Zaporozhye State Medical University

Department of Psychiatry, psychotherapy, general and medical psychology, addiction and sexology

Approved on the methodical conference of department psychiatry, psychotherapy, general and medical psychology, addiction and sexology

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"_____"_____2015 year

Methodological developments

independent studies on the topic "Organic mental disorders" for students of 4th year students of medical faculty (specialty "medicine")

Zaporozhye - 2015

I. Whole lessons:

1.1. The student should know:

- Organic, including symptomatic, mental disorders.
- Dementia different etiologies.
- Mental disorders in somatic, endocrine, infectious diseases.
- Types of head injuries and traumatic disorders classification of mental activity.

Etiopathogenesis, pathological anatomy and methods of diagnosis of traumatic disease. Somato-neurological disorders in TBI.

Non-psychotic forms of acute traumatic mental disorders. Traumatic psychosis acute period of traumatic and long-term mental disorders. Late traumatic psychoses. Features of clinical manifestations of traumatic disease in children.

1.2 The student should be able to:

Identify the symptoms and syndromes of mental illness during communication with the patient.

- Qualify their character and possible dynamics.
- Correctly describe the mental state of the patient's medical records.
- To conduct differential diagnosis of symptoms and syndromes.
- Provide medical assistance in emergency conditions.

II. Content of independent work:

Disorders due to organic brain damage

The consequences of brain injuries mainly occur in different intellectual and mental, emotional (affective) disorders and volitional. Typical traumatic disease should be considered following forms of mental pathology, as episodes potmarenoyi consciousness, convulsive seizures and other paroxysms of epileptic range, long term or recurrent psychosis hallucinatory-delusional nature, persistent changes in the person with the formation of systematic delusional ideas of persecution, jealousy, contention or hypochondriacal content. Every manifestation of disease or a set of them be determining

additional risk factor or illegal actions.

Traumatic brain injuries are different types and degrees of mechanical damage to the skull bones, brain and its membranes and blood vessels.

Traditionally distinguish closed (usually) and the options open head injuries. In closed traumas stored isolation intracranial cavity is in open violation of the closure and the intracranial cavity connected to the external environment. In both cases damaging effect on the brain is determined by his concussion, contusion, brain tissue injury with rupture of soft meninges and compression (compression) pour blood. Often all abnormal phenomena develop simultaneously. Between closed and open (nepronykayuchymy and penetrating into the substance of the brain) injuries are transitional forms.

Concussion and contusion of the brain in combination, together with massive vnutrishno¬cherepnymy hemorrhages (hematomas) are pathomorphological substrate so. Called. severe (critical) brain injury, characterized by long-term loss of consciousness (coma) and massive disorders of vital body functions.

In terms of the course of the clinical picture of traumatic brain injury are divided into several successive stages. The first of these - the original. This is actually a direct result of trauma: loss of consciousness of varying depth and duration from mild short ohlushenosti (obnubilyatsiya, zahmarennya) to severe coma; lasts a few hours, days or weeks. Patients appear idle and silent, occasionally fall into a drowsy state of drowsiness or permanently. In this state, ruled out not only purposeful and planned activities, but also motor activity in general. It is clear that such conditions can not be the main risk factor or cause of antisocial actions therefore have a special meaning for forensic practice and forensic psychiatric examination.

The situation changed immediately as soon vanishes stunned, coma and reached the acute phase begins restore lost mental functions. In this period (3 -8 weeks) on a background of mental retardation in about one third of cases can occur single or serial convulsive seizures. They are deployed (large) or abortive, often with distinct focal component for clinical signs which even in the early stages of traumatic disease can determine the preferential localization of the lesion of the brain.

In the first days, weeks after a traumatic episode may experience psychotic states which

are mainly syndromes twilight (twilight), delirious, oneyroyidnoho (snopodibnoho) amentyvnoho and dizziness. It is also possible Korsakov amnestic syndrome, Sea (durkuvatist -svoyeridne language and motor agitation against the background of high mood), affective psychoses in the form of depression or mania. Except amentia Oneyroid and they all have forensic importance, because in these cases because of dizziness, availability hallucinatory-delusional experiences, memory disorders and critical abilities, coarse emotional pathologies threatened patients commit unlawful acts. Not always promptly and unambiguously diagnosed psychotic state because of the suddenness of its appearance, sometimes nerozhornutist clinical picture or resemblance through painful actions and behavior of the works, deterministic real situation, socially significant requirements of the environment. The complexity of the diagnostic skills of the patient during the commission of his illegal action happens in practice, particularly because of the lack of necessary information reflected in the documents representing SNACK: first testimony, the testimony of the accused and a professional assessment of medical specialists character of neuropsychiatric disorders directly associated with craniocerebral trauma.

In cases of severe traumatic brain injury, characterized by multiple foci of damage after leaving the coma can develop a picture of confusion amnestic disorientation, confusion, chaotic movements and thought processes. One important component of this form of disorder of consciousness is psychomotor agitation and stereotyped linguistic fragmentation of production, not logically related to external circumstances; This clinical picture amentia. Further clarity of consciousness with the restoration and improvement of behavior to the fore in the form of memory impairment antero- and retrograde amnesia (loss of memory for events before and after the episode of impaired consciousness), and fiksatsiynoyi amnesia, recognizable and false memories is formed Korsakov syndrome invariably mentioned in the list of psychopathological pictures that develop in the acute period and the next period effects (up to 6-12 months) traumatic brain injury. In terms of prognosis following traumatic disease dynamics need to recognize unfavorable, because the remote stages of developing resistant psychoorganic traumatic disorders or dementia.

Some delirious episodes, oneyroyidnoho, especially dizziness twilight in different versions may arise at each stage of the course of traumatic disease. In the acute period of traumatic psychoses first place occupied twilight conditions.

Numerous varieties of twilight (twilight) darkening more or less placed in a structure likely clinical signs of acute, sudden, without previous start precursors; the relative brevity; ohoplenist consciousness emotion of fear, nudi, anger ("the tension of passion"); disorientation, the existence of distinct hallucinatory images and pictures of ominous-zalyakuvalnoho content; acute sensory type mayachen; rude aggressive agitation or apparent consistency and even conditionality actions; critical, sudden end; Terminal dream amnesia of what happened.

In this state, patients often commit serious offenses and doubt that they should be ekskulpovani (as in the cases of other forms of dizziness) never occurs. In forensic psychiatric practice to identify twilight (twilight) episode with psychotic state ("intermittent painful disorder of mental activity") the complex psychological and even forensic ratings surprise, neochikuvanist, bezmotyvnist, cruelty, rejection of measures to conceal and experiences of alienation on the offense. The list of characteristics do not necessarily reflect the variety of options twilight (twilight) condition and characteristics of impaired consciousness. From the clinical signs that reflect the essence of this form of pathologically altered consciousness, above all, necessary to determine the disorientation in his own person and the environment. In this condition a person is deprived of the ability to perceive reality and at the same time carry out targeted activities in accordance with the requirements of social prohibitions even the instinct of self-preservation. Its behavior is determined by uncontrollable impulses, primitive emotions. Excessive, pathological activity leads to a sharp depletion of nerve resources, as twilight episodes of dizziness usually end terminal sleep and for them to be characterized by forgetting (to some extent) of the events.

Delirium develops mainly in people with a history of long-term alcohol, formed craving for alcohol (second stage chronic alcoholism). Characteristic false orientation in the environment; while maintaining the orientation in his face dominated by bright plastic representation sensual, visual memories, true verbal and visual hallucinations

stsenopodibni. Patients are like spectators and while actors ("the actors on the stage of life") who live and adequately respond to the vision and entertainment events; they za¬hyschayutsya or attack. Delirium are inconsistent imaginative nature. The mood is very changeable, there is panic and anxiety, curiosity is excited, the IRRITANT lust, then euphoria. Maxims patient fragmentary, inconsistent.

If psychopathology mainly represented ghostly mix of fantastic ideas and fragments of real perception of the situation in the complete detachment from the real situation of the patient, in such cases, it is the oneyroyidne dizziness.

The illegal actions committed by patients during or prysmerko¬voho delirious stupor, no different variety. Typically, these criminal acts against life and health of persons (murder, grievous bodily harm), government agencies (resistance to authorities, the public, the police, offenses against them and attacks on their lives), public security and public order (obscene acts, violation of safety rules). In these conditions patients can not commit acquisitive offenses and other illegal activities. Consciousness disorders deprive people opportunities to make decisions that result from choosing deliberate motive actions directed on satisfaction of a need, which fully takes into account the existing order.

By states that may be the main cause of illegal actions of traumatized patients can be attributed v. BC. "transitional" syndromes, ie psychiatric conditions who develop, usually in the next term consequences of traumatic brain injury (2-6 months sometimes - year). Then usually disappear neurological, vegetative-vascular and mental disorders acute period, and the clinical picture in the foreground residual residual symptoms of cerebro-organic damage. Universal representative residual disorders is cerebral asthenia (tserebrasteniya). It can take different colors, but the main and most expressive features combines a syndrome irritating weakness. Increased vysnazhlyvist and fatigue, worsening instability attention and memory (eg, RAM), reduced physical and mental performance, failure in the performance of creative and hard work - all this combined with emotional lability, irritability and temper excessive, inadequate sensitivity and touchiness. Patients can not restrain the external manifestations of emotional reactions, painful experience of failure and mistakes can not tolerate intense and different

environmental stimuli (bright light, loud sound) and pain. They can easily arise collaptoid and pamorochni episodes vegetative-vascular dysfunction, functional disorders of internal organs (dyskinesia stomach, intestine, bile ducts, and so on. F.); vestibular disorders because they do not tolerate trip in transport. Characteristic are headaches, dizziness, impaired appetite and sleep. Against the backdrop of traumatic tserebrasteniyi course as psychotic break "transitional" syndromes.

They are overvalued and paranoid ideas affective hallucinatory-paranoid (shyzofrenopodibni) pictures and Korsakov amnestic syndrome. Sometimes develop temporal pattern of intellectual and memory decline -tranzytorne dementia.

Different versions of depressive and manic states and overvalued ideas in forensic psychiatric sense need careful justification and evidence-morbid psychotic their skill level (as the medical criteria of insanity) at a time when the wrongful act committed. If there is delusional-hallucinatory syndrome expert assessment of the patient's mental state can not be an alternative.

Cerebro-organic disorders caused by brain injury, then subjected to reverse development (rehrediyentna dynamics). This does not mean that in all cases fully recovered to the previous normal level of mental function and the psychological profile of a person. Often formed cerebro-organic defect which together with the adverse external influences (infectious and somatic diseases, intoxication, acute and chronic trauma) causes and mechanism of long-term and even progressive course of traumatic disease of the brain. For example, cerebral fatigue for many years can determine the structure of neuropsychiatric disorders residual period (term effects). Not always, however, this condition Moderate and stable, indicating perevazhnofunktsionalnyy nature of mental disorders.

In the late period - year and years after a brain injury - these painful events continue to develop, acquire features of psycho-organic syndrome of different severity, which is characterized by a triad of typical psychological disorders: incontinence affects, impaired memory and weakening understanding.

Clinical forms of psycho-organic syndrome associated with heneralizoranym brain

damage or signs of dominance (local) damage and resulting disruption of the endocrine glands (endocrinopathy), which the regulation pidbuhrovym (hypothalamic) of the brain. In general and forensic psychiatry psycho-organic syndrome presented symptoms such as unstable background mood, irritability, lack of restraint in actions and utterances, intensity of negative emotions, fatigue, severe weakness concentration focus (active attention), worsening of memory on past and current events forgetting, narrowing the range of interests, depletion intellectual life. Together with neurovegetative disorders all these manifestations of mental disorders often cause partial or even total disability (disability), but not always the deformation of its individual units, values, orientations and ability to correctly understand the social significance of their actions and activities. In other words, brain injury does not affect the structure of the individual, but also through organic lesion of the brain that regulate autonomic-endocrine activity and emotional processes congratulatory (life) character, causing the organic changes in the psyche. This is primarily eksplozyvnist excessive severity of the reactions of dissatisfaction and anger, temper, isteroyidnist, repeatability unproductive emotions and actions (perseveratyvnist), rigidity (stiffness), jams, sensory (high sensitivity) and resentment. The simultaneous effect of stressful situations, promotes concentration and reaction of these forms of stereotyping, which creates additional difficulties for social adaptation of patients, reducing their compensatory capabilities.

In forensic psychiatric perspective a central place occupied by the forms of personality pathology, called psychopathic states. It is in these cases of such painful disharmony person who caused no constitutional hereditary, that is, genetic factors, and cerebro-traumatic lesion or procedural disease (schizophrenia). Psychopathic disorder traumatic origin is essentially one embodiment psycho-organic syndrome characterized primarily affective-volitional disorders. Often there eksplozyvnist (cutting, rough vzryvchastist) form of hysterical reaction that is characterized by show off and their connections. An essential component of any kind of psychopathic syndrome appear complicated in structure, subjectively severe, with large charge kryminohennosti mood disorders, defined as dysphoria. They occur spontaneously or under the influence of unfavorable external environment and paradoxical combination of different nudi, podavlenosti,

depression and anxiety hnivlyvistyu, hateful tension, painful experiences uncertain fears, involuntary or perceived willingness to brutal aggression.
Dysphoric states to some extent is the background, such as amplified to the point of leading syndrome, it loses its independence. Overall, they represent an important link cerebro-organic disorders and is a major clinical arguments that define the essence of forensic psychiatric expert opinion.

III. Recommended Books.:
Basic:

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Basic:

1. Psychiatry / Ed. O.K.Napriyenka.- K., 2003
2. Psychiatry (clinical and diagnostic algorithms): Training manual / Ed. prof. LM Yur'yevoyi.-D.: ART PRESS, 2002.-168s.
3. VD Mendelevich Psyhyatrycheskaya propedeutics: Practical guidance for doctors and students. - Moscow: TOO "Tehlyt", 1997.-496p.
4. Burlachuk LF, Morozov SM Dictionary-Directory on psyhodyahnostyke.-SPb., 1999.-518s.
5. Clinical psyhyatryya / Ed. N.E.Bacherykova.-K .: Health 1989-512s.
6. Guide to psyhyatryy / Ed A.V.Snezhnevskoho.-In 2 tomah.- Moscow: Medicine, 1983.
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Additional

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4. Krepelyn E., "Introduction to Clinical psyhyatrycheskuyu" Binom, Moscow, 2004
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19. Kempinski A., "Melanholyya" Science, St. Petersburg, 2002
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systematics)." M., Medicine, 1975
25. K. Schneider, "Clinical psyhopatolohyya", M., "Sphere", 1999
26. Principles and Practice psychopharmatherapy: Per. s English. SA Malyarova / F.Dzh. Yanychak, JM Davis, SH.H. Preskorn, F.Dzh. Ayd ml. - K .: Nika Center, 1999 - 728 p.
27. "Physical culture Lechebnaya psyhyatrycheskoy bolnytse" V.Y.Zapuskalov, S.A.Kasparova et al. (Under. Ed. Y.Z.Kopshytser) M Medicine 1965
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30. E. Kretschmer "Structure of PE and character"
31. Licko AE "Psyhopatyy and accentuation of character in the adolescents'
32. K. Leonhardt "Aktsentuyrovannыe personality"
33. Zeigarnik BV "Patopsyholohyya» 1986
34. Karl Jaspers' General psyhopatolohyya "M." Practice "1999
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