils) and beasts and so on. He can hear their voices, and can be very afraid of them. Patient imaginary becomes a participants in all these events – he tries to protect himself, attack, hide himself or run away, or tries to catch them. Patient can harm himself very seriously – jump through the window, kill someone and so on.

Mares are connected to delirium which is very unstable.

Sometimes in delirium experience and in moving excitation are expressed elements of patients’ working and everyday activity(professional delirium) for example: car driver “drives the car” on the bed.

Alcohol delirium can continue from some hours to some days (abortive form) 2-7 days (classic form) sometimes very often long form. Usually patients can go out of this state after a long night dream, having partial recollection about this disorder. Due to patient’s self suggestion on the primary or on the stage of improving artificially can appear some symptoms. One of them is Lipman symptom, while pressing patient’s pupils and saying him, that he sees something, it is possible to arouse visual mare. During alcoholism Ashafenburg symptom - while bringing something near to patient and asking him if he hears something, patient begins to speak on the phone with an imaginary person. During Rayhard symptom patient is given clear paper and asked to read, he begins to read an imaginary text.

**Alcoholic hallucinoses.** Illness in majority cases begins in an acute form when on the base of dimness of consciousness appear auditory mares in the form of monologue or questions and answers. Patient hears voices speaking about himself, that discredit him, mock him, insult him, punish him, and so on. Voices are heard by the radio, from the street from inside the floor, in the night hours they become more obvious. Patient’s critical attitude towards this condition is absent.
In some cases alcoholic hallucinoses can continue for a long time, for one or two months.  

**Alcoholic paranoid.** Alcoholic paranoid is characterized by delusions of pursuit, poisoning and jealousy. It appears step by step in the first period only by being drunk, and in future it becomes constant and systematic. It seems to patient, that someone wants to arrest him, to convict, to pursuit him and so on. Other peoples’ behavior, their conversation, moving, relation and so on is analyzed in a delusional way. On this ground is formed suspiciousness. Patients suspect everyone in everything and they refuse even to eat because they are afraid, that food is poisoned. Patients are full of fear and alarm especially in the evenings.  

In alcoholic paranoid a special role plays delirium of jealousy arises on the base of heightened sexual desire accompanied by suspicion and impossibility to fulfill it become in impotence.  

If alcoholism leads to delusional ideas of jealousy, it is necessary to hospitalize patient, because he can become really dangerous.  

**Korsakoff’s psychosis.** This illness was described in 1887 by Korsakoff as alcoholic polyneuritis, special psychosis and the 12th international medical congress called it by the name of the author: Korsakoff’s psychosis.  

Korsakoff’s psychosis is met at old people who abuse alcohol for a long time. Mental disorders are not often during Korsakoff’s psychosis. Disease very often begins by step, slowly in many cases it can develop after delirium tremens.  

Korsakoff’s syndrome is characterized by fixating amnesia, confabulations and retrograde amnesia. Because of amnestic disorder, patients are disoriented in places and time. They cannot understand where they are, are unable to tell the date, month, day of week.  

Memory function is decreased so much, that patient cannot remember whom he met short time before, what he asked, even cannot remember what they have written just now.  

As patients do not lose ability of logical thinking, they realize their bad state and try not to show and compensate loss of memory. For example: when patient cannot answer the given question, he tries to avoid it saying “Is it question for me to answer” or “I have no calendar for telling what date is today”.  

Korsakoff’s syndrome is characterized also by polyneuritis, during which atrophy, pareses or paralyses, weakening of tendon’s reflexes, disorder of sensitiveness, athaxia express. Illness is chronical and can continue for years.
Narcomania

Narcomania is a chronic disease during which the organism is accustomed to drugs and arouses bodily, neurotic, psychic and other disorders. Narcomania is social evil, because it spreads very quickly and influences negatively on society. The number of narcotics is rather large. Their use is forbidden (except the cases when they are used as medicines). Narcotics cause euphoria, feeling of satisfaction and lead to the formation of physical and mental dependence. In the first stage under the influence of narcotics the mood is elevated, illusional-hallucinatory good feelings rise. In the second stage inhibition of the neural system is observed: mood is decreased, weakness, fears appear. And in case of high doses patient falls asleep. In case of prolonged or periodic usage of these substances tolerance of the body increases. Absence of narcotics lead to somatic and mental disorders (abstinent syndrome). According to UNO data in the world 47,2 milion people suffer from narcomania.

Toxicomania

Toxicomania is a disease aroused by abusing drugs and toxic material which are not involved in the list of narcotics. Psychotropic medicines are such type of materials: neuroleptics (aminazin, tizercin, haloperidol, leponex, etc), tranquilizers (diazepam, relanium, elenium, fenazepam, etc), stimulators of the neural system (sidnocaeb, fenamin, cofein,etc), antidepressants and antihystamin drugs. Reasons for development of toxicomania are different: prolonged usage of tranquilizers in chronical diseases, in neurotic conditions, self-treatment, etc. Psychopathic features, infantilism of character are also important. Adolescents copy others’ behavior (“if others use, then we can also try and see what is happening”).

CHECKING TESTS

1. For alcoholic degradation is not typical
   a) Steady changes of intellect and memory
   b) Violation of ethical norms
   c) Schizophrenia
   d) Abscense of critical attitude to pathological condition
2. Symptom of the first stage of alcoholism is
   a) Degradation of personality
   b) Mental dependence
c) Physical dependence
d) Rough disorders of intellect

3. All following psychoses are complication of alcoholism, except
   1) Korsakoff’s psychoses
   2) Alcoholic delirium
   3) Progressive paralysis
   4) Alcoholic paranoid
   5) Schizophrenia
   a) 1,2,4  b) 2,4  c) 3,5  d) 5

4. Mention all conditions, that delusion of jealousy is not typical
   1) Alcoholic paranoid
   2) Alcoholic delirium
   3) Alcoholic hallucinosis
   4) Korsakoff’s psychoses
      a) 2,3,4  b) 1,2,3  c) 2,3  d) 1,3

5. All mentioned are typical of abscinent syndrome, except
   a) Somato-vegetative disorders
   b) Sleep disorders
   c) Decrease of mood
   d) Delusional interpretation of surrounding world
   e) Mental automatisms

6. All mentioned are typical of 3-rd stage of alcoholism, except
   a) Expressed degradation of personality
   b) Polineuropathies
   c) Intellectual-mnestic disorders
   d) Only mental dependence

**Answers:** 1. c, 2. b, 3. c, 4. a, 5. e, 6. d
CHAPTER 6

Epilepsy

Epilepsy – is a chronic disease, which is characterized by aroused paroxysmal disorders as convulsive attacks and equivalents and also by the progressing disorders of personality.

**Prevalence of epilepsy.** 20-40 milion or 0,63% in the world suffer from epilepsy, morbidity is 0,05%.

Two types of epilepsy are distinguished: 1. True epilepsy or idiopathic and 2. Symptomatic, for which the convulsive attacks are the symptoms of the main disease – physical trauma of brain, tumors, syphilis, poisoning etc.

In epilepsy two groups of disorders exist

1. Epileptic paroxisms, which include big and small convulsions, epileptic psychoses and mood disorders
2. Progressive disturbance of intellect and character, which leads to special dementia and personality changes.

**Convulsive type of paroxisms.** To this group refers the **big epileptic seizure** (grand mal). In the period of forerunners quite often precedes grand mal (dysphory, melancholy, headache, lethargy), which can last from several minutes till several days.

Seizure often starts with aura, which lasts several seconds (sensorial, visual, hearing, psychosensorial, smelling, tasting, visceral, moving).

Then the consciousness is turned off immediately (coma). Patients fall down, often hurt themselves. Right away tonic convulsions appear (spasm of breathing muscular system, diaphragm, glottis – cry). Cyanosis develops. This phase lasts 20-30 seconds.

Clinical phase is the following: convulsive breathing, cyanosis is followed by hyperemia. Rhythmical convulsional shortening of skeletal muscular system is expressed. The phase lasts 1,5-2 minutes.

After the attack general relaxation of muscles takes place. The consciousness restores at once or slowly. Patients often fall in sleep. Sometimes epileptic equivalent may occur – consciousness disorder of crepuscular type like. After the attack patient has retrograde amnesia.

The condition when an attack is changed by another one and the patient’s consciousness is not recovered between the attacks is called **epileptic sta-**
tus. It is accompanied with asphyxia, swelling, then with edema of the brain, which traumatizes it by punctuated hemorrhages.

**Small seizure** (petit mal) – is characterized by absence of convulsive components. Twitching in separate groups of muscle or automatist activities happen rarely. The duration is 2-6 seconds.

**Absence** – lasts fraction of a second. Person freezes in the posture in which the seizure began. As the attack is too short in time, very often it is not noticed by people around, but it is clearly recorded by EEG.

**Form of seizure-less epileptic paroxysms**

Paroxismal disorders of mental functions, which are also called psychiatric equivalents belong to seizure-less epileptic paroxysms. They occur, in fact, as substitution for convulsive attacks. They are episodic disorders of mood and consciousness. At the same time one should know that mood and consciousness disturbances can occur related to convulsive attacks, i.e. before and after it.

Mental equivalents, as seizures, occur suddenly, without reason and end with partial or complete amnesia.

Consciousness disorders are very common in epilepsy. **Twilight disorder** of consciousness is characterized by sudden episodic narrowing of consciousness, which is accompanied by orientation (towards surrounding place, time, own person) disorder and comprehension disturbances. In this condition, patient comprehends the world through the narrow tube, seeing only a certain part.

There are horrified visual and auditory hallucinations, fragmentary delusional ideas. Patients are afraid, they are anxious, psychomotor excitation, and aggressive behavior is expressed. Patients can be very dangerous for themselves and surrounding people.

**Epileptic delirium.** It is characterized by disorder of orientation in place and time, but self-orientation is preserved. It is rich in profuse visual hallucinations, psychomotor agitation. Hallucinations are of bright colors, frightening. The patient’s behavior corresponds to the character of hallucinations and delusional ideas. Patients have fear, anxiety; they run away, protect themselves, and attack. After overcoming this condition, they remember only their unhealthy feelings, but never remember real events (partial amnesia).

**Epileptic paranoid.** On the background of narrowed consciousness and dysphoria, appear delusional ideas of persecution, jealousy, physical influence, grandeur and religious content delusional thoughts. Sometimes there can be extasy and ambulatory automatisms.
**Epileptic stupor.** It is expressed by mutism, catalepsy and passive negativism.

Special states of consciousness. It is characterized by profuse psychosensory, emotional and thinking disorders. It suddenly seems to patient, that the environment has unexpectedly changed, the buildings are waving (shaking and falling on him) or everything has become strange and unknown to him. Amnesia is partial.

**Ambulatory automatism** - patient does rather difficult, outwardly common activity, but at the same time he doesn’t give an account of his behavior, remembers nothing about his/her activity in this period. Duration – from several hours till several days and weeks.

Fugue – the patient begins to run in the room and suddenly stops that activity remembering nothing about it in future.

Trance – it’s a longer condition, patients do habitual, already automotized activity, but don’t realize them, i.e. the patient can buy a ticket and go from one town to another and after consciousness recovery don’t remember anything.

**Somnambulism** - is variety of ambulatory automatism. Patient falls in trans in the middle of the night, wakes up, does a number of automatic actions (puts on his clothes, collects his things, etc.). Then with the attack ending patient again lies in bed and remembers nothing about what happened to him.

Seizure-less paroxysms without consciousness disorders are **affective paroxysms.**

**Dysforia** is a mood disorder without consciousness disorder, it starts and ends suddenly. Duration is several days. Patients are depressed, gloomy, cruel, displeased and can be aggressive. In dysforic condition can be seen dipsomania (hard drinking) and dromomania (desire to wander).

Extasis – it’s paroxysmally developed (sudden, episodic) exaltation, the state of internal euphoria without any reason.

Seizure-less paroxysms include also narcolepsy and cataplexy.

**Narcolepsy** – is characterized by attacks of irrepressible sleepiness. Patients sleep in work place, even during walking, biking. Duration of the dream is not long. The deepness can be different. The dream, as usual, is not deep, patients wake up by slight noise, touching him. Decrease of muscles’ tonus and amplitude of tedious reflexes, myosis are marked during dreaming.

**Cataplexy** – is sudden short-time lasting weakening of muscles, which is accompanied by patient’s falling. Cataplexy is often accompanied by nar-
Epilepsy’s attacks. Patient’s head hangs over, hands pull down, feet weaken. Patient can move neither head, nor extremities. The attack is accompanied by reddening of the face, hyperhidrosis, slowing down of the pulse, reflex disappearing from the mucous membrane, tendon, skin. Consciousness is saved. Lasting – from several seconds till 3 minutes.

Personality changes. Epileptic changes of personality are expressed by changes of character, thinking disorders and dementia. All these occur as a result of lingering pathological process and serve an important diagnostic symptom, because they are very typical of epilepsy. Patient’s mental functions are slow (bradipsychia), it is difficult to go from one idea or action to another, it needs more time and pressure. Circumstantiality of thinking is expressed; it’s difficult for the patient to distinguish important issues from secondary, they stuck in details. Oligophasia; decrease of vocabulary, is seen and patients fill this lack with mimics and movements. Emotional disorders are also typical; emotional reactions are steady, long and strong. Patients express emotional explosones, have aggressive behavior. Bipolarity of character is typical; on the one hand they are very polite, flatterer and on the other hand opposite; very cruel, revengeful, spiteful. They have emphasized attention to their health condition, they are egocentric. Parallel to these changes concentric dementia arises, which is characterized by bradipsychism, bradiphrenia, thinking is concrete, decreased memory, interests of the patient is concentrated to their self condition, till their physiological needs. It is necessary to mention, that epilepsy can have a favourable course, when dementia and all personality changes are not expressed.

Etiology and pathogenesis
Etiology of epilepsy is not yet clear. Researchers give priority to genetic factors. In the development of epilepsy important role has organism’s tendency towards seizures. This is connected with constitution, type of neural system, characteristics of metabolism. Besides heredity, external-organic disorders of the brain during pregnancy and childbirth are also important.

Differential diagnostics. Genuine epilepsy is distinguished from symptomatic epilepsy, which has etiological reason (brain injury, syphilis, alcoholism, etc). Special personality changes and intellect disorders, which are
absent in symptomatic epilepsy are also important for differential diagnostics.

Treatment –is complex, it includes both medication, and psycho-hygienic, diet, regimen of work and rest. Antiepileptic medication is mainly anticonvulsants (Phenobarbital, benzonal, hexsamidin, finlepsin, convulex, etc), Vitamins of B group, tranquilizers.

CHECKING TESTS
1. Which emotional disorder is typical of epilepsy
   a) Ambivalence
   b) Emotional weakness
   c) Dysforia
   d) Parathymia
   e) Apathy
2. All are typical of epileptic dementia, except
   a) Bradipsychism
   b) Oligophasia
   c) Bipolarity
   d) Emotional incontinence
   e) Disorder of memory
3. Which thinking disorder is typical of epilepsy
   a) Schizophasia
   b) Pathological circumstantiality
   c) Autistic thinking
   d) Mentism
   e) Incoherence of thinking
4. For epileptic paroxysms is typical consciousness disorder, except
   a) Epileptic twilight condition
   b) Trance
   c) Big seizure attack
   d) Dysforia
   e) Somnambulism
5. In which case coma rises
   1) Grand mal
   2) Absence
   3) Fugue
   4) Petite mal
      a) 1.2.4  b) 1.2.3.  c) 2.3.4  d) 3.4
6. All mentioned are epileptic equivalents, except
   a) Epileptic delirium
b) Epileptic twilight condition  
c) Epileptic paranoid  
d) Epileptic dementia  
e) Epileptic stupor  

7. To prevent epileptic status are used all mentioned, except 
   a) Diazepam i/v  
   b) Amitriptilin  
   c) Magnesium sulfat  
   d) Puncture of spinal cord  

8. Epilepsy is characterized by  
   a) Emotional weakness  
   b) Perseveration  
   c) Dysforia  
   d) Ideatory automatism  
   e) All mentioned  

Answers: 1.c, 2.d, 3.b, 4.d, 5.b, 6.d, 7.b, 8.c
CHAPTER 7

Schizophrenia

Schizophrenia (where “schizo” means splitting, “phren” means soul) is a chronic mental disease. The duration of disease progresses with transformation of personality. Personality defect is expressed in the following way: by decreasing of energetic potentiation, by developing and becoming intensify of autism, disintegration of mental process’ unity, which means, that the adequate correlation between thinking, emotion and behavior is impaired. Mental activity of person decreases, lack of sociability rises, behavior becomes inadequate. Apatico-abulic defect rises during time.

Schizophrenia is an endogenous disease, because in its etiology and pathogenesis the main role has endogenous factors. Onset of the disease is often expressed at the age of 18-30. The disease as an independent nosological unit was first described by German psychologist E. Crepelin in 1896 under the title of “early dementia” (dementia praecox). Crepelin suggested this name, because he generally paid attention to the fact that the disease’s onset was in young age and very soon led to the defect of person.

In 1911 E. Blayer suggested the term “schizophrenia” as the name of this disease, he took as the main factor not the early development defect but the original structure of mental disorders, i.e. splitting of integrity of mental activity, schisis.

Epidemiology. Due to WHO 0.85 – 1% of population of the world is suffering from schizophrenia.

Symptomatology

All symptoms and syndromes occur in schizophrenia, except for those, which are specific for organic lesion of the brain, in particular: disorder of memory, transformation of intellect in organic type and paroxysmal epileptic syndromes. Disorder of associative processes and emotional-volitional sphere are the case of psychopathological disorders, which are presented with all types of schizophrenia, and become the reason for forming such changes of person, which used to call schizophrenic defect. The disorders of thinking and emotional-will sphere are called “negative symptoms”.

Disorders of associative processes:
- schizophrenia, mentism
- arrest/standstill, break of thoughts, its sounding
- perseveration, verbigeration
- symbolic thinking
- philosophic intoxication, resonation

In case of thinking disorder, patient’s thinking lacks of logic; they are sure in delusional ideas, that some outer energy takes their thoughts from the head and their thoughts become known for everyone, thoughts sound loud, they become heard. Symbolic thinking expresses in speech, writing, patient takes a great interest in pseudoscientific or mystic ideas. Thinking gradually loses its links with reality, becomes aimless, lack of means, isolation from reality rises. Patients seclude themselves, become unsociable. This condition and living in the world of own abstract feelings is called autism.

   Emotional-willing sphere is changed:
   - flattening of emotion
   - parathymia
   - ambivalency
   - apathy

Emotional-willing disorders are expressed by changing of patient’s spirit, they become irritable, anxious, depressed, indifferent to the surrounding, they express negative attitude to relatives, patient’s feelings and behavior do not coincide with the situation: patient can laugh, when he hears about death of somebody (parathymia) and opposite.
The weakness of will is expressed in disorder of attention, attraction, unable to regulate action, behavior.
   - ambitandency
   - weakness of attention and concentration
   - unusual sexual behavior
   - behavior, destroying social norms
   - attempts of suicide
   - threats and the act of violence
   - unsociability
   - absence of habits
   - hypo activity
   - fanciful poses and actions
   - unusual ideas and behavior (“drift”)

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In case of will weakness, lack of initiation, patients can be less of action for a long time, they can make stereotype actions. They have disorder of motion, stupor or psychomotor disorders can rise, patients can be in a discomfort pose without feeling it (catalepsy, air pillow).

They avoid contacts, take no care of themselves, become untidy, slovenly. Impulsivity is expressed in his behavior, unexpected actions, unreasonable aggression or stiff on his face, grimaces, echo-reactions are seen.

Disorders of attraction, attention are expressed. They concentrate their attention with difficulty. So it seems, that their memory is disordered, they can read a page of a book and remember nothing, but their memory is not disordered.

Generally all these are negative symptomatic and it is typical of chronic schizophrenia.

Positive or productive symptoms generally are expressed like hallucinate-delusional excitements.

Senestopathy: unpleasant pathological feelings.

Hallucinations: auditorial, olfactory, tactile.

Delirious ideas: persecution, reference, influence, jealousy, hypochondriac.

Senestopathical disorders are marked: patients feel pathological feelings of strange and unusual character (something moves all over the body, cold ball in head, stretching of internal organs, electricity is going all over the body, etc.)

Patients often have hallucinations, especially auditory hallucination, mainly pseudohallucinations. Patient hears short phrases of imperative and commenting character, his name, first name. Hallucinations of olfactory, taste has unpleasant character (food has rotting taste, feeling of gas in air).

Visual true hallucinations are not typical of this disease, but not usually there can be visual pseudohallucinations.

Delusion of persecution is typical of schizophrenia – delusional ideas of persecute, poisoning, reference, physical influence. Usually there can be hypocondrical delusions, when patients complain to various doctors as they suffer from incurable disease. Delusional ideas of poisoning, ideas of grandeur may be seen.

**Syndromology**

In schizophrenic process there can be the following syndromes, which express the depth and type of the pathological process:

- asthenic syndrome
- affective syndromes
- neurosis-like syndrome
- hallucinatory-delusional syndromes
- catatonic syndrome
Clinical Forms

Simple schizophrenia. Developing of negative symptoms is typical of this form. Working ability is lost. In the beginning there can be registered “drift”, changing one occupation with another, changing interests, but all it has short term lasting, in result patient loses interest in everything. Apathy is expressed, patients become unsociable, acute autism is expressed, apatobiologic defect develops very soon.

In this form of schizophrenia productive symptomatology is not expressed.

Hebephrenic schizophrenia. Disorder of behavior, affective disorders and disorder of thinking are brightly expressed in this case of schizophrenia (foolishness, inadequate poses, grimaces, neologisms, schizophrenies, which can reach to “word salad”). Patients laugh unnaturally, utter voices of animals, they become impulsive, fragmental delusions and hallucinations can be expressed.

This form of schizophrenia develops in puberty period and can also be called as “youth” schizophrenia. Defective condition with expressed incoherence of thinking develops comparatively quickly.

Catatonic schizophrenia. Disorders of motor activity is typical of this type, which is expressed by motor excitement or stupor. When patient excited, his movements are stereotype, impulsive, affected, ambitendency can also be expressed. Patient’s speech is characterized by schizophrenia, echo-reactions (echomimia, echolalia, echopraxia), verbiage can also rise.

Patient stays motionless, negativism, mutism are marked, his face is amimic in case of catatonic stupor. Muscle tonus is expressed by higher waxy flexibility (catalepsy), when patient can stay in uncomfortable pose for a long time; for example: lay with rising head under the pillow and doesn’t feel uncomfortability (Dupree’s air pillow symptom), embryonic pose. This condition can be with disorder of consciousness (oneiroid) and without (lucid). In oneroid condition patients see dream-like hallucinations.

Paranoid schizophrenia. The main psychopathological expression is paranoid syndrome, but patient can hide his ill feelings for a long time, in the cause of slow lasting of disease (till 10 years) and its expression is in the middle ages (at the age of 30-40). Auditory hallucinations can be accompanied with delusional ideas of reference, persecution, physical influence. Often in the center of delirious ideas there is mental automatism (syndrome of Candinski-Clerambault). In some cases disease is acute lasting and delusion is systematized from the beginning of the disease, in another case it is expressed as separate phrases, forms a system during
time. Paranoid form is expressed more often and in case of mental disintegration the delusional system is also disintegrated.

**Schizoaffective disorders.** It is fragmental paroxysmal disorders, during which both schizophrenic (negative symptomatology) and affective symptoms (manic and depressive) are expressed. The duration of attack is several days. These symptoms rise during one attack at the same time or in consecutive order. Patients who suffer from recurrent schizoaffective fragments, especially from manic type, often are healthy, defective condition develops seldom.

**Children’s schizophrenia.** All symptoms of schizophrenia in children and adolescents are expressed according to their age. Early signs are decreased activity, changes in usual interests, making their inner world. Delusional ideas are seen seldom; sometimes they can be expressed as if their parents did not like them.

### Course of schizophrenia

Schizophrenia has a chronical course. There are 3 types of the course:

1. Continuously progredient lasting without remissions, (simple form, lucid catatonia and hebephrenic form).
2. Attack-like progredient duration, it is typical of paranoid schizophrenia.
3. Periodic or recurrent duration, which is typical of schizoaffective schizophrenia; the prognosis is relatively favorable.

The level of continuous-progredient schizophrenia is different – from the slow course with moderate changes of personality up to the rough progredient form, during which in 1-2 years after the disease manifestation, catastrophic destruction of personality follows with steady and deep development of terminal state defect.

Paroxysmal-progredient schizophrenia can have a course from relatively favorable till progredient with considerably deep defect. This type of course can also have less-progredient and malignant character. In some cases in 2-3 fits the course of disease becomes continuous; in other cases bright changes of personality become deeper from fit to fit during many years. Recurrent type is considerably favorable; changing of personality is expressed on a less level.

### Etiology and pathogenesis

Genetic factor is the most cogent reason among predispose factors. Comparing monozygotic, or univular, and dizygotic twins is testified that the risk of getting ill among monozygotic twins is higher. So, in case of
getting disease of one of monozygotic twins, the probability of being ill for
the second one is 85-90%, among dizygotic twins this number is 17%. If
one of the parents is ill, the probability of being ill of children is 16%, if
both parents – 70-80%. But the type of inheritance is not determined yet.
In the beginning of the 20-th century there was a hypothesis, that basis of
schizophrenia is toxification. At first it was exogenous intoxication
(tuberculosis, streptococcus, etc), but it was not proved. After that
endogenous intoxication theory was suggested. Due to this theory from
blood was secreted protein called «taraxein», which occur schizophrenic
symptoms in healthy volunteers. Results of researching autoimmune, EEG
activity, stereotonic, dopaminic data don’t present convincing evidences.

**Differential diagnosis**

It is difficult to differentiate schizophrenic symptoms, especially in onset of
disease. Diagnosing schizophrenia doctors must base on negative
symptomatology and specific personality defect.

**Treatment**

- neuroleptics (haloperidol, zipraksa, risperdal, moditen-depo,
  haloperidol-decanoat, etc.)
- antidepressants (prozac, zoloft, amitriptilin etc)
- electroconvulsive therapy
- supporting therapy
- social arrangements for learning the conditions of living patients’
  family

**CHECKING TESTS**

1. All symptoms are typical of shizophrenia, except
   a) Neurotic disorders
   b) Delusional ideas
   c) Hallucinatory-delusional syndrome
   d) Convulsive syndrome

2. For schizophrenia is not typical
   1) Impoverishment of emotions
   2) Memory disorders
   3) Ambivalence
   4) Inadequancy of emotional reactions
   5) Oligophasia
   a) 1,3  b) 2,5  c) 1,3,4  d) 1,5
3. Which is more typical of simple schizophrenia
   a) Domination of negative symptoms (indifference, autism)
   b) Delusional ideas
   c) Waxy flexibility
   d) Foolish behavior

4. Expression of schizophrenic defect is
   a) Oneiroid catatonia
   b) Apato-abulic syndrome
   c) Depressive syndrome
   d) Korsakoff’s syndrome

5. Which are typical of hebephrenic schizophrenia?
   1) Foolish behavior
   2) Depressive syndrome
   3) Syndrome of Kandinsky-Clerambault
   4) Neologisms
   5) Catatonic excitation
   a) 1,2,5  b) 2,5  c) 1,3,5  d) 1,4

6. For paranoid schizophrenia is typical
   a) Mentism
   b) Delusion of physical influence
   c) Pseudohallucinations
   d) Alienation of mental functions
   e) All mentioned

7. Which syndromes are typical of schizoaffective psychoses
   1) Asthenic syndrome
   2) Depressive syndrome
   3) Ganser’s syndrome
   4) Manic syndrome
   5) Korsakoff’s syndrome
   a) 2,4  b) 3,5  c) 1,3,5  d) 3,4,5

8. All mentioned are a course of schizophrenia, except
   a) Continuously progressive
   b) Attack-like progressive
   c) Continual
   d) Periodical

Answers: 1.d, 2.b, 3.a, 4.b, 5.d, 6.e, 7.a, 8.c
Bipolar (affective) psychosis is a mental disease characterized by the periodicity of the occurrence of affective disturbances in the form of manic, depressive or combined states (attacks, phases, episodes), their complete reversibility and the development of intermissions with the restoration of mental functions and personality traits. It does not lead to retardation.

Affective psychosis is characterized by affective phases only, which may be of various depth and duration. Intermission is a light period between affective phases, when patient is fully healthy. The prevalence of affective psychosis is 0.32 to 1000 population.

Clinical manifestations and course.

Depressive states. Typical depression is characterized by a classic triad, which consists of depressed mood (hypothymia), slower rate of associative processes and motor inhibition (depressive triad).

The development of the depressive state starts with a feeling of general discomfort, which is usually dominated by physical disorders at first, and then mental. Patients mention an unpleasant feeling in the epigastric region, a feeling of heaviness or pain in the cardiac region (anxietas precordialis), difficulty in comprehending new information, difficulty in concentrating, a feeling of "emptiness" in the head. Their movements are markedly slow. Patients complain of loss of emotional attachment to close ones (anesthesia psychica dolorosa). Events happening around them are perceived in black colors, and different events from their lives are used by them to create ideas of self-depreciation and self-blame, which bear both magnifying and delusional character. These ideas can lead to suicidal tendencies.

Depressive state is worsening in the morning and softening in the evening. Motor inhibition is also mentioned, it can be from substuporous condition till depressive stupor. In this case the difference from catatonic stupor is: absence of active negativism, flexibility and amimic face.
Manic states are characterized by an elevated mood, increased speed of associative processes and an extreme desire towards activity (manic triad). Cheerfulness, distractibility, a variability of attention, superficiality of judgement and evaluation, optimistic attitude towards one's present and future are all characteristic of patients. They are in an excellent mood, feel unusually energetic; a rush of strength, tiredness is alien to them. Tendency towards activity is seen differently in various patients - they start a number of different tasks, not completing any of them, spend money foolishly and irregularly buying unnecessary things, interfere with colleagues and coworkers' tasks at work, suggest radical changes to the organization of their workplace and so on.

Intellectual awakening is seen in the form of an increased speed of thinking, variability of attention, hypermnesia (enhanced memory). Patients are talkative, talk non-stop, which causes a hoarse voice; they sing and recite poems. Often there are flights of thought (fuga idearum) - acutely accelerated thinking, during which there is an intermittent shift from one incomplete thought to another. Intonation is usually pathetic and theatrical. Everything occurring around the patient, whether significant or inconsequential, interests the patient equally, but does not hold his or her attention for a long time.

Patients characteristically exaggerate their own personality - they discover outstanding capabilities in themselves, often express a desire to change their profession, glorify themselves as outstanding scientists, artists, authors and so on. Sometimes ideas can reach to the level of delusion (delusional ideas of grandeur). Patients look younger, they note increased appetite, decreased sleep duration or stable insomnia, increased sexual drive. A quickening of the pulse, hypersalivation, disturbances in the menstrual cycle of women are all seen in manic states. In manic state psychomotor activation can be expressed as agitation. The difference is that, in manic condition actions are purposeful.

Bipolar psychosis is also characterized by somato-vegetative disorders - weight loss, dry mucous membranes, fluctuation of blood pressure, red, stable dermographism and Protopopov's triad: tachycardia, midrias and constipation.

Mixed forms of bipolar psychosis: angry mania is characterized with motor and intellectual activation, which is accompanied with angriness, irritability and captiousness. Manic stupor – high mood is not accompanied with
motor activation, but inhibition. Agitated depression – during this form agitation and anxiety are expressed.

Atypical types of affective psychosis are seen as cyclothymia and masked depression.

**Cyclothymia** - this is a persistent state of pathologically modified affect with alternating periods of hypomania and sub-depression as separate and dual episodes (phases), divided by intermissions and continually developing.

Hypomania (*mania levis, mania mitis*) - this is a mild form of mania, which includes weakly expressed manic signs. The hypomanic syndrome, similar to classic mania, presents with an increased, hyperthymia affect, accelerated cognitive processes with increased talkativeness, irritability, carelessness. Hypomania, as a rule, is subjectively seen in an egocentric light as a natural, pleasant high. Critical assessment of the disorder is difficult - the signs are only noticed by people who know the patient when he is out of this state.

**Cyclothymic depression** is determined by latent signs of melancholy with unfounded pessimism, despondency, there may be magnified thoughts in the clinical course which correspond to affect - ideas of shame, usually lowered self-esteem with thoughts of personal inconsequence, uselessness towards work or family. Patients complain of tiredness, sleep disorders. As symptoms are expressed less, this patients are out of doctors view.

**Masked depression** includes states when somatic symptoms are the primary signs while psychopathological manifestations are not marked. Most often these are seen as stable, lasting pains, unpleasant feelings (cenestopathies) which increase in the morning. Somatic manifestations of masked depression are numerous. These are headaches, facial pain, backaches, pain in the extremities, various cardiovascular disturbances, problems with the gastrointestinal tract, respiratory organs and so on. Psychopathological manifestations include a feeling of loss of strength, weakness, loss of interest to favorite activities, a feeling of worry. Antidepressants and tranquilizers are helpful.
**Etiology and pathogenesis.** The causes of affective psychosis have not yet been established completely, although in recent decades there has been a great deal of significantly new information. Presently, there is a lot of hope associated with molecular-genetic research which is being carried out quite intensively with regard to affective psychoses as well as other diseases. The basis of this research is clinical genetics, which bears witness to the great role that hereditary factors have to play in the development of this disease. The main hypothesis for the pathogenesis of affective psychosis, particularly endogenic depression, is currently the serotonin hypothesis. According to the serotonin hypothesis, the cause of the disease is the dysfunction of central serotonergic neurotransmission. There is enough convincing evidence of the involvement of the serotonin system in the pathogenesis of endogenous depression. These data categorically confirm the multi-directional disturbances of this system, which finally lead to hypo-functioning of the central serotonergic system during endogenous depression.

**Classification.** Currently, from clinical and prognostic points of view, the most suitable classification is the division of affective psychoses depending on the interrelation and dominance in the clinical condition of the patient of the two polarities of affective disorders - manic and depressive phases.

- **Monopolar depressive**, when there are exclusively depressive phases throughout the clinical course of the disease. **Monopolar manic**, during which only manic phases are noted.
- **Bipolar course** when intermission starts after manic-depressive attack.
- **Alternance** and **continual course**.

**Treatment** – is syndromical. Neuroleptics and tranquilizers are prescribed in hypo-maniacal conditions. In general antidepressants are recommended in case of depressive conditions, and, if necessary, combined with neuroleptics. Salt of lithium and carbamazepine are used in treatment and attacks’ prevention.

**CHECKING TESTS**

1. Definition of bipolar psychoses is
   a) Endogenous disease, which leads to personality defect
   b) Endogenous disease, which is characterized by emotional disorders
   c) Endogenous disease, which is characterized by intellectual-mnestic disorders
d) Endogenous disease, which is characterized by attacks of consciousness disorders

2. Manic stage of bipolar psychoses is characterized by
   a) Elevated mood
   b) Deinhibition of desires
   c) Ideas of self-estimation
   d) All mentioned
   e) None of mentioned

3. All mentioned concern to depressive stage of bipolar psychoses, except
   1) Decrease of mood
   2) Inhibition of associations
   3) Ideas of self-acusation
   4) Activity, aspiration towards activity
   5) Decrease of memory
      a) 3.4.5 b) 4.5 c) 1.4.5 d) 1.2.3

4. To the mixed type of bipolar psychoses does not concern
   a) Masked depression
   b) Angry mania
   c) Manic stupor
   d) Agitated depression

5. Mask depressions, first of all, are expressed by
   a) Inhibition of associations
   b) Somatic disorders
   c) Motor and intellectual activity
   d) Psychomotor inhibition

6. Period between two stages of bipolar psychoses is:
   a) Remission
   b) Intermission
   c) Degradation
   d) Regress

Answers: 1.b, 2.d, 3.b, 4.a, 5.b, 6.b
BRAIN INJURIES

Mental disorders caused by head trauma are very common. Injuries can be during childbirth, domestic, industrial. A significant place has natural disaster, war injuries, especially craniocerebral trauma.

Head trauma is differentiated depending on the type of brain damage - focal, diffuse and combined or based on its gravity - mild (concussion or mild contusion of the brain), moderate (moderate contusion of the brain) and severe (severe contusion and brain compression). One can distinguish initial, acute and delayed stages of head trauma.

Psychopathology during head trauma is seen immediately, and may regress completely or partially over time. Mental disorders seen during trauma are always associated with neurological, otoneurological, ophthalmoneurological and various viscerovegetative disorders.

Disorders of consciousness are seen in almost all patients in the initial stage. It is characterized by different types of consciousness disorders: torpor, sopor, coma, and can last from several minutes till hours. After consciousness is regained amnesia can rise, which can be anterograde or retrograde.

Mental disorders in acute stage. After consciousness recovers there can usually be asthenic condition, which is expressed by headaches, dizziness, decrease of memory, distraction of attention. Sometimes irritability, hyperaesthesia can be seen. Mood is unstable, sleep disorders appear. Usually different vessel and vegetative disorders are seen. Duration of this period is 2-3 weeks and gradually it improves, if it’s not complicated by acute mental disorders (psychomotor excitation, delirium, twilight condition of consciousness, etc).

Delayed period disorders appear after 6 months and more. In the delayed period of head trauma the weakening of all mental activity may be noted or the disturbance of select components while consciousness remains clear, which leads to one of the following syndromes.

Asthenic syndrome (cerebrasthenia), is typically characterized by increased frequency of fatigue in exhaustion, weakness or even transitory loss of ability towards mental or physical work. This syndrome is very common in the clinical manifestation of head trauma in all periods.
Specific asthenic manifestations (general weakness, fatigue, exhaustion, lethargy, daytime sleepiness, adynamia) are accompanied by headaches, dizziness, nausea, speech and memory problems. In its "pure form", asthenic syndrome is seen in the delayed period expressed as simple asthenia - mental and physical exhaustion, a sharp decrease in effective mental activity, sleep disorders (insomnia, fitful sleep, increased frequency of dreams - colorful dreams, nightmares).

Encephalopathy with personality disorder. Affective-volitional sphere disorders are typical. Patients become irritable, egoist, combative, not adaptive to environmental rules, often abuse alcohol and narcotics. Dysphoric states can be observed in these patients.

**Epileptic syndrome** is a common consequence of head trauma, which leads to invalidazation of patients. The structure of the attack depends largely on the traumatic focus. Grand mal seizures with loss of consciousness are the common manifestation. Cases of absence, psychomotor seizures, attacks of viscera-vegetative disturbances and catalepsy are also seen.

Difference from genuine epilepsy is that in this case there is no clear consequence of clonic and tonic seizure attacks, and also personality changes typical of epilepsy in not seen.

In delay period of brain injuries can be observed **affective and hallucinatory-delusional** disorders.

Manic and depressive conditions periodically rise in case of affective psychoses. on the background of depression hypochondriac and dysphoric symptoms can be seen, and in manic state is characterized by affective explosions.

The clinics of hallucinatory-delusional psychoses are expressed by verbal hallucinations and affective tensioned delusional ideas, which have concrete content.

**Traumatic dementia** is characterized by a diminishment of cognitive and mnestic processes, a paucity and simplification of the emotional and personal characteristics of the patient. In patients who have experienced coma for some duration of time, mental retardation becomes obvious as formal signs of clarity of consciousness develop. Verbal memory suffers - patients forget the names of objects, but are able to describe their form, function and so on. Comprehension of current events occurs more slowly, but a realization of their own helplessness remains, with a corresponding emotional reaction. The clinical picture also includes lethargy, emotional instability or euphoria, bursts of irritation.
CHECKING TESTS

1. Brain injuries can lead to
   a) Personality changes
   b) Dementia
   c) Epileptic seizures
   d) All mentioned
   e) None of mentioned

2. For acute period of brain injury is typical
   a) Asthenic syndrome
   b) Cotard’s syndrome
   c) Apatho-abolic syndrome
   d) None of mentioned

3. Cerebrasthenia is characterized by
   a) Headaches, dizziness
   b) Decreased activity, distraction of attention
   c) Somato-vegetative disorders
   d) All mentioned

4. Personality changes connected with brain injury are characterized by all mentioned, except
   a) Affective liability
   b) Dysphoria
   c) Emotional weakness
   d) Alcohol abusement

5. For traumatic epilepsy are typical all mentioned, except
   a) Clear consequence of clonic and tonic seizure attacks
   b) Petit mal, absence
   c) Twilight consciousness condition
   d) Abortive seizure attacks

Answers: 1.d, 2.a, 3.d, 4.c, 5.d
CHAPTER 10

NEUROTIC, STRESS-RELATED
AND SOMATOFORM DISORDERS

Psychogenic disorders develop under acute or lingering influence of stress. These disorders are reversible. The clinical features are characterized by type of psychogenic factor, patient’s premorbid state of personality, condition of the neural system. Two types of psychogenic disorders are distinguished: neuroses and reactive psychoses.

NEUROSES

Neuroses or neurotic disturbances are a group of psychogenic, often conflictogenic, functional neuro-psychic disorders, which occur as a result of complications in some life situations. They are characterized by partial and ego-dystonic multiform clinical manifestations, without changing the self-consciousness of the person and with insight into the disease.

Prevalence of neuroses. Morbidity of neuroses is 74.2 in 100,000 people. Three main forms of neuroses may be distinguished: neurasthenia, neurosis of persistent conditions and hysteric neurosis. Apart from this, neuroses of fear, expectation, depressive neurosis and hypochondriac neurosis are distinguished as well.

NEURASTHENIA is one of the most common forms of neurosis. The clinical picture of neurasthenia is determined by symptoms of psychic hyperesthesia. A characteristic feature of this hyperesthesia is an intense feeling of fatigue. Prevalent complaints include “unbearable” tiredness, complete “prostration”, decrease in vital tone, decrease in physical and mental activity, absence of cheerfulness, energy, constant fatigue and malaise without undue exertion. Hyperesthesia also occurs in the sphere of sensory perception and body sensation. Sensibility to external irritants (photophobia, hyperacusia, hyperosmia) and physiological sensations (hyperpatia, excessive perception of feelings connected with normal physiological functions of the organism: heartbeating, intensified peristalsis, etc.) take place.
One of the constant symptoms of hyperesthesia is headache, a tense state which manifests as pressure, tightening, splitting pains in the forehead and back of the head, the sensation of having a “head that is not fresh”, etc. Disturbance of sleep-wake cycle is also considered to be one of the main symptoms of neurasthenia. Patients feel drowsy during the daytime, but at night they sleep anxiously, often awakening. Pre-, intra- and postsomnic disorders are observed. Besides this, irritability, emotional lability, impatience, worsening of memory, weakening of ability to concentrate and anorexia are also observed.

It is typical of neurasthenia, as well as of other neuroses, that organ systems become sequentially involved in the clinical manifestation of the disease. In the first stage, vegetative disorders appear and irritating weakness is characteristic. If the patient worries or undergoes physical exertion tachycardia, sweating, fluctuation in arterial (blood) pressure, cold extremities, disturbances in sleep and appetite and headaches are observed. In the next stage of neurasthenia, sensory-motor disorders appear, manifested by hyperesthesia in the sphere of sensory perceptions and body sensation, gradually leading to hypochondric inclination. Later, affective disorders in the form of “emotional incontinence” are also seen. Patients do not control their feelings, they lose their temper over nothing, tears appear in their eyes even for very insignificant reasons and they show inadequate reactions of offence or irritation. Besides an increase in vegetative, sensory-motor and affective symptoms, inhibition of intellectual activity also occurs, which is manifested by the ideatory level of neurasthenic disorders, i.e. difficulty in concentrating, mastering the material and education and also memory impairments, which is especially obvious to the patient if he/she keeps his/her former responsibilities. One can also distinguish between hypersthenic, transient and hyposthenic forms or stages of neurasthenia. Irritability, hyperesthesia, predispositions to affective reactions and attention disorders are characteristic of hypersthenic forms of neurasthenia. In hyposthenic neurasthenia the prominent features are a decrease in the capacity for work, permanent sense of tiredness, languor, drowsiness, early exhaustion. Transient forms are characterized by increased irritability, associated with quick exhaustion and malaise.

Neurosis of persistent states or obsessive conditions are the general name of neuroses, expressed as persistent fears, attractions, thoughts, images, recollections, suspicions and actions.
Obsessive thoughts: are difficult to bear and occur despite the will of the person. They may be images, thoughts which come to the patient’s mind repeatedly and stereotypically and which he tries to resist e.g. why man has two legs, but animals have four, why people have differently shaped noses, etc. Despite understanding the absurdity of such thoughts and treating them critically, the patient cannot get rid of them.

Persistent actions or compulsions – are repeated stereotypical actions or steps taken e.g. during conversations one constantly twists a piece of paper in his hands, doodles with a pencil, twists a lock of hair on his or her finger, aimlessly shifts objects on the table, bites his or her nails. Finger cracking and lip biting also relate to these symptoms. Rituals may also be considered compulsive actions – these are obsessive actions and movements, carried out by patients as a necessary ceremony to protect themselves against phobias and obsessive suspicions e.g. the patient with misophobophobia constantly washes his hands, each time soaping them no less than 10 times, counting out loudly and if accidentally he/she loses count, starts from zero again.

In persistent suspicions, the patients have obsessive thoughts about the right actions or decisions taken. The content of the suspicion may be different: whether the door is locked, if windows or taps are closed firmly enough, if the gas, electricity are turned off, or suspicions may concern their professional activity.

Persistent attractions or manias - these include the involuntary arousal of attractions and wishes. Among them are: arithmomania, onomatomania, dromomania, pyromania, dipsomania, cleptomania, suicidomania, homicidomania, trichotillomania.

Contrasting obsessions are also considered to be obsessions - abusive and blasphemous thoughts, with the fear of hurting oneself and one’s surroundings, or thoughts which go against the human morals and ethics e.g. at the sight of sharp objects the mother obsessively imagines herself sticking them into her only son’s throat etc.

Anxious–phobic disorders are one of the most prevalent forms of mental illness. Panic attacks, agoraphobia (in the broad sense of the word) and hypochondric phobias can be seen in the clinical picture.

Panic attacks are paroxysmal in nature and quickly arise as a symptom–complex of vegetative disorders (vegetative crises – rapid heartbeat, chest constriction, suffocation, feeling lack of air, perspiration, dizziness), ac-
companied by the sensation of impending death, fear of losing consciousness or self-control.
We distinguish sympatho-adrenal, vago-insular and mixed crises, as well as permanent, paroxysmal and mixed crises.
Sympatho-adrenal crises are manifested by accelerated pulse, dryness in the mouth, elevation of AP, paleness of skin, numb and cold limbs, chills, polyuria. During vago-insular crises one has cardiac pains and ‘arrest’, a sensation of ‘intermission’, pressure in the chest, sensation of lack of air, dizziness, unpleasant sensations in the epigastric area, increased peristalsis, nausea, hypersalivation, decrease in AP, skin hyperemia, sensation of heat, sweating, polyuria.

**Persistent fears or phobias**, are very agonizing emotional experiences of fear, caused by most different things and events. Among them are claustraphobia, agoraphobia, miso-, gypsum-, oxi-, ereuthophobia, scoptophobia, dentophobia, thanatophobia, taphophobia, arachnophobia, herpetophobia, anthropophobia, lissophobia, nosophobia (cancero-, cardio-, syphilophobia).

**Hysteric Neuroses** or **conversion disorders** manifest through polymorphic functional mental, somatic and neurological disorders and are characterized by great suggestibility and auto-suggestibility of patients, who often intend to draw attention to themselves by all possible means. People inclined towards hysteric neurosis usually have symptoms of psychic infantilism with emotional lability, affective immaturity, immediate emotional reactions, impressionability and animation. Hysteric neuroses are often seen in women. Due to the variety and variability of its clinical picture Charcot called this disease “the great malingerer”. There are three main groups of symptoms in hysteric neuroses – vegetative, motor and sensory. All of them resemble somatic and neurological diseases.
Cardiac, respiratory, gastro-intestinal and sexual disturbances are all forms of vegetative manifestations. Psychogenic cardio-vascular manifestations include tachycardia, unpleasant sensation and pain in the cardiac area, extrasystoly with the sensation of cardiac arrest and intermittent heartbeats. Among respiratory impairments one can note change in inhalation and exhalation rhythms with a feeling of respiratory arrest. During emotional moments, neurotic dyspnea can occur expressed by rapid superficial breathing or “canine breathing”. Laryngospasm, hysteric coughing, sneezing and hiccups are also neurotic respiratory disorders.
Esophageal spasms, anorexia, aerophagia, regurgitation, belching, vomiting, diarrhea, and “globus hystericus” are disorders of gastro-intestinal tract function.

Sensory disturbances are expressed as impairments in sensitivity (anesthesia, hyperesthesia, paresthesia). Most often sensitivity disorders of the extremities are observed which do not correspond to the anatomical location of the nerves and is based on the patient’s understanding, i.e. of the amputation type - in the form of socks, tights, gloves etc. Hysteric amaurosis and muteness are among the sensory disorders most often observed. Convulsive seizures, paralysis, paresis, astasia-abasia, hyperkinesis, contractures, blepharospasm, aphonia, mutism and tremor are motor disorders. Hysteric hyperkineses manifest as tics, rhythmic tremors of the head and limbs, choreiform movements and twitching which are more organized and stereotypical than in chorea. Hysteric paralyses and pareses can be mono-, hemi-, para-, and tetrapareses or paralyses in character and resemble the central spastic type in some cases and flabby peripheric type in others. Usually topography of paralyses does not correspond to innervation or localization of foci in the CNS. They occupy either the whole extremity or part of it, strictly restricted by joint line (from the end of the leg till the knee and so on). Unlike organic paralyses, no pathological reflexes or changes of tendon reflexes and muscular atrophy are observed in hysteric paralyses.

Hysteric seizure occurs as a result of psychic trauma, often in the presence of others. In this case consciousness is not impaired, only affective narrowing of consciousness can take place. Patients are usually cautious while falling, managing to fall down in such a way that they avoid injuries. Movements are broad and chaotic with marked demonstrative poses. The patient rolls on the floor, kicks and hits the floor, trembles all over – there is total tremor with cries, moans and shouts. The hysteric arch can be seen. Unlike epileptic seizures consequent changing of tonic-clonic phase is not noted. It lasts till 30 minutes and more. Pupil reflex to light is retained, when one tries to look at the patient’s pupils, he or she screws his or her eyes, involuntary urination and defecation do not occur. Onset is psychogenic, usually during daytime, in the presence of people. The seizure causes no injuries, and afterwards the patient laughs, cries, sobs etc.

**Treatment**

The treatment is complex in neuroses and includes general strengthening through vitamins, nootropic substances, diet, walking and physical exercise, massages, water procedures, conservative treatment with tranquilizers,
neuroleptics, antidepressants, psychostimulators, which have their specifics in each neurosis, and, of course, psychotherapy. Psychotherapy can be conducted with both individual and group sessions. Rational psychotherapy (neurasthenia), cognitive-behavioral (obsessive-compulsive disorders), hypnosuggestive therapy (hysterical neuroses) and so on can be used. Physiotherapeutic and resort methods of treatment (electro, phototherapy, heating, mud and other baths, medical physical exercises, acupuncture, reflexotherapy) are all widely used.

**Reactive (post stress) Psychoses**

Reactive psychoses are mental disorders of a psychotic nature, resulting from mental trauma, under the influence of super strong shocks, unfavorable events and psychotrauma which is extreme for the person in question. The following states especially facilitate the development of reactive psychoses: asthenization resulting from infection or severe somatic diseases, psychopathic characteristic features, cerebro-cranial injuries, prolonged insomnia, intoxication as well as pubertal and menopausal periods.

**Prevalence of reactive psychoses** is 36.7 in 100,000 population. Depending on the character of mental trauma and their clinical manifestation, reactive psychoses are divided into two groups:

1. affective-shock reactions, usually caused by major threats to a person’s life (fire, floods, earthquakes, accidents – all resulting in extreme damage, causing wounds, death and suffering of a great number of people).
2. Lingering reactive psychoses, such as psychogenic depression, paranoid and hysterical psychoses.

**Affective-shock reactions**

These are short-term psychotic conditions or states resulting from situations which are life-threatening. They are characterized by horror, despair, deep affective narrowing of consciousness, motor and vegetative disorders. There are hypokinetic and hyperkinetic types of affective-shock reactions. In the *hyperkinetic type*, the patient’s behavior loses purposefulness: on a background of rapidly increasing anxiety and fear, chaotic psychomotor excitement appears with disorderly movements and the desire to run away. There is an expression of horror on such patients’ faces, they often utter senseless sounds, shout, weep and sob. This is followed by vegetative reactions such as vomiting, tachycardia, paleness or hyperemia of the skin, perspiration, involuntary urination and defecation. There are disturbances
in orientation in the patient’s self and surroundings. The duration of such reactions is not very long – from 15-20 minutes, as a rule. **Hypokinetic** manifestation is characterized by a state of motor inhibition, leading to total immobility and mutism (affectogenic stupor). The patient usually stays at the place where the event causing fear occurred – they are unable to utter a single word, act or move in order to save oneself from the oncoming danger.

“Emotional paralysis” occurs, inevitable despair or apathy and indifference to everything. The patient’s gaze is directed to space and there is a countenance of fear and horror. The patient’s eyes are wide-open, skin is pale and covered with cold sweat, involuntary urination and defecation is observed. The duration of stupor ranges from several minutes to an hour. Experiences related to the acute period of psychosis are usually forgotten. On coming out of acute psychosis there is marked asthenia, which lasts for 2-3 weeks.

**Reactive (psychogenic) depression.** Depression is one of the most frequent forms of psychogenic reaction. The most common psychic trauma resulting in depression is a situation of emotional deprivation, i.e. the loss of a close relative through death or departure, a family tragedy. Depressive symptoms usually arise within a few days after receiving information concerning the event or accident. It is assumed that internal psychological processing of the given situation, evaluation of the significance of the loss takes place during those days. The clinical presentation of reactive depression is characterized by a state of suppression, sense of despair and hopelessness, tearfulness, vegetative disorders, insomnia as well as concentration of the whole content of consciousness on the specific tragic events. If the patient manages to avoid remembering or thinking about these events during the daytime, by evening the state of depression increases in severity and at night the events recur in the form of nightmares. The patients are more disappointed and hurt by life than sad. Self-criticism and insight into the illness are preserved. Though the patient has a reduced sense of self-esteem, ideas of self-accusation rarely occur. The sense of blame is not directed at the patient himself, as in case of endogenous depression, but more to the surroundings. All thoughts are focused on the people involved in the tragic events. Depression is followed by vegetative symptoms including sleep and appetite disorders, tachycardia, hyperhydrosis and hypertension. Hypnogogic hallucinations reflecting the mental trauma may be seen.
Reactive Paranoid. The paranoid state is usually preceded by a period of marked anxiety, trouble, suspicion and a presentiment of impending misfortune. It is often followed by an unexpected feeling of mortal danger. The emotional saturation of delusion and expressed affects of fear and anxiety are peculiar to reactive paranoid. More often there are delusions of persecution and reference. In one case, this is the threat to one’s physical existence or violence, in another case it could be moral damage either to the patient himself or to his relatives. Both visual and auditory hallucinations are possible. It seems to the patient that they are surrounded by enemies, that their relatives are no longer alive. Some of them hear whispers, later distinct human voices, planning murder. Horrified, they attempt to escape, jump through the window, attack their presumed enemies.

To the group of reactive paranoids belong inductional delusion and foreign language environment’s paranoid (Allers-paranoid). In the first case psychogenic factor is long-time relationships with patient. The delusional ideas of patient without insight accepted by the healthy person. Next variant of reactive paranoid can develop in the situations of mental isolation, i.e. being in an unknown or foreign language environment with lack of contact with one’s surroundings due to a language barrier. Delusional ideas of reference manifest on the background of fear and anxiety.

Hysteric Psychoses (Dissociative Psychoses). Hysteric psychoses form a heterogenous group of psychotic states. They may manifest as twilight narrowing of consciousness, Ganser syndrome, pseudodementia, puerilism, syndrome of mental regression, hysteric stupor. There are no clear boundaries among the various types of hysteric disorders. A combination of different hysteric disorders or the successive transformation of one form into the other is often observed.

Consciousness may be narrowed under the influence of affect. Amnesia is observed during this period.

Hysteric Twilight Narrowing of Consciousness. This state is characterized by narrowing of consciousness, disorientation, errors in perception reflecting the psychotraumatic cause followed by selective fragmentation of amnesia. The clinical state is distinguished by a mixed manifestation and the demonstrative nature of the patient’s behavior. Laughter, singing and crying may be interrupted by convulsive fits. Freezing in a sorrowful posture may suddenly be transformed into temporary excitement. There are abundant visual hallucinations and bright visions. All of the patient’s experiences are focused solely on the psychotraumatic situation. For example, a
woman who has been raped may hide under a table, trembling and crying. But, more often, the situation is re-experienced in a way for favorable to the patient, opposite to the circumstance which really occurred. For example, a prisoner found guilty may say that he had been declared innocent, or a mother who has lost a child may claim that he will soon be back from school and lays the table in expectation. Exit from the psychosis is gradual. 

**Pseudodementia** is a form of seemingly occurring dementia, which is a separate form of reactive hysterical psychoses. It is characterized by the assumed loss of the simplest knowledge and wrong answers and actions. The patient seems desperate while giving wrong answers to questions previously answered correctly. He may look around, smiling stupidly, as if faking dementia. The content of the wrong answers is always linked to the psychotraumatic situation and is in keeping with the general theme of the questions asked. The answers given by a patient with pseudodementia is often the opposite of what is considered correct, e.g. white is called black. The same goes for actions. For example, the patients may put shoes on their hands and stretch their feet through shirt sleeves.

**Puerilism.** Infantilism of behavior may appear after the development of narrowed consciousness. The most common symptoms of puerilism are childish speech, movements and emotional reactions. The patients speak in a childish voice and intonation, take small steps while running, play with dolls, stamp their feet and ask to be carried, promise to ‘behave properly’, are capricious, suck their fingers, try to touch everything and run instead of walking.

**Ganser syndrome**, which is most often seen in prisoners. Clinical manifestation is characterized with twilight narrowing of consciousness with the development of pseudodementia, but in this case hallucinations, which express psychogenic factor, appear. The condition has acute course: from several days to months, ended with complete amnesia and full recovery.

**Hysteric Stupor** is accompanied by hysterical narrowing of consciousness, expressed psychomotor stupor, mutism (which may be complete or partial). The patient’s mimicry reflects affective tension, suffering, anger or despair. Duration is about one week.

**Iartrogenias** - are different psychogenic reactions, caused by doctor’s or other medical staff’s incorrect attitude to the patient (doctor’s careless telling about the patient’s bad condition, letting patient to viewing his medical card, etc.). Psychogenic reactions, caused by doctor, can have the character
of hypochondriac thoughts, depressive states, and overvalued ideas. Iatrogenias are usually expressed with anxious-suspicious persons, or with persons asthenizated in the cause of somatic or infection disease.

**Treatment**

Treatment of reactive psychosis is complex and depends on the leading clinical syndrome and the causes of the development of the illness. First of all, therapy aims to remove the psychotraumatic circumstances in addition to which medicinal, psychotherapeutic and social means are used. Depending on the leading clinical syndrome neuroleptics, antidepressants and tranquilizers are used.

**CHECKING TESTS**

1. Conversion disorders are typical of
   a) hysteric neuroses
   b) neurasthenia
   c) obsessive-compulsive disorders
   d) are not typical of neuroses

2. Which is not typical of neurasthenia
   1) main reasons are lingering psychological traumas, exhaustion
   2) hyperaesthesia, irritability
   3) sperung
   4) somato-vegetative complains
   5) delusional ideas
   a) 1,2,3  b) 2,3  c) 3,5  d) 3,4

3. Critical attitude is typical of
   a) Obsessions
   b) Compulsions
   c) Obsessive memories
   d) All mentioned

4. Rituals are typical of
   a) Neurasthenia
   b) Hysteric neuroses
   c) OCD
   d) Are not typical of neuroses

5. All the followings are hysteric psychoses, except
   a) Pseudodementia
   b) Korsakoff’s syndrome
   c) Puerilism
   d) Ganser’s syndrome
6. Which is not typical of reactive paranoid
   a) Delusional ideas of reference
   b) Delusional ideas of persecution
   c) Delusional ideas of poisoning
   d) Delusional ideas of influence

7. Mental disorders are connected with psychotraumatic factor
   a) Endogenous depression
   b) Reactive depression
   c) Both of them
   d) None of them

8. For which psychogenic disorder is typical narrowing of consciousness
   1) Neurasthenia
   2) OCD
   3) Reactive depression
   4) Affective-shock reactions
   5) Hysteric psychoses
      a) 1.3.5  b) 2.3.5  c) 1.4  d) 4.5

9. Amnesia is typical of
   a) Hyperkinetic
   b) Hypokinetiс
   c) None of mentioned
   d) Both of mentioned

   **Answers:** 1.a, 2.c, 3.c, 4.c, 5.b, 6.d, 7.a, 8.d, 9.d
Psychopathy is personality’s anomaly, which is characterized by disharmony of mental functions and it is the cause of strange behavior, conflicts. Shnyder tells that psychopaths either suffer themselves in the cause of their not-ordinary character, or make others suffer. “Pathological person”, “anomaly of character”, “psychopath constructions” are synonyms of the term “psychopathy”, some authors call psychopaths as deformity of character. Sensitiveness is the main specification of psychopathy, and promotes more for conflicts. In spite of the fact that person’s character saves during psychopathy, even higher intellect (there can be talents among psychopaths) cannot completely correct psychopathic character, and more, psychopathic thinking becomes subjective and one-sided (affective thinking of psychopaths).

Two factors participate in forming psychopathy: inborn biological defect of the nervous system and outer world influence.

Small changes of behavior cannot be symptoms of psychopathy. We talk about some character’s expressions (accentuation of character), which can be extreme of norm, when separate characters are more expressed, than others.

Term “expressed person” is suggested by German psychiatrist K. Leonard (1968), he suggests also classification of expressed types.

A. E. Lichko suggests term “expression of character” and his classification (1980).

Expression develops in the period of character’s forming and can be changed connected with age. In the period of forming expression person becomes unsocialable at all or then it can be changed.

Psychopathy must be distinguished from not only persons of strange character but also from other mental diseases.

Diagnosing psychopathy is usually based on the following criteria:

1. stability of pathological specification of person, ability of its regression.
2. complete expression of person’s pathological features, when not only separate characters of person are pathological, but the whole mental structure.
3. full expression of pathological character, when person changes his attitude to the surrounding world and persons.

These criteria are based on the work of P.B. Hannushkin, and express psychopaths’ character in general.

Psychoses in contrast to psychopathy specifies by delusions, hallucinations, darkness of consciousness, etc. Except it psychopathies have no duration of disease (start, progressing, and end). Psychopathy is a constant pathological condition throughout a person’s life.

There is no general classification of psychopathy nowadays. Works of P.B. Hannushkin, G. Shnayder, E. Krepelin, K. Krechmin, O. V. Kerbicov are well-known in this sphere. They describe often met types of psychopathy.

**Prevalence** of psychopathies is 10.3-13.5%.

### Types of Psychopathy

Fist symptoms of psychopathy rise in childhood and in youth, but in the period of sexual developing symptoms can calm or disappear at all (depsychopathization), or on the contrary – sharp expression, till hard psychopathy is formed.

Following types of psychopathy are marked:

*Asthenic psychopathy* – quickly getting tired, sensitiveness is typical of this type. Asthenics are much distrustful, sensitive, shy. They are “mimosa” - like persons, who can lose control because of intellectual and physical tension, difficult situation in life. They are afraid of all it, that is why they avoid contacts, like to be in the “shade”. They are afraid of difficulties, to be a subject of laugh.

Asthenic psychopaths often complain of feeling bad, headaches, weakness, heart beating, giddiness, sadness; they have fluctuation of pulse pressure.

Symptoms mentioned above rise in case of changes in life (replacement, changing work place, etc.).

*Psychasthenic psychopaths* and asthenic psychopaths are similar by many sides of character, but the main is anxiously-doubtness. Any case, action, activity they analyze in details. Constant doubting of actions, behavior, activity leads to difficulties, which make psychasthenics’ life dreadful. They review their life and try to find mistakes, reasons and start accusing themselves. They lose self-confidence, it becomes the reason for isolation from the outworld.
Different pathological conditions rise in case of decompensation (ideas, fear of hard disease), which can be the reason of developing of hypochondriac symptoms. 

Excitable psychopaths (epileptoid), they are marked by higher sensitiveness. Any small action can be the cause of affective expression of sensitive reaction, it can be: anger, fear, happiness, etc. Sometimes sensitiveness can be so higher, that it becomes the reason for disorder of consciousness (pathological affect): patient gets irritated, loses control. In such condition they become dangerous for surrounding people, can make different aggressive actions. In spite being active, whenever they faced to social difficulties, they at once lose hope, often hurt themselves.

In some cases in 30-40 years psychopathic specification of the character changes (improve); and in the case of difficult social condition patients can be complete social desadapted.

Always higher spirit, well feeling typical for hypothyrmics psychopaths. They are active and much-talking persons, incline to over-estimate themselves and their ability. Over self-confidence often leads to conflicts. They often become “soul of company”, good organizers, sometime risk to realize new ideas. Making noise and activity around themselves, they are always in the center of attention, that is why they informed about all news, participate in every arrangements. Their life is bright, but without deep interests and close friends.

Always bad spirit typical for hypothymic psychopaths (disthimics). They are calm, amiable, polite, very kindness persons. They are suffer from feeling of their inferiority, insignificance. They do not wait goods from life; they accuse themselves in any misfortunes. If they are happy in present of family members, it is only mask. Sometimes on the background of bad spirit they can have different hypochondriac complaints. Psychotherapy is useful for these patients, but good influence of psychotherapy lasts short time.

Hysteric psychopaths are generally follow the will to attract public attention in any case. It is expressed in everything: appearance (bright closes, cosmetic), behavior, speech.

Hysteric patients have character instability, changeability. Their point of view, behavior, feelings depend from situation. Imitation of suicide, which sometimes ends deplorably, has the same goal. Some of them try to show their straggle with difficult disease (hysteric seizures, dumbness, disorder of breathing, blindness and etc.).
Hysteric psychopaths have no limit between imagination and reality. It is cause of pathological lying (pseudologia fantastica), when willing presets as reality. Such psychopaths sometimes begin believe in their lie. Hysteric psychopaths have neuroses, especially for women in period of menopause, pathological features of character expressed. In good social conditions there can be long compensation.

Unsteady psychopath is weak-willed person, who falls under others’ influence easily, especially bad one. They have no deep knowledge, no closes friends, they change dictions and goals without hesitation. They study bad in school, in spite of intellectual ability can be good. They do not work on the same place for a long time in the cause of breaking rules of job. They live for a moment. They look for easy life and pleasures, sometimes they abuse alcohol, narcotics. Good surrounding, family’s care and attention may lead to compensation.

Schizoid psychopaths – they are shy, sensitive, vulnerable persons on one hand, and indifferent, gloomy, cruel persons on another hand; they persistent in reaching their goals. They all have the same specification – autism. Coldness of feelings are typical for all of them, it is expressed in behavior, movements, activity. Their movement are artificial, facial expression has lack of activity. Interests are one-sided specific, no-ordinary. Contacts with the surrounding world are limited. Their expressions short and sharp, sometimes not understandable, they often use symbols. They devote their free time to “autistic” occupations: reading, walking in loneliness.

Narrowing of interests, one-sided thinking typical for paranoiac psychopaths. They are egocentric, suffer with expressed self-importance. They think, that everything connected with them are worthy of importance. They are persistent, doubtful; everyone who doesn’t agree with them, become their enemy. Fixing on insulting they plan to revenge, write complains. The main clinical specification of paranoiac psychopaths is over-estimated idea. In contrast to delusion it connects with real happenings, but often the basing has one-sided type: they do not pay attention on real reason, only in what they are interested.

Sexual disorders (perversions): Sexual disorders can rise during different psychopathies, but often they rise with irritable, unsteady, hysteric psychopaths, and also during different other diseases (schizophrenia, neuroses, endocrine diseases and others). Usually precondition for rising sexual disorders with psychopaths is early formed sexual excitation. Influence of society, alcoholism, narcomania also play role.
The following are sexual disorders:


**Dynamic, etiology of psychopathy**

Psychopathies can be inborn and acquired. Inborn psychopathies are the cause of harmful substances influence on fetus. Heredity factor, traumas during labor, symptomatology in early years of living, syphilis and parents using alcohol, infections and poisoning. Bad condition of the surroundness cause for psychopathies (upbringing, mental traumas). There is discussable question – can the pathological developing which formed under influence of mental trauma be classify as psychopathy?

Increasing or decreasing of psychopathic specification typical for dynamic of inborn types of psychopathies. It expresses in fluctuation of spirit, ill reactions in case of mental trauma, pathological developing of personality. Exacerbation of symptomatic specifications for psychopathic person causes influence of bad conditions, sometimes without influence of any outer irritators. They are conditions of decompensation, which can rise in period of menopause, pregnancy, labor. And opposite, with ages psychopathic specification of character can be disappear.

Acquired pathological developing of character of children and teen-agers connect with upbringing in collective and in family. If child was humbled, punished unreasonably, parents were not kind to him, there begin forming inhibition ring. And other case – realizing child’s all wishes, never saying “do not it”, always admiring with him, saying that he is not ordinary lead
to developing self-admiration, willing always be in the center of attention, i.e. forming hysteric character. So, unfavorable condition of the surrounding society, especially in childhood, when forming specification of higher nervous system, can cause to such disorders, which rise with inborn psychopaths. It can be reason that no distinguishing in symptomatic developing of clinical picture will be. But in contrast to psychopathy, primary stage of person’s symptomatic forms in certain time, and in the same time there is forming of symptomatic sights of character, behavior, which typical for psychopathy. In this period teen-ager’s behavior differently, in school, home, in street.

**Diagnosing and treatment**

During diagnosing of psychopathy main role belongs to objective evidenceness of his every day life, and not other information, for example information of neuropathology, test on EEG and etc. Inborn psychopathy must be contrast to organic leisure of brain, epilepsy, schizophrenia and other diseases, during which there are psychotic conditions. These diseases can cause person’s psychopathisation, when clinical picture expresses psychopathy-like character. Though these psychopathy-like conditions express symptoms of different diseases. So, psychopathy of person and character remember psychopathy in case of simple type of schizophrenia, but there are symptoms which testify rising defect of schizophrenia. In such cases anamneses and clinical examinations let to reveal start of the disease and specific changes of character. Inclination to allergic reaction and dysphories typical for pathological developing of person and psychopathy. They can not stand alcohol (even in small doses).

Treatment of psychopathy includes as treating by medicines, so as medical-pedagogical treating and providing patients with job. It is advisable to use wildly psychotherapy treatment. During mental treatment, it is important to take into consideration, that there can be changeable reaction on treatment by medicines with psychopaths. Psychotropic medicines in small doses combine with calm/light antidepressants and relaxing medicines decrease affective irritation.

**Working examination.** In case of decompensation patient can lost working ability and it may last temporary. In case of long-terming decompensation patient has invalidity of third stage.

**Forensic mental examination.** Psychopaths mainly admit responsible. They are irresponsible in the case of deep decompensation.
CHECKING TESTS

1. Definition of psychopathy is
   a) Character disharmony
   b) expression of character
   c) inborn disorder of intellect
   d) endogenous chronical disease

2. Overvalued ideas are typical of
   a) Schizoid
   b) Paranoial
   c) Hysteric
   d) Anstable

3. Which is typical for hysteric personality
   1) Being in the center of attention
   2) Dysphoric conditions
   3) Somato-vegetative disorders
   4) Autism, unsociableness
   5) Easy influenced by surroundings
   a) 1.2.3, b) 2.5  c) 1.3  d) 3.4  e) 1.4.5

4. Which are not type of psychopathy
   1) Paranoial
   2) Paraphren
   3) Hyperthym
   4) Parathym
   5) Psychasthenic
   a) 1.2.3  b) 2.3  c)2.4  d) 1.3.5

5. Pathological affect is typical of
   a) Asthenic psychopathy
   b) Epileptoid psychopathy
   c) Paranoial psychopathy
   d) Schizoid psychopathy

6. Which one is outcome of psychopathy
   a) Steady condition
   b) Degradation of personality
   c) Transition from one type of psychopathy to another
   d) Apatho-abulic defect

7. Which one is outcome of psychopathy
   a) Full recovery
   b) Slow improvement
   c) Steady, unchangable condition
   d) Wavy course
   e) Progressent course

8. Aspiration towards surrounding’s attention
a) Asthenic psychopathy
b) Psychasthenia
c) Hysteric psychopathy
d) None of mentioned

Answers: 1.a, 2.b, 3.c, 4.c, 5.b, 6.a, 7.c, 8c
CHAPTER 12

MENTAL DISORDERS
IN INVOLUTION AGE

Person’s ageing lasts with some biological regularity, which can be cause of mental and somatic changes. These changes have their specifications and number of reasons. Gradually the brightness of imagination is faded, temp of associations becomes slow and, in general, all mental functions become slow. Brain work, reproduction of necessary information in memory needs more time, than before. Sensitive sphere of person also changes: person becomes emotionally unstable, touchy, they can have fixing inclination on negative feelings.

There are also somatic changes in the organism, which also can be cause of mental disorders. Metabolism becomes slow, organs’ blood circulation, especially the brain’s, is slow. Changing of the endocrine system plays a main role: lowering of hypothalamus function, period of menopause. Mental disorders in pre-senile period mainly is connected with these changes.

Age regressing is not always the cause of mental disease. Some specifications of character, stresses, chronic somatic illnesses and others can be the cause of mental diseases. These diseases are divided in two main groups: pre-senile, or involution psychoses, and senile. Pre-senile psychoses are expressed in 55-65 ages, senile psychoses rise at the age of 70 and above.

The following belong to involution psychoses:

1. Involution depressions (involution melancholy)
2. Involution paranoid

Involution depression
Clinical findings of involution depression rise against the background of melancholic spirit, anxiety and motor activation. In the initial stage of the disease, patient becomes nervous, gloomy and depressed. Slowly he becomes anxious. Patient is beside oneself, starts to strike to his knees, face, and makes loud exclamations. Patient expresses self-accused delusional ideas. Remembering mistakes made in life, they say, that they have done crime, and must be punished. They accuse themselves in relatives’ misfortunes, because they have not prevented it. Patient expresses melancholic
ideas, he feels himself hopeless, he becomes more nervous, all these lead to its top, and rise in *raptus melancholocus*, during which patient considers, that the only way to get from this situation is committing suicide. Patients can express hypochondriac delusional ideas, when they are sure to be incurably ill. In initial stage somatic depressions rise (lack of appetite, decreasing of weight, sleeplessness and others). Nihilistic delusional ideas accompany disease, when it seems to patient that one of his organs doesn’t exists, gets worse, does not operate. In some cases hypochondriac-nihilistic delusional ideas rise against the background of anxious-depressed spirit, they have megalomaniac character. In this case patient perceives himself as alive body; they express ideas of world break (Cotard’s syndrome). Auditor, verbal illusions are typical of involution depressions. Patient’s attitudes to himself, talks of surrounding people, hears his name, accusing addressed to him. In some cases involution melancholic process is accompanied by psycho-motor inhibition. Patient spends days lying or staying sitting in the same pose; gives late reaction to questions, answers in a low voice, in few words. Mutizm, negativism does not rise. Sharpaney’s syndrome is typical of this disease: patient’s relatives change his flat for leaving “bad neighbors” and it becomes the cause of many suspicions, fear and anxiousness. Cleist’s symptom: patient asks for help and when doctor or relative wants to help, he turns and refuses their help. Duration of disease is long-draw.

**Involution paranoid**

Disease is characterized by stepped increase of delusional ideas against the background of clear consciousness. This delusion in general has stealing, losing, poverty, sometimes jealousy and pursues characters. Involving patient’s relatives in the delusion is also typical of the disease (members of family, neighbors, relatives, co-workers, with whom patient has everyday contact). Delusion ideas are connected with patient’s social conditions, that is why it is called “social delusions”, “delusion of small circle” or “kitchen delusion”. Suspicious persons suffer from this disease more often. During the initial stage of disease patient accuses relatives of bad attitude, he complains that, they do not pay attention to him. They gradually become sure, that during their absence neighbors insert in their flat, steal, damage their things, put dirt in food, turn on gas, etc. Patient’s intellectual abilities, social adaptation are saved for a long time. His behavior is not changed, and that is why surrounding people perceive them as healthy. Patients
change lock, replace more than one locks, pay attention to objects’ replacement in flat, make some marks, strew flour in front of the door to find steps coming home. Patients study neighbors’ day regimen to know when they are absent to go out at the same time. Patient turns to the police to protect himself and punish the “enemy”.

Auditory, smelling, tasting hallucinations rise. In initial stage hallucinations have elementary specification: patients hear knocks, which, as they are sure, are made specially to disturb them. Afterwards they hear talks from the next room, neighbors’ home. They smell poison, gas from their flat. In some cases they feel stream of hot and cold air.

Emotional sphere of patient is also changed: they become depressed, anxious; in some cases they express aggression. Duration is prolonged, patients must be hospitalized.

**Treatment.** In case of involution paranoid is used neuroleptic, involution depression – antidepressants (amitriptilin, Prozac, Zoloft), neuroleptics (triflazin, tizercin, chlorprotixen).

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**Senile psychoses**

Such kind of psychoses is characterized by progressing of dementia. In the base of them is lying the atrophic process in the brain. Often it arises at the age of 70-80 and especially happens in women.

**Prevalence** of senile psychoses is 4-20%.

There are simple form of senile psychoses, confabulator, delirious forms and also atypical forms: Alzheimer’s and Pick’s diseases.

Simple form of senile psychoses – it is characterized by a slow course, which is divided into three stages: initial, dementia and exhaustion (marmorasmus).

Initial stage is expressed by false memories accompanied with fixated amnesia. Patients forget names, numbers, current events. Gradually they forget names of subjects, people, even relatives, in late period they don’t recognize them. Disorientation in place and time is rises. Patients lose previous interests, lose attachments, egoism, roughness appear.

Intellect is also distorted: till expressed dementia. Emotions are decreased, incontinence appears. The sphere of interests is limited by physical needs. The rhythm of dreaming changes: sleepiness during the day and sleeplessness at night.

On the base of all above mentioned delusional ideas of persecution, poverty can be seen. Also there can be auditory hallucinations.
The last stage of simple form is characterized by physical and mental exhaustion. Total dementia is expressed: patient doesn’t recognize surroundings, loses ability of speech, eats uneatable things, they cannot care themselves. They die in embryonic pose.

**Vernik’s presbyophrenia (confabulator form of senile dementia).** It is characterized by expressed disorders of memory. The lack of memory patients fill with events from the past or imaginary, fantastic memories appear (pseudoreminescence, confabulation). Patients collect their things, prepare to marry, tell about different events which as if had happened to them, perceive their children for parents. The mood is elevated, they are talkative and complacent.

**Delirious form (senile delirium)** arises during the complication of senile dementia by somatic disease. It is processing with delirious disorder of consciousness. The perception is distorted (illusion-hallucination perceiving of reality). Motor excitation is not expressed. Delirium can appear as professional or musitated types.

**Atypical forms of senile psychoses**

**Alzheimer’s disease.** Disease was described by German psychiatrist Alzheimer. It begins in pre-senile ages (50-60, sometimes 45 years). Alzheimer’s disease is primary neurodegenerative disease, which is characterized by steady decrease of cognitive, especially memory and intellect disorders and results in full dementia and is accompanied by violation of focuses and disorder of the highest cortical functions (aphasia-apraxia-agnosia).

**Prevalence of Alzheimer’s disease.** 2.5-10% of men and 3.6-11.2% of women suffer from this disease.

The central place in dementia developing are memory disorders according by the types of progressing amnesia, full amnesic disorientation is progressing. Disorder of attention, perception, realizing of surrounding begin very early, losing primary modes of life with the formation of apraxia are typical of this disease. The collapse of speech is expressed by amnesic and sensory aphasia, then logoclonia, dysarthria, echolalia, alexia, agraphia, acalculia are progressing.

In some cases there can be psychotic condition: suspiciousness, hallucinations, fragments of paranoid delusions, also psychomotor excitation with impulsive actions, epileptoform seizuers and episodes of consciousness disorder.
The result of the disease is the full collapse of psychics. Patients lye in embryonic pose, neurological symptoms begin, and they die in condition of marasmus. It lasts in average 8-10 years.

**Peak’s disease** develops in 50-60 years and even earlier, is characterized by dementia and atrophy of frontal, temporo-parietal part of the brain cortex.

**Prevalence** of Pick’s disease is 0,4-2%.

In the very beginning the progressing changes of personality, behavior are visible. Aspontaneous, passivity, indifference, emotional deadness: speech, thinking, motor activity become poor. The critic level of judgements and conclusions, stereotypes of treatment and actions arise and then – in speech and in writing. Patients become indifferent, not interested in surroundings. Gradually they lose ability of usual actions (apraxia) and agnosia. Steriotypia, aimless repetition of actions and speech are specific. Step-by step patient loses ability of speech, expressed memory disorders, especially amnestic aphasia develops.

The result of the disease is total dementia, marasmus. Duration is slow and long: patients live in average 6-8 years.

**Mental disorders of vessels genesis.** Unlike atrophic disease of the brain which is always processing with disorder of mental activity, in case of vessels’ collapse there will be neurological and mental disorders (neurosis-like, mental-like, affective).

During progressive vessels’ process we can see some personality declining and losing of mental activity – psychoorganic syndrome. Vessel dementia can sharply arise after disorder of brain’s circulation of the blood. There is often marked lacunar dementia during cerebral atherosclerosis. It is characterized by memory impairment in particular in remembering new material. Nucleus of personality, realizing of the disease and critical marking of the patients’ condition are saved. Mental and motor activities become slow, depressed or anxious mood, placidity predominate. There is marked circumstantiality of thinking, sanity of ideas, reducing of mental activity.

The treatment is symptomatic due to psychopathological condition: nootropics, preparations with metabolic influence and psychotropic preparations in small doses.

**CHECKING TESTS**

1. Which is typical of involution depression
   a) Korsakoff’s syndrome
   b) Cotard’s syndrome
   c) Kandinsky-Clerambault syndrome
d) None of mentioned

2. Which one of mentioned is not pre-senile psychoses
   a) Involution depression
   b) Involution paranoid
   c) Alzheimer’s disease
   d) All mentioned are pre-senile psychoses

3. For involution paranoid is typical
   a) Delusional idea of influence
   b) Delusional ideas of stealing, reference, persecution
   c) Auditory hallucinations
   d) All mentioned
   e) None of mentioned

4. Atypical form of senile psychoses is
   a) Confabulator type of dementia
   b) Delirious type of dementia
   c) Alzheimer’s disease
   d) All mentioned

5. In which case main features of character is preserved
   a) Pick’s disease
   b) Alzheimer’s disease
   c) Veissel dementia
   d) Simple form of senile psychoses

6. All mentioned are typical of vessel dementia, except
   a) Circumstantility of thinking
   b) Total dementia
   c) Emotional weakness
   d) Fixated amnesia
   e) Partial dementia

**Answers:** 1.b, 2.c, 3.b, 4.c, 5.c, 6.b
Mental retardation is a condition of impaired or incomplete development of mentality (mind). It is characterized by disorders (disturbances) of cognitive, speech, motor and social capabilities which supply intelligence and their disturbances give rise to disorder of adaptive behavior. There are a lot of reasons for mental deficiency. Cerebral affection of the fetus as a result of severe pregnancy toxemia, chromosomal abnormality, metabolic disorders of pyruvic acid (phenylketonuria, phenylpyruvic oligophrenia), German measles, Rhesus factor, parents’ severe infectious disease, parents’ acute alcoholism, etc. Severe infection, intoxication, brain injury in childhood can also cause retardation of mental development.

There are 3 types of mental retardation - slight mental deficiency (moronism), moderate mental deficiency (imbecility), strong mental deficiency (idiocy).

**Moronism.** In presence of slight mental deficiency the development delay of the speech habits takes place, but most of these children have an opportunity to use their speech in different conditions of life, to take part in clinical discussions, look after themselves (washing, dressing, food intake etc.), and helping in the house.

As a rule such children have poor progress in studies, especially while learning reading and writing. They often attend specialized institutions with the aim of developing different skills (habits) and compensatory abilities. In most cases it is possible to place them in a job in which the practical or manual part is more important such as non qualified or semi qualified manual work. During emotional and social immaturity their place in social life becomes limited. For instance, they are not able to deal with family life and upbringing in general they are often confronted with difficulties getting used to the cultural standards and traditions. Such kind of people have restricted stock of words (their vocabulary is about 2000-3000 word), the memory is mechanical and it is difficult for them to calculate (it is easier for them to deal with additions and subtractions), their thinking is concrete, it’s difficult for them to draw conclusions and
generalizations, figurative meaning of proverbs is not always clear, they cannot distinguish the main sense from the secondary one. They are suggestible, quick-tempered, quick to take offense, unforgiving, they may be aggressive but at the same time they work hard which helps them to adapt to life (social adaptation).

Imbecility. The stock of words of the imbeciles is poor (200-300 words), pronunciation is wrong, they cannot count, distinguish colors, they are not able to attend any kind of school. It is also difficult for them to do common work/labor. Imbeciles need care; they are strongly attached to their parents and to their carer. Their attitude towards such people is positive but with others they can be malicious and aggressive.

**Idiocy** is often accompanied by anomaly. There is a lack of speech in this case. Patients emit inarticulate sounds. They only satisfy their biological needs (they cry when they are hungry or need care, bite their fingers, scratch the face).

Idiots may be torpid and lethargic (for the most part they sleep) or they always cry and shout, extremely restless in bed.

**Clinical types of oligophrenia**

Clinical types of oligophrenia are different, the followings are the most common.

*Oligophrenia in the cause of genes’ diseases.*

Phenylpyruvic oligophrenia (phenylketonuria) It is reason for innate anomaly of metabolish. Phenylketonuria is accompanied by deep mental hypoplasia, often as idiocy or imbecility.

Disease is expressed at the age of 3-8 months by hair depigmentation, iris of eyes, specific smell of urine and sweat, exudative diathesis. Such children must keep diet from the first months. Large liver mass and cataract are typical of this disease. Diet-therapy with the exception of galactose is used.

*Chromosomes diseases.*

Daun’s disease is expressed in the cause of trisomia (unnecessary chromosome) in 21 pair of autosoma. The characteristic appearance: squinting eyes with epicanthus, enlarged tongue with deep sulci, small rare teeth, small turned-up nose, thickening of upper lip, redness in cheeks, diminished head, fingers of hands are short and thick. Patients have middle stage of dementia (imbecility, moronity).

Klinefelter’s syndrome is characterized by disorder of proportion of sexual chromosomes by types of X polysomia (there is unnecessary X –
chromosome in the cell, except the usual XY-chromosomes). Only men suffer from this disease. Patients are tall, have long extremities, eunuchoidism, low intellect, as a rule they are sterile.

Turner’s syndrome is the reason for X-monosomy. Only women suffer from it. In cell there are 45 X-chromosomes instead of 46. They have delayed sexual developing, are short.

*Oligophrenia by exogenous origin.*

First of all there must be marked oligophrenia in the cause of hazards: parents’ alcoholism, toxicoplasmoz, virus diseases of mother, German measles, chronic infections, syphilis, birth traumas (head trauma, meningitis, asphyxia), which are inflected on the organism during embryonic developing or in prenatal period. The level of dementia is different—from the light one till idiocy.

**Treatment.** Complexes of medical and pedagogical effects are used. It is important to learn the patient self-service, or in some cases—professional habits. Writing, though ting, reading must be taught according to special programmers.

**CHECKING TESTS**

1. Inborn disorder of intellect is called
   a) Dementia
   b) Mental retardation
   c) Debility
   d) None of mentioned

2. All mentioned are stage of mental retardation, except
   a) Moronity
   b) Dementia
   c) Imbecility
   d) Idiocy

3. Absence of speech
   a) Moronity
   b) Imbecility
   c) Idiocy
   d) All mentioned

4. All the followings are expressed by intellect disorders, except
   a) Amentia
   b) Idiocy
   c) Concentric dementia
   d) Imbecility
   e) Partial amnesia

5. All mentioned are right for mental retardation, except
a) It is inborn  
b) It has progressive course  
c) Expressed by weak developed mental functions  
d) Imposibility to study in general school

6. Outcome of mental retardation  
a) Stable, none progressive condition  
b) Progressive decrease of intellect  
c) Regredient course  
d) Regress of pathological symptoms under medications

7. Full recovery is possible  
a) Mental retardation  
b) Dementia  
c) Both of them  
d) None of them

**Answers:** 1.b, 2.b, 3.c, 4.a, 5.b, 6.a, 7.d
CHAPTER 14

PSYCHIATRIC EXPERTIZE

MILITARY EXPERTIZE

All recruits no matter if they have health complaints or not, pass medical examination in military comissariats. Even for small doubt concerning to neuropsychiatric disorder, they are sent to psychiatric hospitals for military expertise.

medical and other documents (testimonials, references, extracts from the history, etc) are help for expertise.

Special medico-military commission determines recruits’ neuropsychiatric health.

Based on the conclusion of the expertise military commissariat determine whether recruit is going to the army or giving grace, or sending for treatment and other issues.

There are cases when soldiers in the army get sick, they are immediately sent to military hospital, where their treatment is organized, but if disease take malignant and dangerous character, soldiers pass military expertise, which determines their future service continuation.

FORENSIC EXPERTIZE

Forensic-psychiatric expertise is more complex and important, because it also deals with medical and juridical issues to solve.

The expert committee is composed of 3 members: president, member and reporter.

Forensic-psychiatric expertise examination appointment is based on the cases, when there is doubt about criminal’s, victim’s and witness’s mental health.

Forensic-psychiatric expertise examination is appointed on the decision of the court. Based on this conclusion expertise committee solves the following problems: examine person’s mental health condition, if the person is criminally sane or not, both making crime and during the examination.
Following types of forensic-psychiatric expertise exist: ambulatory, stationary, examination in the investigator`s room, Expertise in court, distance and postmortal examination. The conclusion of expert committee is based on two major criteria: medical and juridical. If the patient is not sane, he is exemed from juridical responsibility and is sent to compulsory treatment. Forensic-psychiatric expertise committee also deals with civil matters, including to have the issue of competence, individual`s legal status, i.e. the right to elect and be elected, to write contract, in the court or elsewhere protect his rights and so on. Person, who suffers from mental, chronic disease with severe and bad prediction is right less.
INTERNATIONAL CLASSIFICATION OF DISEASES – 10

CLASSIFICATION OF MENTAL AND BEHAVIORAL DISORDERS

F0  Organic, including symptomatic, mental disorders
F1  Mental and behavior disorders due to use of psychoactive materials
F2  Schizophrenia, schizotypal and delusional disorders
F3  Affective disorders
F4  Neurotic, stress-related and somatoform disorders
F5  Behavioral syndromes due to physiological disorders and physical factors
F6  Behavior disorders in adult
F7  Mental retardation
F8  Disorders of psychological development
F9  Child and adolescent emotional and behavior disorders
Glossary of Psychiatric Terms

Abulia – a lack of will or motivation which is often expressed as inability to make decisions or set goals.

Acalculia – the loss of a previously possessed ability to engage in arithmetic calculation.

Akathisia – an inner feeling of excessive restlessness which provokes the sufferer to fidget in their seat or pace about.

Affect – a person's affect is their immediate emotional state which the person can recognise subjectively and which can also be recognised objectively by others.

Akynesia – a state of motor inhibition or reduced voluntary movement.

Ambivalence – the coexistence of contradictory emotions, attitudes, ideas, or desires with respect to a particular person, object, or situation.

Amnesia – loss of memory.

Apathy – lack of feeling, emotion, interest, or concern.

Astasia-abasia is a form of psychogenic gait disturbance in which gait becomes impaired in the absence of any neurological or physical pathology.

Aura – a premonitory, subjective brief sensation (e.g., a flash of light) that warns of an impending headache or convulsion.

Autism – is a lifelong developmental disorder that affects the way a person communicates and relates to people around them.

Automatism are sequences of activity that occur without conscious control.

Affect – observable behavior that represents the expression of a subjectively experienced feeling state (emotion).

Aphonia – an inability to produce speech sounds that require the use of the larynx that is not due to a lesion in the central nervous system.

Catatonia is a syndrome of psychological and motorological disturbances.

Compulsion – repetitive ritualistic behavior such as hand washing or ordering or a mental act such as praying or repeating words silently that aims to prevent or reduce distress or prevent some dreaded event or situation.

Confabulation is the confusion of imagination with memory, and/or the confusion of true memories with false memories.

Coprolalia is the involuntary utterance of socially inappropriate phrases.

Delirium – an acute organic brain syndrome secondary to physical causes in which consciousness is affected and disorientation results often associated with illusions, visual hallucinations and persecutory ideation.
Deja vu – a paramnesia consisting of the sensation or illusion that one is seeing what one has seen before

Dementia – an chronic organic mental illness which produces a global deterioration in cognitive abilities and which usually runs a deteriorating course.

Depersonalization – an alteration in the perception or experience of the self so that one feels detached from, and as if one is an outside observer of, one's mental processes or body

Depression – an affective disorder characterised by a profound and persistent sadness.

Dysarthria – Imperfect articulation of speech due to disturbances of muscular control or incoordination.

Echolalia – the pathological, parrotlike, and apparently senseless repetition (echoing) of a word or phrase just spoken by another person.

Echopraxia – repetition by imitation of the movements of another.

Jamais vu – an abnormal experience where an individual feels that a routine or familiar event has never happened before

Negativism is found if, on examination, a patient resists attempts to move him and does opposite to what is asked.

Nihilistic delusion – the delusion of nonexistence of the self or part of the self, or of some object in external reality

Obsession – recurrent and persistent thought, impulse, or image experienced as intrusive and distressing.

Perseveration – tendency to emit the same verbal or motor response again and again to varied stimuli.

Schizophasia or colloquially "word salad", is characterized by a patient's speech being an incoherent and incomprehensible mix of words and phrases.

Stupor – a state of unresponsiveness with immobility and mutism

Trichotillomania – the pulling out of one's own hair to the point that it is noticeable and causing significant distress or impairment.

Verbigeration – stereotyped and seemingly meaningless repetition of words or sentences.
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