MINISTRY OF HEALTH OF UKRAINE

ZAPORIZHZHIA STATE MEDICAL UNIVERSITY

Department of psychiatry, psychotherapy, general and medical psychology, narcology and sexology

SURVEY METHODS AND RESEARCH. MAIN PSYCHOPATHOLOGICAL SYNDROMES

Tutorial

for 4th year students of international faculty №2

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Автор:

Safonov D.M., assistant of the Department of psychiatry, psychotherapy, general and medical psychology, narcology and sexology, PhD.

Рецензенти:

Dotsenko S. Ya., Professor, Head of the Department of Internal Medicine 3, PhD, MD;

Dariy V. I., Professor of the Department of Nervous Diseases, PhD, MD.

Safonov D.M.

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The tutorial provides materials on modern ideas about the survey methods and research of basic psychopathological syndromes in accordance with the requirements of the curriculum program «Psychiatry and narcology» for the 4th year students of International Faculty №2. The authors used modern requirements for teaching, control of theoretical knowledge, skills and practical abilities in the system of credit transfer of educational evaluation. The materials of tutorial should help students to improve their knowledge and skills in the basic methods of diagnosing mental disorders, expand their understanding of the basic psychopathological syndromes. The tutorial is a guide for conducting practical classes in psychiatry and were developed for the first time. Due to the progressive development of psychiatry, changes in the requirements for specialists, this tutorial will not meet the pedagogical and professional needs over time, so it will be improved and supplemented.

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FOREWORD

The proposed tutorial is compiled in accordance with the "Educational-professional program of higher education" and built according to the working program of the discipline «Psychiatry and narcology». The manual is prepared on the basis of materials developed by the teaching staff of the Department of psychiatry, psychotherapy, general and medical psychology, narcology and sexology of Zaporizhzhia State Medical University. It reveals the clinical signs of the most common psychopathological syndromes, provides clinical illustrations (cases) of the described conditions. Methods of clinical diagnosis of each of these conditions are described in depth. The tutorial is structured as a practical lesson, after discussing the study material contains questions for self-control of students' knowledge. The presentation of the main methods of diagnosis of basic psychopathological syndromes in the tutorial is stereotyped and carried out using the experience of a number of textbooks and manuals for high school. However, the development of a methodological approach, the choice of form and style of the considered educational information is unique. Given the progressive development of psychiatry, changes in the requirements for specialists, this tutorial will be improved and supplemented over time.

CONTENT

INTRODUCTION

Relevance, goals, organizational structure of the lesson

1.1. Relevance of the topic.

Modern medicine requires the doctor of any specialty to apply in his practice medical and diagnostic knowledge and skills in relation either to basic mental illnesses or borderline neuropsychiatric disorders. This necessitates the mastering of the comprehensive methods for the study of the mentally ill in both clinical and outpatient settings, followed by skilled analysis and differentiated use of modern methods of therapy and rehabilitation of the mentally ill people.

1.2. Learning objectives of the lesson:

Students must:

1. Know the definitions: «symptom», «syndrome», «nosology».

2. Know the etiological factors of mental disorders.

3. Know the pathogenetic mechanisms underlying mental disorders.

4. Know the basic principles of curation of patients with mental disorders.

5. Know the main stages of the diagnostic process in psychiatric practice.

6. Know the characteristics of the main psychopathological syndromes.

7. Know the signs of emergencies caused by mental disorders.

8. Know the basic principles of emergency care for patients with mental disorders.

9. Know the indications for the use of measures of physical restraint and isolation of patients with mental disorders.

Students must:

1. Be able to detect signs of basic psychopathological syndromes in a clinical setting.

2. Be able to assess the severity of basic psychopathological syndromes in a clinical setting.

3. Be able to make a differential between similar psychopathological syndromes.

4. Be able to provide emergency care to patients with mental disorders.

1.3. Objectives of personality development:

Develop a sense of responsibility for the timeliness and correctness of the decision to assess the general condition, the presence of complications. To form deontological ideas about the peculiarities of the future specialist's attitude to the patient with mental disorders and his family.

1.4. Lesson plan and organizational structure:

№	The main stages of the lesson, their functions and content	Learning objectives in the levels of mastery	Methods of learning control	Materials of methodical maintenance (control, clarity, instructiveness)	Time (min.)
I. Preparatory stage					
1. 2. 3.	Organization of classes Setting learning goals and motivation **Control of the initial level of knowledge, skills, abilities:**			Academic Journal "Learning Objectives" "Actuality"	40
	1) Basic principles of diagnosis of patients with mental disorders	I	Level I test control	Methodical developments	
	2) Definitions «symptom»,	II	Individual examination	Thematic tables,	

	«syndrome» and «nosology». 3) Etiological factors, pathogenesis of mental illness. 4) Clinical characteristics of basic psychopathological syndromes. 5). Signs of emergencies caused by mental disorders. 6) Basic principles of emergency care for patients with mental disorders.	 II II II II	Level II test control	posters, slides, structural and logical schemes Questions for individual examination Test tasks of I, II level Typical tasks II equal	
II. The main stage					
	Formation of professional skills and abilities: 1) Mastering the anamnesis taking and evaluation of these data; 2). To form the ability to conduct somatic, psychoneurological and laboratory-instrumental examination of the patient's status, to interpret these data. 3) Master the ability to justify the syndromic diagnosis and make a plan for	 III III III	Methods of skill formation: professional training, solution of level II tests, typical level III cases professional training in solving atypical clinical cases, level III tasks	Algorithms for the formation of practical skills: methodical developments. Neurological hammers. Tables. Tests, typical cases of the III level Algorithms for the formation of professional skills. Situational atypical tasks.	100

	examination of the patient. 4). Be able to make a differential diagnosis based on clinical and ancillary laboratory data.	IV		Simulation games. Equipment.	
III Final stage					
1. 2.	Control and correction of the level of skills and abilities Summarizing the lesson (theoretical, practical, organizational)	III	Methods of skill control: individual control of practical skills and their results. Analysis and evaluation of clinical results, solutions of tests, cases	Equipment The results of the clinical examination. Level III tasks Level II tests Approximate map for independent work with literature	40

PECULIARITIES OF CURATION OF PATIENTS IN PSYCHIATRIC CLINIC

In psychiatric diagnostic practice, clinical and paraclinical methods of examination of patients play a leading role.

Clinical methods include the following:

1) observation of the patient's behavior;

2) interviewing the patient (conversation);

3) analysis of anamnesis data, consisting of subjective (obtained directly from the patient) and objective (from the words of relatives or persons who know the patient well);

4) clinical examination of the somatic and neurological condition of the patient and the state of all spheres of his psyche.

Conversation with the patient should be conducted in a calm, polite manner, asking the question clearly, in a comprehensible form, addressing the patient by name and patronymic. The calm tone of the conversation, combined with slow, careful movements, creates an atmosphere of benevolence, and the patient calms down a bit, allowing the doctor to talk in the right direction. Consideration should be given to the possible slowdown of the patient's thinking as a result of the action of sedatives, so the doctor should, after being asked, pause and speak quietly at a slow pace.

The patient should not be cut short if he or she goes into too much detail about the facts or goes on to another topic. It is necessary to find a pause in the speech of the patient, sympathetically summarize his statements (for example: "Yes, as we understand it, you were very ill at the time"; or: "Thank you, we have already decided a little about your kidney disease"), and further politely direct the conversation to the required direction. It is very important to gain the patient's trust, and only a thoughtful, purposeful and friendly conversation can guarantee the necessary frankness. In the case of volatility, constant distraction, irritability of the patient

should quietly repeat the same questions, perhaps in slightly different words - softly but persistently. If the patient refuses to answer the question, changing the direction of the conversation will help relieve unnecessary tension, distract the patient, and later return the conversation to the desired topic.

If a patient is being examined by a student, he / she should understand that he / she has some legal responsibility for his / her actions, so he / she should not give the patient advance promises, information about the results of the examination, interfere with the medical program tips. At the same time, he is not an average interlocutor, so topics that are not relevant to the specific purpose of curation are also undesirable. After the examination, it is advisable to thank the patient for communication, politely say goodbye to him and wish him the fastest recovery.

STAGES OF THE DIAGNOSTIC SEARCH

Diagnosis is a form of human cognitive activity that can be applied to all general laws of knowledge. Skillful diagnosis is one of the most important conditions for the effectiveness of the patient's treatment. The stage of diagnostic search involves adhering to a consistent pattern of identifying specific patterns of complex pathological process, which makes it possible to establish a definitive diagnosis. The main elements that underpin the diagnosis process are symptoms, syndromes and nosological forms.

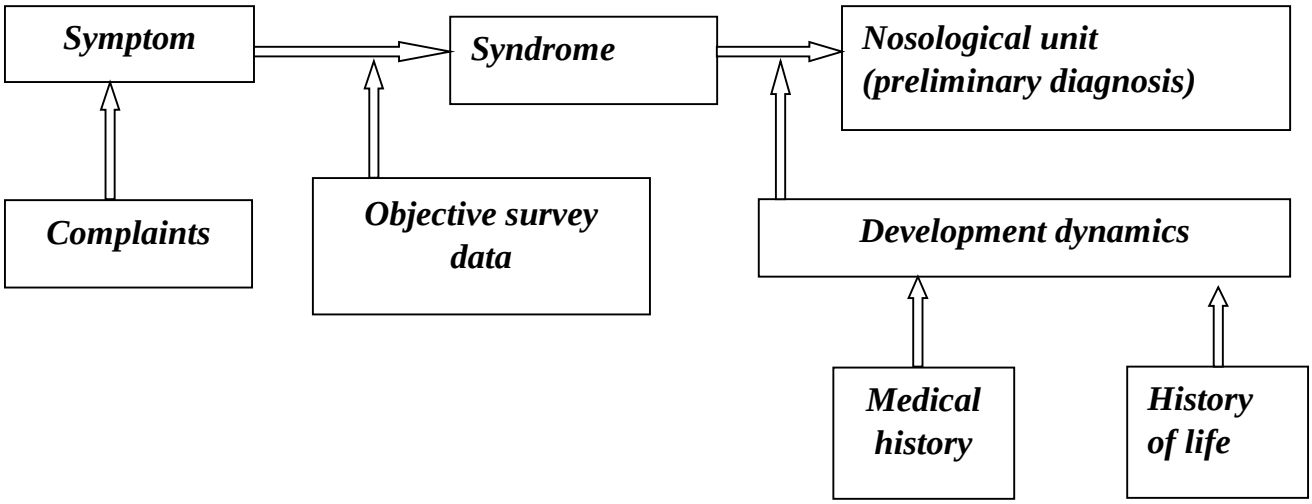
The symptom is a separate manifestation of the disease, a single consequence of the pathogenetic process. We do not observe all the constituent parts of the latter, dealing only with its manifestations, in symptoms.

The syndrome is a set of interrelated individual symptoms that are combined by common pathogenesis.

The nosological form (the disease itself) is a group of pathogenetically related syndromes with special, individual dynamics of development.

Figuratively speaking, the symptoms are the individual bricks from which the walls (syndromes) are built, and the latter are the building (nosological form, disease), where the personality of the course (dynamics) acts as the mortar.

Diagnostic search has three interrelated steps: preliminary, clinical, and definitive diagnosis. The first stage should follow the scheme shown in Pic. 1.

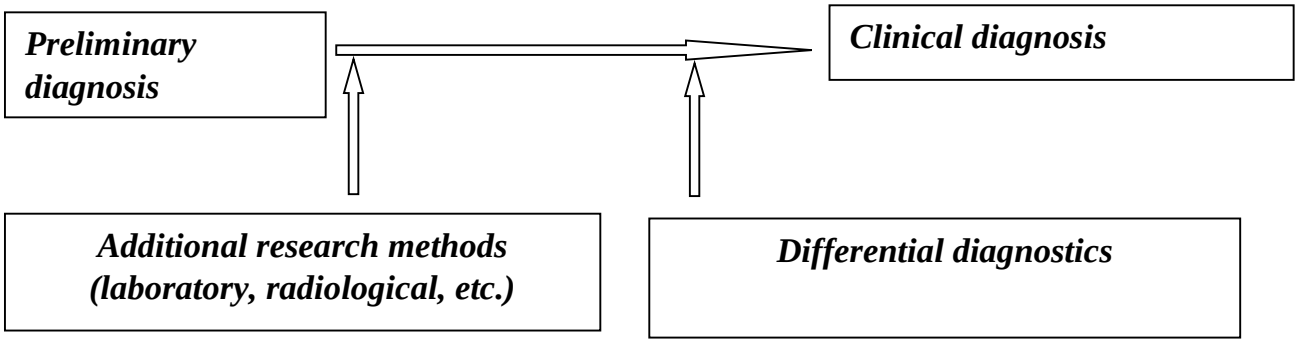


Pic. 1. Scheme of the first stage of diagnosis of mental illness.

According to the scheme, on the basis of the collected complaints and the results of the objective examination, they distinguish the symptoms from which syndromes are formed by their grouping by the pathogenesis of psychopathology. History of illness and life make it possible to identify individual features and dynamics of their development, which guides the diagnosis to a particular disease. The doctor thus expresses a preliminary opinion about the patient's health status, which is formulated in commonly used medical terms.

The second stage is the establishment of a clinical diagnosis, which should also be carried out according to the scheme (Pic. 2).

As the scheme demonstrates, additional research methods allow the doctor to delve into the essence of the pathological process, identify its individual features, change or refine the previous diagnosis.



Pic. 2. Scheme of the second stage of diagnosis of mental illness.

Differential diagnosis is the most difficult element of diagnosis. It is based on the most important operations of thinking - comparison, generalization, classification, reflecting the level of clinical thinking of the doctor.

The third stage of the diagnostic search is to establish a definitive diagnosis. It is based on the results of the treatment and the dynamics of the patient's health during and after him. There is even a special form of diagnosis, "exuvanticus diagnosis" (through treatment).

Depending on the outcome of the treatment, the doctor's preliminary diagnosis is confirmed or modified or refined by the pathomorphological examination data (in case of death of the patient). If the disease has a chronic course and there is no complete cure, a diagnostic search is supplemented by observation of the patient in remission (for example, determining the type of course of schizophrenia is possible only if there are data on the dynamics of exacerbations and remissions).

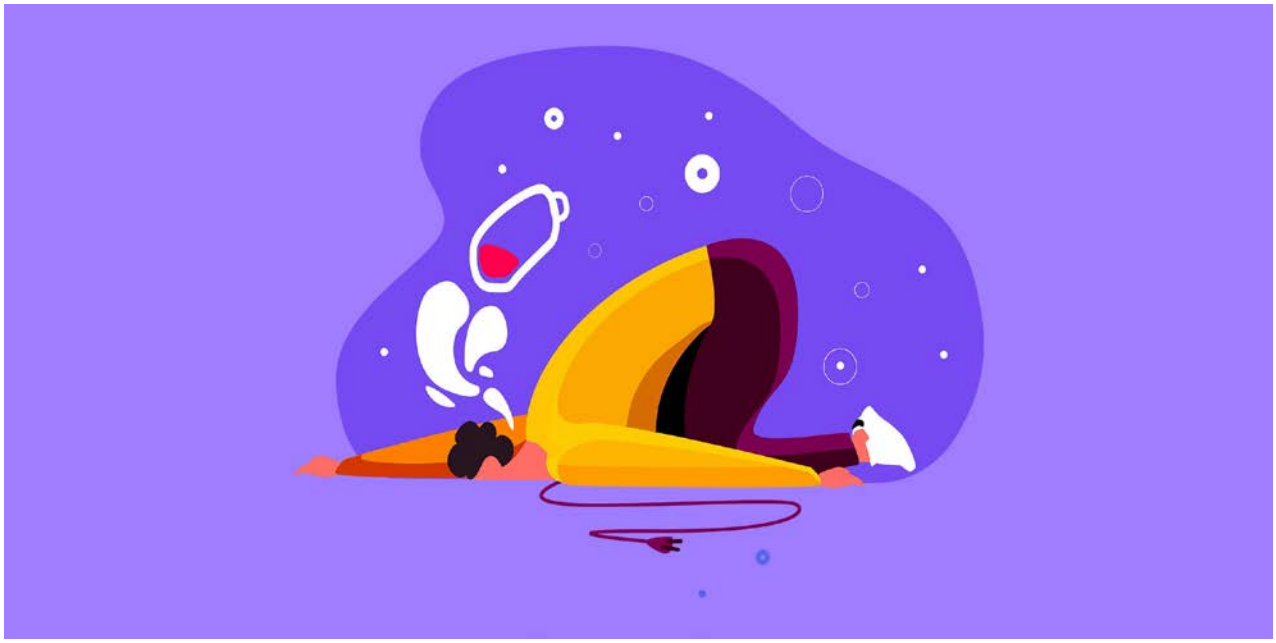
PSYCHOPATHOLOGICAL SYNDROMES

The disease is never a separate symptom. When analyzing her clinical picture, the syndrome-related symptoms are noted. The syndrome is a set of related symptoms that share a common pathogenesis. In the syndrome coexist both positive psychiatric disorders (asthenic, affective, neurotic, delusional, hallucinatory, catatonic, convulsive), and negative (destruction, fall, defect). Positive symptoms

are always variable, negative ones are invariant. Syndrome - a stage of the disease. The nosological specificity of the syndromes is not constant. The same syndrome can be observed in different diseases. Syndromes in diseases of the same etiology may differ from each other, and, conversely, there are many identical syndromes that arise for different reasons. The main syndromes most often observed in the clinic of mental illness.

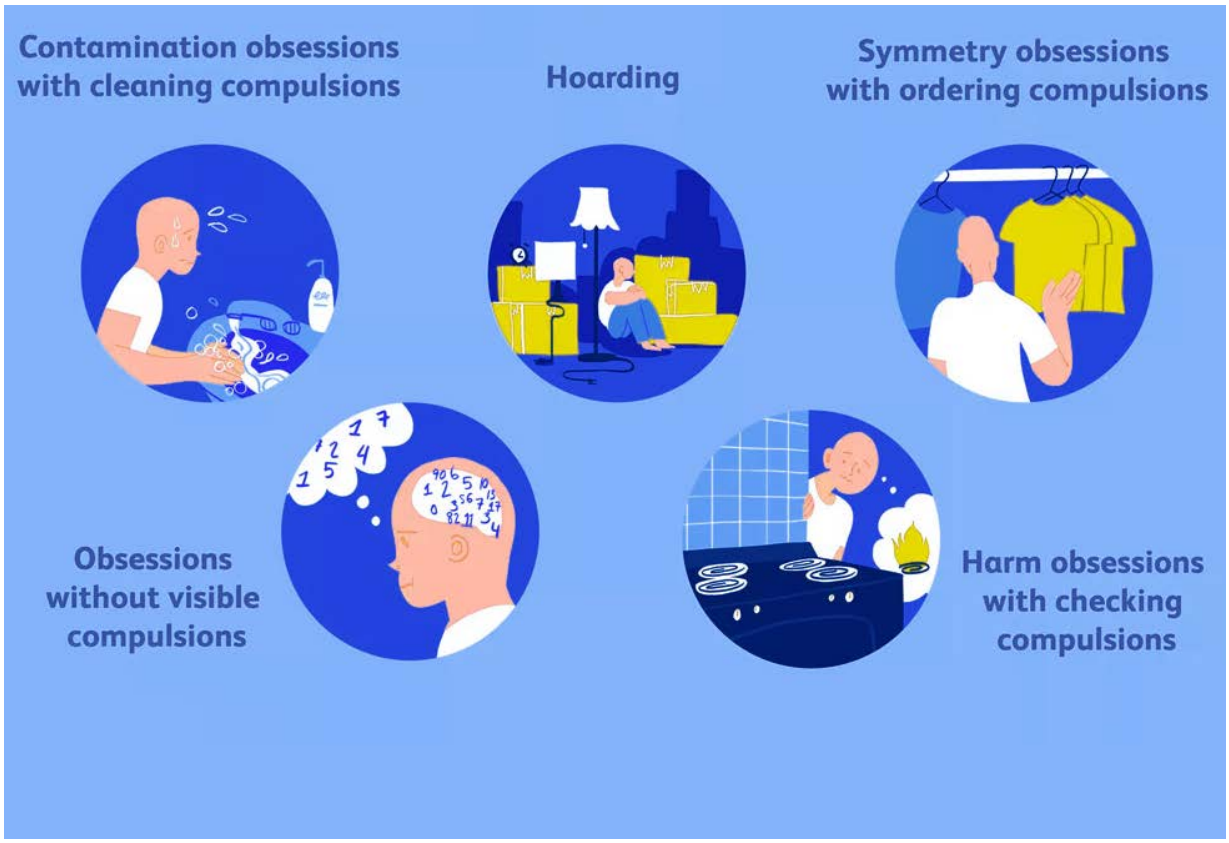
NEUROTIC SYNDROMES

Asthenic syndrome (asthenia) - a state of increased mental and physical fatigue, excessive irritability, low spirits and unstable mood, combined with autonomic symptoms and sleep disorders. Asthenia symptoms are less noticeable in the morning and increase in the second half of the day, especially in the evening. If in the clinical picture of asthenia is dominated by inflammation, explosiveness, impatience, feeling of internal tension, then it is a question of hypersthenic asthenia. In the case of not only mental, but also physical fatigue, the feeling of powerlessness of asthenia is classified as hypostenic, its most severe form. Asthenic syndrome is often observed not only in mental illness, but also in most somatic ones (Pic. 3).



Pic. 3. Art illustration of asthenia.

Obsessive syndrome (obsessive condition syndrome, anankastic) manifests itself in various obsessions. They are most often characterized by phobias (obsessive fears), obsessive accounts, doubts, memories, "mental rumination". The clinic is dominated by phobias of hypochondriacal content: cardio-, cancerous-, syphilo-, AIDS-, tanato-, noso-, phobo-, as well as claustro-, agoraphobia. In addition to obsessive ideas and fears can be obsessive actions (more often in children): coughing, raising eyebrows, shoulders, trying to suck finger, biting nails (onychophagy), pulling hair (trichotillomania). There may be certain rituals - phobia-related obsessions and actions that reduce other obsessions. Realizing the absurdity and unreasonableness of these habits, the patient still does not get rid of them, and they affect his behavior. The patient, having made a willful effort, is able to overcome painful experiences. Obsessions are observed with neurosis of obsessive conditions, psychasthenic psychopathy, schizophrenia, organic brain lesions (Pic. 4).



Pic. 4. Main manifestations of the obsessive syndrome

Pic. 5. Art illustration of hypochondriacal syndrome.

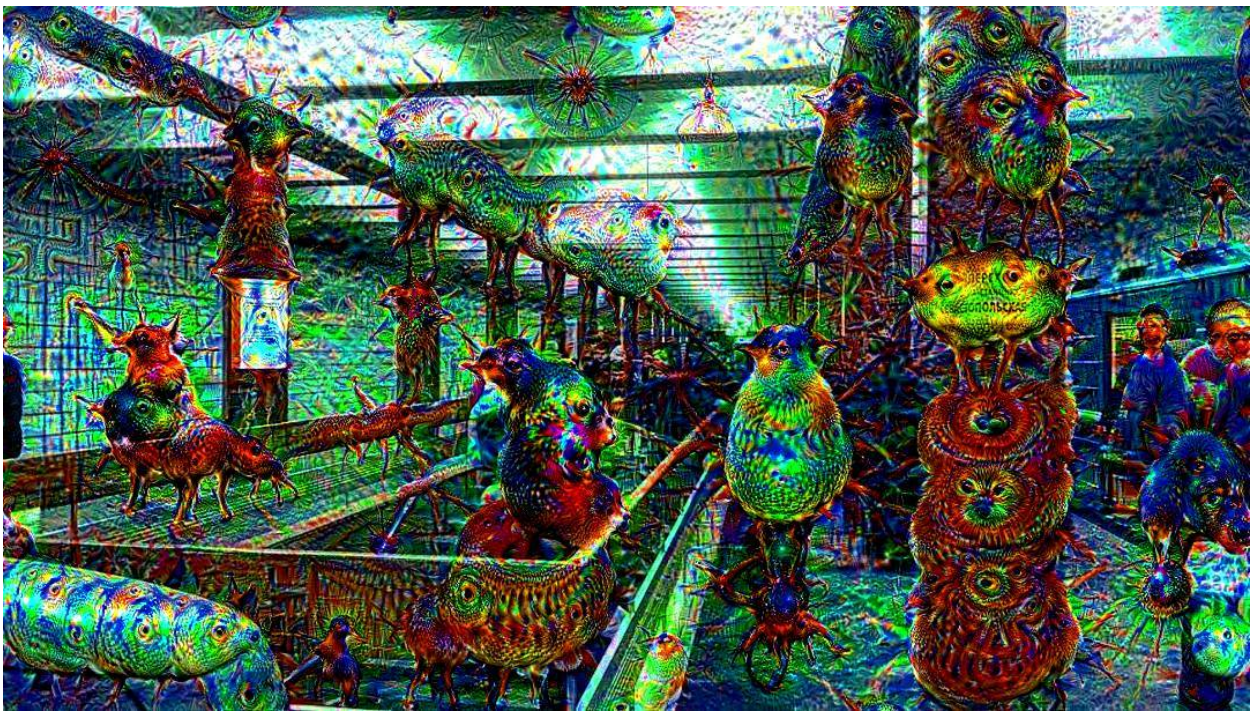
Senestopathic-hypochondriacal syndrome is a neurotic syndrome that is manifested by various, rather unpleasant, painful, unbearably severe sensations. The patient may complain of burning, contracting, transfusion, contraction, swelling, etc. in various parts of the body, internal organs (senestopathy). There are hypochondriacal precious ideas - violations of judgment. The patient "manifests" in itself signs of severe incurable illness. They occur on a real basis, but the patient interprets these circumstances one-sidedly, he/she is in a state of emotional tension. Causes of pain can not be detected by objective methods of research. Senestopathic-hypochondriacal neurotic syndrome is characteristic of neurotic disorders, mainly neurasthenia and hysteria. Senestopathic syndrome may take part in the structure of other syndromes, including malignancies. Observed in schizophrenia, manic-depressive psychosis (depressive phase), organic brain lesions (Pic. 5).

Hysterical syndromes. *Hysterical neurotic syndrome* is characterized by emotional lability with rapid manifestation of feelings (sobbing, sobbing, moaning), rapid change of positive feelings to negative and vice versa, accompanied by various secondary somatic and neurological conversion disorders. Disorders of the motor sphere, sensitivity, autonomic functions are manifested by functional paresis, paralysis, local contractures, hysterical attacks. At the latter there are no disorders of consciousness, changes of functions of cardiovascular and respiratory systems and sequence of phases of a convulsive attack. There can be hysterical stuttering,

aphony, mutism, sundomutism, blindness, sensitivity disorders such as stockings, gloves or hematypes, astasia, abasia. There are vegetative disorders: vomiting, hiccups, belching, sensation of "ball" in the throat (globus hystericus), tachycardia, shortness of breath, polyuria. Hysterical syndrome is characteristic of hysterical neurosis.

In addition to the neurotic hysterical syndrome there are *hysterical psychotic syndromes*. Hysterical darkening of consciousness is manifested by narrowing it with incomplete orientation in the surrounding environment, bright, clear stage-like, achromatic hallucinations with subsequent, more often retarded, amnesia. Hanser syndrome is one of the variants of hysterical darkening of consciousness when complete disorientation, visual, rarely auditory hallucinations can be observed. Detectable ideas of relationship, influence, persecution are revealed. Characteristic is the speech, the behavior of the patient is senseless. The impression is that it simulates mental illness. The pseudodementia syndrome is a state of helplessness, manifested by the loss of the simplest skills, elementary knowledge. The patient deliberately incorrectly answers against the background of dementia, grotesqueness, but is well-advised when he is asked difficult questions regarding the psycho-traumatic situation. Puerilism is a mental condition in which adult behavior is not age-appropriate and child-like. Regressive behavior is observed with childish manners, intonations, gestures, emptiness, meaninglessness, naivety of judgments against the background of depressed mood and confusion. Psychotic hysterical disorders in most cases are caused by psychogenic factors, and they are attributed to reactive psychoses.

Depersonalization syndrome is manifested by a disorder of self-consciousness. The perception of the self-changes. Thoughts, the actions of the patient are guided by the feeling of alienation from the self (as if standing on the side). The unity of personality is lost. Violated body chart: "change" volume, length, width, position of individual parts of the body. Often accompanies derealization.



Pic. 6. Art illustration of derealization syndrome.

Derealization syndrome - a pathological condition in which the world, the situation is perceived by the patient is unrealistic, fuzzy, indistinct, colorless or in one color, devoid of life. The environment seems dull, frozen, flat. Patients claim that everything has changed, everything is not that way it was before the illness, sometimes they cannot explain what these changes are (Pic.6).

AFFECTIVE (EMOTIONAL) SYNDROMES

Emotions – a special class of mental states that reflect the attitude of the person to the world, to other people, to himself and to the results of his activity.

Kinds of emotions:

primitive (lower) – experiences related to satisfaction or dissatisfaction of the physiological needs;

higher – are the experiences that arise on the basis of satisfying of the spiritual needs;

positive – emotions related to fulfilling of needs;

negative – emotions that cause frustration and require the change of the situation;

stenic – emotions that increase and enhance the human activity;

asthenic – emotions that inhibit the activity of the organism, reduce the energy of the subject.

Neurochemistry of emotions. Pharmacological analysis of the formation of positive and negative emotional states in humans and animals has allowed to establish that these states are built on the basis of certain neurochemical mechanisms. Among the mediators, the balance, which in the brain determines emotional reactions, special role belongs to norepinephrine, dopamine and serotonin. In addition, recent years have shown an important role in the formation of emotional reactions of a number of neuropeptides and hormones that act in the brain as neuromodulators or neurotransmitters.

Norepinephrine, which is produced mainly by the neurons of the blue spot of the reticular formation of the brain stem, has a powerful effect on the emotional state of the person. Decrease in the production of this mediator causes depression, and its excessive formation leads to excessive excitation and stress overload.

Dopamine, which is produced by neurons of the midbrain black substance, is the major mediator through which the state of pleasurable sensations and euphoria, produced by various naturally occurring influences, is realized. The central zone in the brain, the activation of which dopamine causes a pleasant sensation, is the nucleus accumbens, located in the depth of the cerebral hemispheres at the base of the striped body. The increase in dopamine content in the adjacent nucleus explains in particular the euphoric effect of such substances as morphine, cocaine and amphetamine

Experimental evidence of dopamine's involvement in the formation of pleasurable sensations is that under conditions of self-stimulation, experimental animals always prefer to stimulate areas where dopaminergic pathways pass. The

blockade of dopaminergic receptors by, for example, an antipsychotic drug such as haloperidol, blocks the self-stimulation response in animals.

Important involvement of dopamine in the formation of positive emotions in humans is confirmed by clinical observations. So in Parkinson's disease, when the neurons of the midbrain black substance cease to synthesize dopamine, its lack in the brain of such patients causes them a constant depressed state.

Serotonin, which is produced by the neurons of the nuclei of the suture of the bridge and the anterior part of the brain stem, manifests itself as a mediator, which has a very wide spectrum of action. Proof of this is the very name of this substance, which is due to the fact that the ability of serotonin to increase the tone of blood vessels in serum (Latin serum - serum) was initially discovered. In terms of emotions, serotonin is central to the formation of positive states. It is this mediator because of its calming effect and ability to inhibit anxiety, anxiety, and aggression, in the popular literature, the figurative definition of "hormone of happiness".

Basic concepts

Emotions have a number of properties: quality, content, orientation, duration, expressiveness, source of origin, etc. The basic qualities of emotional states are necessary signs of the subjective attitude of the person to the object. These include: positive, negative, ambivalent and uncertain attitude.

Positive subjective attitude is an indicator of what satisfied, is satisfying, or could satisfy an emergent need. Negative subjective attitude is an indicator of what hindered, is hindeting, or could hinder it. The ambivalent subjective attitude reflects the simultaneous coexistence of positive and negative attitudes towards the object. Uncertain subjective attitude reflects a brief state of orientation in new experiences, quickly turns into positive or negative.

Emotional manifestations are divided into emotional states, attitudes and reactions.

An emotional state is a stay in any mood associated with the overall somatopsychic tone of the subject and, as a rule, has a protopathic nature. Emotional

attitude characterizes the connection of the subject with the competing object and expresses its active position in the subjective evaluation of the latter. An emotional reaction arises as a direct subjective response to any influence, impression.

Depending on the immediate form of experiences, orientation, duration, expressiveness, intensity and source of occurrence, emotional manifestations are divided into sensory tone, mood, feelings, passion, affect and emotional and stress states.

Mood is a long, relatively balanced and stable general emotional state, coloring individual mental processes and human behavior. The mood is determined by the overall somatic tone and the general state of the environment. Mood is the sum of emotions over a period of time.

Feeling is an emotional attitude that differs in terms of a clear time constraint, intensity of experiences, and reflects a specific meaningful subjective assessment by a person of a certain object.

Passion is a long-lasting, significantly expressed and intense emotional attitude to the orientation, concentration of feeling on a certain object or activity.

Affect is a short-term, greater force of emotional reaction that quickly captures a person, with rapid mimic and vegetative manifestations and is accompanied by some violation of control over their behavior in formally clear consciousness.

An emotional-stressful state is an emotional reaction that reflects a person's attitude to reality in situations that cause emotional stress. They manifest themselves in a certain behavioral reaction called emotional-stress.

Outward emotions are manifested by facial expressions, pantomime, features of speech and somatovegetative phenomena. Facial expressions - coordinated movements of the facial muscles that reflect the emotions of the person. Pantomime - gesture - coordinated body and arm movements that accompany and express different emotional experiences and mental states. Parameters of speech expressing

emotional experiences (paralinguisms) are its tempo, strength and intensity of voice, its intonation, timbre, sonority.

The most objective indicators of emotional manifestations, which are not subject to volitional delays, are somatovegetative symptoms: skin-galvanic reaction, peristalsis of the gastrointestinal tract, pupillary reflexes, saliva and sweat secretion, change of cellular and biochemical content of blood etc.

Manic syndrome is characterized by a triad of major clinical manifestations: morbidly elevated mood (euphoria, hyperthymia); accelerated flow of ideas, thoughts, memories (mental and linguistic arousal); too active, activity (motor excitation) in the presence of distracted attention. Thus the patient overestimates the abilities, desires. Delirious ideas of majesty may appear. There are several variants of manic syndrome, namely: cheerful mania when inflammatory affect predominates; angry mania (increased irritability, attraction, anger); confused mania (manic lingual confusion with psychomotor arousal). In addition to the relatively simple variants of manic syndrome, there are also complex variants of it: manic-delusional syndromes (combination of maniacal state with acute sensual looming of persecution, staging); manic-hallucinatory (combined with hallucinations) (Pic. 7).

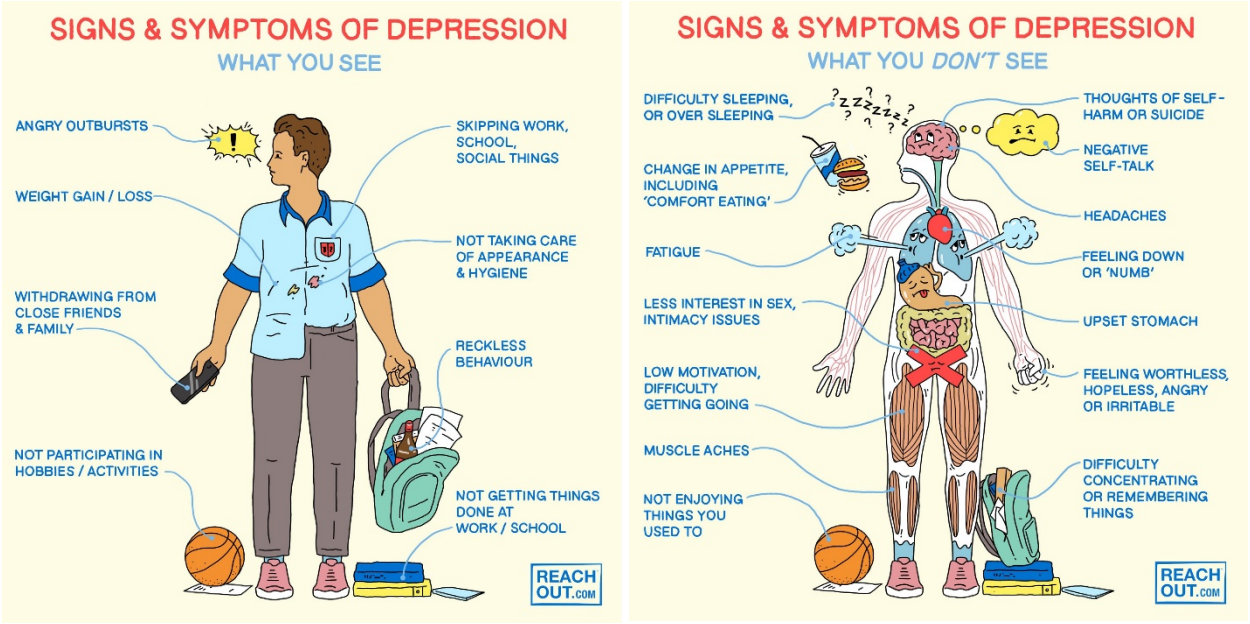
EXAMPLE: There is nothing better this fall, usually starting in September. You work a lot, but you don't get tired. You realize ideas immediately, only they come up. I make it everywhere and always at the height. I notice that I can drink more and not be drunk, to them, I do not even notice that, but always with appetite. Many friends and girlfriends appear, money goes sometimes in one day. One drawback is the increase in debt.

Pic. 7. Main signs of manic syndrome.

Depressive syndrome is a depressive triad: morbidly lowered, depressed mood (depression,) with a feeling of longing, down to despair, hopelessness; the slow flow of ideas, thoughts, speech (mental and linguistic retardation) and attention to their experiences; motor inhibition. Patients have delusional ideas of self-blame, self-humiliation, sinfulness, inferiority, thoughts of suicide, attempts to bring the bills to life. This combination of depressive symptoms is dangerous for the patient (suicide). Variants of depressive syndrome are more than manic: anxiety depression is a rather intense anxiety; agitated depression - melancholic arousal with fussy anxiety; anesthetic depression - with insensitivity to pain, conscious and profound experience of the decrease or loss of this feeling (anaesthesia dolorosa psychica); asthenic depression accompanied by asthenic symptoms combined with exhaustion; tearful depression - with weakness and tears; adynamic depression - with the loss of urges, desires, impotence. Masked (hidden, somatized) depressions are characterized by various somato-vegetative, senestopathic sensations, in the first

place, and subdepressive state - in the second. There are the following variants of masked depression: algic-senestopathic (cardiac, abdominal, cephalgic, panalgic), agripnic (with sleep disturbance), diencephalic (vegetovisceral, vasomotor, pseudo-asthmatic) and obsessive. Depressive syndrome can be combined with persecute looming (depressive beating), hallucinations and mental automatism (depressing hallucinatory) (Pic. 8).

EXAMPLE: This condition starts in the morning. You usually wake up early, about five o'clock, and lie down with your eyes open. Terrible tightness and stone on chest. Getting up, but not wanting, it seems awful that there is a huge day ahead. At work, too, nothing good, you want to get cornered. Longing is literally paralyzing, and the whole world seems gray and dim, as if seen through dirty glass. All meaning is lost and in the future there is nothing good.



Pic. 8. Main signs of depression.

Dysphoric syndrome (dysphoria) is manifested by a decrease in mood, annoyingly sad irritation, anger with fear, morbid ideas of harassment and aggressive tendencies. A small irritant that causes negative emotions (anger, sadness, fear) can provoke dysphoria.

EXAMPLE: Usually, after a while, there are whole days after the attacks, when you just feel angry at everyone. Whatever anyone says, I want to object,

protest. You really want to throw yourself at the objector or not so looked. It happens that you specifically provoke, but it does not give relief. Annoying sounds and bright light, clothing and transport. In these black days I get into different stories all the time.

Euphoria is a state of carelessness with a desire for contemplation, but often with active actions that are characterized by relief. Characteristic for the use of psychoactive substances. If there is no purposeful activity during the euphoria, it is called Moria, which is characteristic of lesions of the frontal brain.

Ecstasy – a sublime mood with the idea of going beyond one's own body and merging with one's surroundings, such as nature. The equivalent of orgasm. It can be observed as a special type of seizure.

Anxiety is a state of confusion with increased motor activity, sometimes tremor, palpation, trembling (often in the peritoneal region), tachycardia, increased blood pressure.

Anxiety is an emotional state or reaction characterized by internal agitation, compression, and tension localized in the chest. It is accompanied by timid anticipation of the approaching calamity, pessimistic fears facing the future. Unlike anxiety, anxiety is an activating affect.

It is part of the structure of neurotic, anxiety-depressive, acute delusional, affective-delusional syndromes and darkening of consciousness.

Often accompanied by depression, but it occurs within the framework of certain anxiety disorders, which, in general, turn into panic.

Anxiety is supported by the following cognitive circuits: the heart can stop, it is beating too much - I can have an attack anywhere - as a result of the attack I will die – amplifying anxiety and repeating the stereotype circle.

EXAMPLE: After the exam, they did not say their assessment immediately, but only came in the morning. She didn't sleep all night, couldn't find a place - what if there were two. She walked around the room, looked out the window, drank a sleeping pill, but it didn't work. Shaking hands, heartbeat and clenching in temples.

Confusion - a volatile, labile emotional state with the experience of wonder, helplessness.

It is included in the structure of darkening syndromes of consciousness, atypical affective, affective paranoid, acute delusional syndromes, reflecting their particular severity.

Affective syndromes are observed in manic-depressive psychosis, organic brain lesions, schizophrenia, epilepsy, neuroses, personality reactions to external factors.

HALLUCINATORY SYNDROMES

This is a group of positive (productive) syndromes, including looming and hallucinations.

Hallucinatory syndrome (hallucinosis) is characterized by a constant influx of hallucinations from the same analyzer, but with different content. There are verbal, visual and tactile hallucinosis. Often there is auditory verbal hallucinosis, consisting of an influx of verbal (human speech) true or pseudo-hallucinations in the form of a monologue (monococcal hallucinosis), dialogue, multiple "voices" of various content that threaten, accuse, blame. Particularly dangerous for the environment and for the patient is the prescriptive (imperative) hallucinations. Visual hallucinosis involves an influx of large number of true visual hallucinations. There are several types of it. For example: visual hallucinosis Bonnet, which develops in the elderly with total or partial loss of vision (cataracts, etc.); peduncular (hallucinosis Lermitta), which occurs when the pathological process is localized in the legs of the midbrain. It consists of numerous moving, microscopic and "living" visual hallucinations. Tactile hallucinosis (dermatozoa loosening of Ekbolo) is manifested by tactile hallucinations, unpleasant sensations on the skin and under the skin (as if skin parasites are crawling), and may be combined with loosening of obsession. Hallucinatory syndromes are observed in schizophrenia, epileptic psychoses, organic brain diseases.

Paranoiac (paranoia) syndrome is characterized by primary systematic interpretative looming, detail thinking, and affect walliness. The system of distorted judgment (looming) is based on a chain of evidence that has a subjective internal logic. Some facts are one-sidedly interpreted, and the evidence that contradicts a certain belief is ignored. By theme emit paranoia jealousy, persecution, invention, hypochondriacal. Looming ideas are grouped on the basis of central thought. Delusional judgments become a system of views that determine the outlook of the individual in general. These judgments focus the entire mental life of the patient. Paranoia syndrome begins to develop after an unpleasant experience, a conflict, with precious ideas that are transformed into delusions of majesty, relationship, influence, persecution. Observed in schizophrenia, involutionary, vascular psychoses, organic brain lesions, paranoid psychopathy in a state of decompensation.

Paraphrenic (paraphrenia) syndrome combines the delusional ideas of perseveral content: relationship, physical and mental impact, poisoning. During the formation of looming, the ideas of greateness develop, which have to do with disorders of perception (hallucinations, phenomena of mental automatism). According to the mechanism of formation, para-phrenic looming can be interpretive and sensually-shaped. Depending on the predominance in the structure of the paraphrenic syndrome of mental disorders, there are the following variants of the syndrome: systematic paraphrenia, characterized by systematic looming persecution and majesty; fantastic paraphrenia - dominated by numerous expansive delusions (greatness); confabulatory paraphrenia - numerous delusional confabulations; expansive paraphrenia - expressed high affective state and delusions; hallucinatory paraphrenia - dominated by fantastic hallucinations of exaltation. Paraffin syndrome is observed in schizophrenia - as a stage of its continuous or seizure course, and in organic psychoses.

Paranoid syndrome includes secondary looming and delusions of perception (hallucinations, illusions, senestopathy). Most often with paranoid syndrome, there are persecutory delusional ideas (persecution, relationship, poisoning, obsession,

dysmorphia.). Waving ideas are fragmented, fragmentary, fragmentary. In the statements of the patient there is no "rod" around which a beacon system would be formed (unsystematic beating). Waving ideas are accompanied by affective tension (fear, anxiety, anger, motor excitement). Paranoid syndrome is associated with many mental illnesses, including schizophrenia, epileptic, vascular, pre-existing, reactive and symptomatic psychoses.

Kandinsky–Clérambault mental automatism syndrome is characterized by delusional ideas of persecution, influence (mental or physical) and manifestations of mental automatism (the patient perceives himself as alienated, as if he did not belong to himself). At the same time, he feels as though he is thinking, experiencing and acting not on his own, but someone controls them. Free of thoughts (forced thinking, thought management), emotions ("make you angry, happy"), actions ("someone makes you talk, walk".). The degree of alienation, mastery, influence on certain mental processes distinguish three types of mental automatisms. Associative automatism includes alienation of thoughts, memories, involuntary influx, acceleration of thoughts (mentism); the feeling that one's thoughts are known to others (a symptom of open-mindedness) or people surrounding the patient express their thoughts aloud (a symptom of "echo-thoughts"). Sensory (senestopathic) automatism is manifested by pseudo-hallucinations and senestopathies with a sense of influence, intervention, alienation ("cause compression, twisting, pain, cold, appetite, sexual feeling"). Motor (kinesthetic) automatism - the belief of the patient that all movements, including speech, occur under the influence of an external force ("turn into robot, puppet", "control from space"). If the patient has symptoms of associative, sensory and kinesthetic automatism, then it is a detailed syndrome of mental automatism. There is Kandinsky–Clérambault syndrome in schizophrenia, organic brain lesions (Pic. 9).

Pic. 9. The patient with Kandinsky–Clérambault syndrome «protects» his head from outside influence by wearing a cap made of aluminum foil.

Capgra’s syndrome (J. M. J. Capgras, 1923) is characterized by impaired ability to recognize people. Patients do not recognize their relatives, acquaintances, speak of them as false figures who are twins or twins. It is believed that they make up for certain people (a symptom of a negative double). Sometimes strangers are perceived as good acquaintances (a symptom of a positive double). Capgra's syndrome includes Fregoli's symptom when patients claim that their "persecutor" changes their appearance so that they are not recognized. The delusional ideas of intermetamorphosis are one of the variants of false recognition. Patients believe that "persecutors" change not only the appearance, but also the moral and spiritual state of others, the surrounding environment. In this case, false recognition does not

extend to one person, but to many people. Capgra's syndrome is often combined with delusional ideas of persecution, influence, manifestations of mental automatism and is observed in many mental illnesses, nosologically it is not specific.

SYNDROMES OF PATHOLOGY OF THE EFFECTORAL-VOLUME SPHERE

Pic. 10. The patient with catatonic syndrome.

Catatonic syndrome is a symptomatic complex of mental disorders, mainly in the motor area. It consists of a catatonic stupor or catatonic excitation. There are several varieties of catatonic stupor: stupor with waxy flexibility (catalepsy), increased muscle tone, symptom of "air cushion" (Dupre), embryonic posture; a negativistic stupor with complete immobility, passive negativism; stupor with muscular numbness (the most severe form of stupor - prolonged stay in the embryonic posture with pronounced tension of all muscle groups). Among the variants of catatonic excitement are: confusion-lazy-pathetic (a combination of confusion, exaltation with disorderly chatter and motor excitation); impulsive (sudden, destructive, short-lived). Catatonic disorders can occur in persistent consciousness (lacid catatonia) or in a somnolent state (oneroid catatonia). Catatonic stupor and catatonic excitement are indications for immediate hospitalization (Pic. 10).

Gebefrenic syndrome is manifested by inert euphoria (bizarre, inadequate cheerfulness, dementia, emptiness, sometimes - childish behavior). The patient

becomes mannered, theatrical, inadequate gestures, posture, facial expressions appear. Gebefrenic arousal is characterized by a delusional behavior in combination with echo-symptoms (echolalia, echopraxia, echochemistry). Catatonic and hebefrenic syndromes are characteristic of the same-named forms of schizophrenia.

ORGANIC BRAIN SYNDROMES

These syndromes include organic psychosyndrome, korsakovsky (amnestic), paralytic (pseudoparalytic) and frontal.

Organic Psychosyndrome. In fact, it is a group of psychopathological syndromes caused by organic brain damage. The similarity of pathogenetic mechanisms leads to some common features of this type of syndromes of different etiology. Organic psychosyndrome (psychoorganic) is characterized by general mental disability, memory impairment, especially for recent events, acumen, performance, and attenuation of affective-volitional properties (E. Bleuler, 1916). N. Walther-Buel (1951) identified a triad of symptoms characterizing the clinical manifestations of organic psychosyndrome: memory impairment (impaired comprehension, understanding); intemperance; lability of emotions. The clinic of the syndrome includes signs of focal disorders of language, gnosis and praxis. Organic psychosyndrome can become residual in nature as a result of acute exogenous psychosis. Then its course is stable. But often it is a sign of progressive organic disease. At the same time there is a certain dynamics - from cerebrostenic signs to deep bewilderment. Along with the dementia in organic psychosyndrome, psychopathic personality changes are observed. Depending on the predominance in the clinical picture of signs of dementia or psychopathic changes, there are two variants of the organic psychosyndrome: the characterpathic and the dementia. They can be certain stages of a painful process: characterpathic changes turn into gross psycho-organic dementia. Organic psychosyndrome is observed in chronic exogenous and endogenous-organic brain lesions (progressive paralysis, vascular

psychoses, senile dementia, Peak and Alzheimer's disease, consequences of traumatic brain injuries, brain tumors, infectious and non-toxic).

Korsakov's (amnestic) syndrome was described by S.Korsakov (1887) as an independent illness (encephalopathy) caused by alcoholism. However, it was later observed that such a mental disorder is observed in many organic brain lesions. Some authors identify Korsakov and organic psychosyndromes (E. Bleuler, K. Laspers). The main disorder in Korsakov's syndrome is the loss of memory of current events (fixation amnesia) with preserving it in the events of the past. All new impressions instantly fade from memory. Patients do not remember anything, do not know where they are, who is near them, what day of the week is today, what number, year. After talking with the doctor, they forget the fact of the conversation. When they meet him in a minute, they are perceived as a stranger. They do not know their ward, beds, do not remember, were they having breakfast or lunch (amnestic disorientation). Everything that happened before the disease is stored in memory and reproduced adequately. Knowledge is acquired and acquired. As the disease progresses, memory of past events is lost. Memory gaps are filled with false memories (confabulations), or actions are distorted in time (pseudo-reminiscences). Such patients are motionless, helpless, frail and passive. They have affective lability or euphoria. Korsakov's syndrome can be alcoholic, traumatic, vascular and other organic origin.

Paralytic (pseudoparalytic) syndrome is a kind of organic psychosyndrome and is manifested by a marked reduction or complete absence of self-criticism and criticism on the environment, profound violation of the level of judgments, mystical disorders, mainly on the events of the present and recent past, disturbance. Such patients are easily amenable to suggestion. Against the backdrop of good-naturedness, there is a dull euphoria with irritability, ”incontinence affect”. Appetite reaches a degree of bulimia. Patients are untidy, do not watch their appearance, eat their hands, pick up malnutrition, sleep dressed. Can without permission to take food and belongings of neighbors, the

mood is sublime. Eminent ideas of greatness (wealth, high status, noble descent) are being developed. Patients talkative, constantly laughing, unceremonious in communication, prone to inappropriate jokes, obscene statements. They move a lot, can show meaningless efficiency. Neurological disorders: dysarthria, anisocoria; sluggish reaction of the pupils to light; miosis; asymmetry of innervation of the facial nerve; anisorelection; seizures. Paralytic syndrome is observed in progressive paralysis (late syphilitic psychosis). Pseudoparalytic syndrome is similar to the clinic and develops in many organic brain diseases (traumatic brain injuries, vascular and tumor pathological processes, intoxication psychoses). May appear immediately after delirium, stunning.

The frontal (lobe) syndrome is characterized by a combination of features inherent in total dementia, with an aspotency or general disfigurement. Aspotency is accompanied by marked reduction or complete loss of motivation, adynamy, silence and impoverishment of expressive language, loss of interest in the environment, indifference. In the event of a high temper, the mood is high, safety is expressed, in some cases dementia with a tendency to inappropriate jokes and actions, reminiscent of childish void is observed. In patients disappears self-criticism, there is a gross leveling of personality traits. The frontal syndrome can be transient – it becomes organic psychosyndrome (traumatic brain injury, alcoholic encephalopathy); chronic with progressive course (Peak disease, tumors of the frontal lobe of the brain).

URGENT CARE IN ACUTE MENTAL DISORDERS

A doctor called to a patient with a mental disorders should bear in mind that the forms of communication with such patients are sharply different from the forms of communication with patients with somatic diseases. First of all, an individual approach based on the nature of the psychopathological symptoms during the examination is needed. It is advisable to obtain prior information about

the reasons for the ambulance call and the patient's condition from relatives or persons who observed the patient's behavior. This information is usually sufficient to form a preliminary hypothesis of diagnosis and tactics.

When making contact with a patient, a sympathetic tone for the principal must be observed. Doctor should never challenge one or another of the patient's statements, prove the absurdity of his or her ideas and ideas, but at the same time not express consent with the patient or give him / her a reason to draw such a conclusion. One should not resort to deception, impute roles or functions that are not true. It is best to immediately inform the patient that person in front of him/her is a doctor, whose tasks are limited solely to establishing the patient's state of health and, if necessary, providing medical care.

GENERAL PRINCIPLES OF URGENT CARE IN ACUTE MENTAL DISORDERS

Before examining a patient with acute mental disorder, the reason for calling a doctor is clarified with the help of relatives or persons who have observed the patient's behavior and who has heard his statements.

When contacting the patient and a safe environment, an objective examination is carried out. The doctor must observe the following basic provisions:

- be calm, careful, quick to evaluate the situation, behave when making a call impassively and confidently:
- avoid in their actions anything that will provoke further anxiety and excitation of the patient;
- accurately document all received data in the call card.

On the basis of subjective and objective examination data, a preliminary diagnosis is made at the syndromic level. For example: "Acute hallucinatory-paranoid syndrome".

PROCEDURE OF HELPING PATIENTS

Acute mental disorders

1. Providing safe for the patient and surrounding people access to medical care.

2. Carrying out specific therapy aimed at eliminating psychomotor arousal.

3. Addressing the issue of hospitalization.

In cities where there are specialized psychiatric teams, the doctor, diagnosing acute disorders of the psyche, is obliged to call a psychiatric team for help. In towns/villages where there is no psychiatric ambulance service, the hospitalization of mental patients is carried out in accordance with the instructions of the local health authorities.

Before transporting to the hospital, relatives of the patient in the presence of a doctor inspect the clothes in which the patient will go. Patient is dressed without leaving the room where the doctor is. On the way to the ambulance, patient's arms are supported in the lower third of the forearm. Supporting of the patient by relatives is desirable in all cases, except for those when the patient himself has a negative attitude towards their presence.

In the ambulance car, the doctor sits near the patient. In the evening and at night the lighting is turned on inside of the car. The patient should lie on a stretcher. Talking to a patient on the road distracts him from morid experiences.

In the reception department, the patient is transferred to the medical staff of the hospital. All values, money and documents are described in the act. In the accompanying coupon, it is necessary to indicate all circumstances related to the call of the doctor, known anamnestic data, features of the patient's behavior at the place of call and during transportation. These directions are often the only source for patient information for the hospital doctor and should therefore be as complete as possible.

Indications for hospitalization are antisocial behavior of the mentally ill and psychotic conditions that lead to antisocial actions and autoaggression:

- hallucinatory and delusional syndromes;
- syndromes of darkening of consciousness;
- severe dystrophic, depressive, manic and hypochondrial syndromes;
- severe decompensation in patients with psychopathy;
- alcoholic delirium and other psychoses that threaten the health and life of the patient.

Patients with mental disorders on the background of severe somatic diseases are subject to hospitalization in psychosomatic wards.

EXCITATIONS IN MENTAL DISORDERS

Excitation is one of the manifestations of a disease in which specific features for each disease are revealed. A pronounced, affective arousal, characteristic of acute disorders, prognostically more favorable and better amenable to cupping.

The doctor should remember that states of excitation often develop on the background of acute traumatic brain injury, acute disorders of cerebral circulation, precomatous conditions, poisonings, myocardial infarction, infectious diseases. Underestimation of the somatic condition can lead to incorrect medical and tactical actions.

Hallucinatory-delusional excitation

Hallucinations (disorders of perception) have a wide range. Patients hear voices - multiple or individual, different in content: threatening, punishing, approving, commenting on their behavior. The source of the voice may be at a distance or in close proximity, it may be inside the head or body (pseudo-hallucinations). In some cases, voices are silent and perceived as alien thoughts.

The ratio of disorders of perception and delusional experiences may be different. Sometimes the status of the patient is exhausted only by disorders of perception or, conversely, by idle ideas, as a rule, all these disorders are accompanied by either general excitement or motor stiffness.

One should not convince the patient of the fallacy of his experiences. It is best to try to establish a sensitive and indifferent contact.

Hallucinatory-delusiomal excitation is observed in schizophrenia, organic brain diseases, involutionary psychosis, alcoholic hallucinosis.

Urgent care

The most effective is the use of psychotropic drugs. The main agents are neuroleptics, mainly sedative: Aminazine solution (chlorpromazine) 2.5% - 1-3 ml intramuscularly with the addition of Novocaine or Tizercin solution (levomepromazine) 2.5% - 1-3 ml under the control of blood pressure, if necessary pre-inject 2 ml of Cordyamine (Nicetamide) into the muscle.

With strong excitation, tendency to aggression, anger, drugs can be administered intravenously with a dilution of 10 ml of 40% glucose solution. Effective introduction of a solution of haloperidol 0.5% - 0.5 - 1 ml intramuscularly.

Hospitalization in a psychiatric hospital. In cases where the patient inflicted significant injuries before the arrival of the ambulance, hospitalization in a surgical or toxicological hospital with the subsequent organization of individual observation is necessary.

Depression excitation (agitation)

Most often observed within the depressive phase of manic-depressive psychosis.

Clinical manifestations

- expressed feeling of longing and despair, accompanied by a feeling of special pain, heaviness in the heart (behind the sternum);
- patients rush, moan, wring their hands, lie down, get up again;

- speech production can be very scanty or plentiful; it is focused on itself, on its experiences; ideas of guilt, hopelessness, loss of meaning of life are expressed;
- along with sadness there are feelings of anxiety and fear;
- there is a danger of suicidal attempt.

Less pronounced manifestations in the phenomena of deep inhibition or even stupor, sometimes with periods of sudden onset of excitation. However, there is also a mournful mimicry in the stupor, an extinct look, a curved posture.

Urgent care

It consists in intravenous or intramuscular injection of 2-4 ml of 0.5% solution of seduxene (Diazepam) and (or) 1-2 ml of 0.5% solution of haloperidol intramuscular. Emergency hospitalization in a psychiatric hospital is required.

Manic excitation

Occurs in endogenous psychoses (manic-depressive psychosis, schizophrenia), organic diseases of the CNS, as well as some intoxication.

Clinical manifestations

The mood is elevated, the speech is accelerated, expressed distraction, attention is constantly shifting from one subject to another; motor excitement reaching to the "motor storm". There is a heightened sense of self-worth, uncritical re-evaluation of one's personality. In some cases, delusional ideas of world and cosmic importance are expressed. Periodically may be observed state of anger that arises when counteracting one or another desire of the patient.

Urgent care

Intravenous or intramuscular injection of a solution of aminazine (chlorpromazine) 2.5% - 2-4 ml (with intravenous dilution of 1-2 ml in 20 ml of 40% glucose solution). Intramuscular injection of haloperidol 0.5% - 0.5-1 ml or tisercin (levomepromazine) 2.5% - 2 ml intramuscular injection.

Hospitalization in a psychiatric hospital.

Dysphoric excitation

It usually occurs in patients with organic brain pathology and in oligophrenes.

Clinical manifestations

A mood disorder with a character of angry dissatisfaction, mainly towards others. Everything is annoying, anger, rage. Aggressive actions can sometimes take place, sometimes very violent. Aggression is usually aimed at those who are weak and defenseless. This condition usually lasts for hours or lasts for several days.

Urgent care

In mild cases, intramuscular injection of 2-4 ml of 0.5% solution of seduxene (Diazepam). In the tendency to aggression and destructive action: a solution of aminazine (chlorpromazine) or levomepromazine (tizercine) 2.5% - 2-4 ml intramuscularly.

In severe cases - hospitalization in a psychiatric hospital.

Catatonic excitation

Observed in schizophrenia, organic brain diseases, prolonged symptomatic psychosis.

Clinical manifestations

Impulse excitation usually occurs in a calm, often even stuporous patient. There is sudden and externally no motivated attack on the surrounding or destructive actions, with a subsequent return to their original state. "Silent" excitement.

In the prolonged course of excitement heterogeneous motions are performed, having a delusional nature. Patients bend, bounce, roll on the floor, solidify in meaningless poses. Sometimes something mutters, shouting words, scraps of phrases. In this state, they can carry out unmotivated aggression or destructive actions.

Urgent care

Aminazine solution of 2.5% - 2-4 ml intramuscularly or 1-2 ml intravenously with a glucose solution - 20 ml. In the same doses - a solution of tizercinau (levomepromazine).

Excitation is well stopped with intravenous haloperidol 0.5% - 0.5-1 ml with glucose solution 40% - 20 ml.

Hospitalization in a psychiatric hospital.

Psychopathic excitation

There are two main options: hysterical and explosive.

Clinical manifestations

Patients with hysteria behave demonstratively, theatrically-bizarrely: they wring their hands, fall to the floor, groan, turn to those around them for help in a grotesque manner or quarrel. They can attack with an attempt to hit, scratch, scatter objects, sometimes inflict superficial, non-dangerous injuries, tear clothing. This condition can take hours. Difficulties in diagnosis occur when simulating epileptic seizures. It is necessary to differentiate on the basis of absence at hysterical seizure of the correct sequence of tonic and clonic phases, absence of apnea with cyanosis and reaction of stored pupils to light.

The explosive variant is characterized by spectacular storm explosions that occur on non-existent cases. Patients scream, scratch themselves, tear clothes, inflict superficial injuries on sharp objects, break furniture, break dishes. May be aggressive towards others. At the height of excitement, a narrowing of consciousness is possible, sometimes to hysterical twilight states with an influx of bright hallucinations that replace the real situation.

Urgent care

Diazepam solution 0.5% - 2-4 ml intramuscularly or intravenously. If it is not possible to stop the excitation by injection of relanium (dizepam), an intramuscular solution of aminazine (chlorpromazine) 2.5% - 2-4 ml is introduced. Removal of persons surrounding the patient.

Hospitalization in a psychiatric hospital only in particularly severe cases.

Anxiety-hypochondrial agitation (with fear of death)

Clinical manifestations

It is usually dominated slight or even strong fear of death from a "break" or "stop" of the heart. Patients rush, continuously check the pulse, listen to themselves or freeze in any pose. They beg to be rescued, they demand immediate hospitalization. On the face is the expression of fear, breath and pulse are accelerated, no objective signs of impaired internal organs are determined.

Emergency aid

Injection of Diazepam solution 0.5% - 2-4 ml intramuscularly or intravenously. Orally - Phenazepam 0.5-1 mg. Recommend to see a neuropsychiatric clinic. Hospitalization is not required.

Syndromes of dizziness of consciousness

Dizziness of consciousness occurs on the background of severe infection, intoxication, organic brain damage (trauma to the skull, brain tumor).

The fact of darkening of consciousness is established on the basis of these four signs:

- disorientation in place, time and surrounding;
- alienation from the outside world, which is manifested in its incomplete scope, in the fuzzy perception of the real world, in the fragmentation, or in the complete impossibility of its perception;
- incoherence of thinking, weakness of thoughts;
- amnesia for the period of darkening.

Amentative syndrome

It is characterized by confusion of conciousness, disorders of synthesis and mental activity.

Clinical manifestations:

- motor excitation in bed;

- senseless movements of hands, feet, head, which intrude episodes of inhibition to substuporous (rarely stuporous) level;

- mood is unstable, with the predominance of negative effects of anxiety and fear;

- grossly disrupted orientation;

- patients undergo separate auditory hallucinations, illusions, erroneous cognition and fragmentary imaginative delusional ideas of attitude, special significance and persecution.

For patients in the state of amentia, the most characteristic are the accessibility to external impressions, the ability to perceive individual objects, the particularities of this situation, and at the same time the inability to connect them together in the mind, to give a holistic assessment of what is surrounding. Unable to comprehend the events that occur, patients experience a morbid sense of their own mental helplessness, the inability to know what surrounds them.

The facial expression in patients is alarmingly-surprised, the look is bewildered, the speech is disconnected, such that it contains episodes of the past and present with no apparent logical connection.

Disorientation of patients in the surrounding is peculiar. Most often, the patient, not being able to know what surrounds, makes a number of superficial assumptions about it, appeals for help to those around and, despite their explanation, and does not stop at any of them.

Amentia is more likely to be delayed, lasting from a few weeks to 2-3 months (sometimes longer). Exit is gradual with exposure of asthenia. When you come out of this state - complete amnesia. Most often the amentive syndrome is observed at infectious and somatogenic psychoses, but also occurs at, organic and vascular psychoses of intoxication.

Urgent care

The excitation requires the injection of a solution of Seduxene, Relanium, Valium (Diazepam) 0.5% - 2-4 ml intramuscularly or intravenously in 40% glucose solution 20 ml.

Hospitalization in a psychosomatic department.

Delirious syndrome

Delirium is a syndrome of clouded consciousness, characterized by disorientation in time and place while maintaining orientation in one's self, an influx of bright (mostly visual) hallucinations, often accompanied by feelings of fear and excitation.

In the debut of the syndrome, patients are experiencing abundant, often colorful (“colored dreams”) hypnotic hallucinations, grandiose battles, atomic bomb blasts, terrible catastrophes, and destruction. When eyes are opened, all these visions disappear, but the patient's consciousness is captured by abundant, unusually figurative and vivid periodic illusions: in the carpet patterns (on the floor), appear and crawl insects, which gradually grow to a large size in the patient's eyes, but reaching the end carpets where they disappear; in the branches of the trees the patients see the changing faces of the people, in the noise of the leaves - they hear the whispering speech and so on. Characteristic complex hallucinations that are difficult to intertwine in the mind of the patient with the elements of the real situation: from the far corner of the room, two green snakes crawl straight after the patient one after the other, and he already smells them: opening a blanket on the bed, on a sheet - sees a flock of rats that are digging, around the bloody meat, he smells it.

In a state of delirium, the patient is at the center of events that make up his hallucinatory disorientation. The patient always escapes, sometimes attacks, defends against hallucinatory images and from quite real people, evaluating their actions in a delusional manner and testing fear towards them.

The intensity of hallucinatory, delusional and affective disorders and the depth of dizziness of consciousness in delirium vary in severity. Usually in the morning and day time, all this symptomatology weakens, even reduced to an unstable clarification of consciousness. Patients calm down, consciously perceive the issues, available to the contact. However, by the evening the symptomatology intensifies again, peaks at night.

In addition to this typical delirium, there are two other clinical variants of it - professional delirium and severe variant.

In acute delusion, as a severe form of delirium, consciousness is clouded deepest. Motor excitation is confined to the limits of the bed and acquires the character of monotonous, poorly coordinated primitive movements (in the form of "picking up", attempts to remove something from the skin, grasping and other movements). There is a choreotic linguistic confusion (the so-called "muscular delirium"). Somatic condition becomes life-threatening.

Delirium is most commonly found in infectious, toxic psychoses, as well as in vascular, traumatic and organic diseases of the CNS. Most often it lasts for 3-5 days, sometimes up to 10 days.

Urgent care

Sibazone solution (Diazepam, Relanium, Seduxen) 0.5% - 2-4 ml intravenously. Haloperidol 0.5% 1-2 ml solution in 10-15 ml glucose solution 40% intravenous or intramuscular in 20 ml isotonic sodium chloride solution.

Hospitalization in a psychiatric hospital.

With professional delirium and acute delusion - hospitalization on a stretcher to the intensive care unit. On the Road - Oxygen Therapy.

Onyroid

Onyroid is a dreamlike, dreamy dizziness of consciousness with disorders of orientation and self-consciousness, with fantastic experiences and visions that form

into a specific plot and create a whole (space flights, adventures, etc.), an active participant of which the patient is felt inside.

Epidemiology of the onyroid

A valid oneyroid is often the culmination of the onset of recurrent schizophrenia, less common in other diseases.

The clinical picture

In the first stages of development of the onyroid, sleep disturbances are noted, and then there is a staging od delusions: it seems to the patient that everything around him is specially tuned and that scenes are played out for him. At this time, the patient has a dual orientation: he is at the same time in the real and fantastic world, partly understanding it. Then begins to grow fantastic dreamy symptoms, and there is a misperception of the exclusiveness of one's self and mission.

The patient experiences colorful fantasies: he visits other worlds, may be in paradise or hell, is the liberator of all mankind, controls the movement of planets, etc., but his behavior is not consistent with the experience: he is alienated from the environment in a stuporous or substoroporous state, with eyes wide open and directional distance fixed motion (eyes can be closed); speechless or senselessly pathetically excited, facial expressions frozen, tense or captured. Sometimes there is wax flexibility, and some patients may even go with a "charmed smile."

A dreamlike condition can be combined with signs of delirium, verbal hallucinosis or acute paranoid. Unlike delirium, one does not have an inclination but negativism.

The main features of the onyroid are alienation from the outside world, fantastic dreamy experiences, dual orientation, exclusiveness of one's self and inconsistency of the patient's experiences and behavior.

After leaving the onyroid appear partial memories, more complete and consistent - about subjective phenomena and insufficient or completely lost - about real events. Duration - up to several weeks.

Urgent care

Emergency care is similar to treating delirium.

The issues of hospitalization in a psychiatric hospital are solved individually, depending on the severity and nature of the underlying disease.

Pathological intoxication

It is rarely observed, mainly in the presence of additional adverse factors that weaken the nervous system (forced insomnia, fatigue, intercurrent somatic and infectious diseases). It develops more often in people who do not suffer from alcoholism after consuming a small amount of alcohol.

Clinical manifestations

Develops sharply. Characterized by a narrowing of consciousness. The patient acts in accordance with his morbid experiences, does not respond to the speech addressed to him, utters gritty phrases.

At times, he experiences intense fear, seeks to escape or defends himself against "persecutors," while carrying out devastating and aggressive actions. Such conditions last from a few minutes to several hours and also stop abruptly, ending with sleep.

There are no signs of intoxication.

Urgent care

- a solution of Levomepromazine (Tizercin) 2.5 - 2 ml or a solution of Seduxen (Diazepam) 0.5% - 4 ml;
- hospitalization in a psychiatric hospital

Acute alcoholic hallucinosis

Clinical manifestations

It is an influx of auditory verbal hallucinations. The patient hears the voices of two or many people who discuss his behavior, reproach in unpleasant actions, conspire to kill him, give different advice, make fun of him. The patient responds vividly to what he hears and enters the voices with contention. Acute auditory

hallucinosis lasts from several hours to 2-3 weeks, usually accompanied by anxiety and confusion.

Consciousness is not disturbed - orientation in time and place is completely preserved.

Urgent care

- haloperidol solution of 0.5% - 0.5-1 ml intramuscularly;

- Relanium solution (Seduxen, Diazepam) 0.5% 2-4 ml intramuscularly; - hospitalization in a psychiatric hospital.

Epileptic status

It is a condition in which epileptic seizures follow one another directly or at very short intervals. Between attacks, consciousness does not return, which poses a threat to the life of the patient.

Clinical manifestations

Patients are comatose with frequent and permanent seizures. History has epileptic seizures. Death is possible from brain edema or acute respiratory failure.

Urgent care

The main tasks of the pre-hospital stage are: prevention of head and torso traumatization, restoration of airway patency, anticonvulsant therapy. For this purpose the patient needs:

- position that eliminates traumatization of the head and torso (put on a horizontal surface, turn the head to the side, ensure the airway);
- removable dentures should be removed in the intervals between seizures, if any. Aspirate the mucus from the mouth and throat;
- in cases of impaired self-breathing, tracheal intubation is performed.

Anticonvulsant therapy

Seduxen, Relanium (Diazepam) 2 ml of 0.5% solution for 20 ml of 40% glucose intravenously or intramuscularly, Lasix 20-40 mg for 5-10 ml of isotonic sodium chloride solution intravenously or intramuscularly. In the absence of effect,

intravenous sodium thiopental or hexenal (hexobarbital) at the rate of 10 mg per 1 kg of body weight of the patient (60-80 ml of 1% solution). You can use 10-20 ml of 20% Sodium Oxybutyrate (Sodium Oxybate) solution. In resistant cases - inhalation anesthesia with nitrous oxide and oxygen in a ratio of 2: 1; Lasix (Furosemide) 20-40 mg intravenously or intramuscularly.

The patient is hospitalized on a stretcher in the intensive care department.

Delusion

Delusion is defined as a set of erroneous conclusions, thoughts, conclusions that emerge on a morbid basis, conquer consciousness, misrepresent reality, and cannot be corrected.

The main signs of delirium are: complete conviction of the patient in his truth; impossibility of correction in a natural way - by explanation, conviction, suggestion; everything that corresponds to the content of nonsense, develops and strengthens it, and which does not respond - is discarded with a tendency for its strengthening and expansion.

There are delusions of persecution, actions, greatness, condemnation, wealth, depressive delusions, etc. Nonsense can occur as a complication on the background of severe somatic disease with a pronounced intoxication syndrome after TBI and others. Delusions are often combined with hallucinations, in which case they speak of hallucinatory-delusional conditions.

Urgent care

In case of acute hallucinatory-delusional state of treatment consists of the following directions:

1. Call the psychiatric team.
2. Physical detention of the patient until her arrival.
3. Soothing psychotherapy.
4. Drug therapy.

Physical detention is carried out by orderlies.

Soothing psychotherapy should be permanent. The patient should not be questioned about the nature of his or her experiences; one should not argue with him, but one cannot agree with his wrong statements. It is desirable to achieve voluntary administration of drugs.

Drug therapy involves prescribing neuroleptic (sedative) drugs.

Drugs and doses - see. Delirious syndrome.

It is necessary to urgently hospitalize in a psychiatric hospital.

Twilight state of consciousness. Dizziness of consciousness

The twilight state (dizziness) of consciousness is defined as the sudden and short-term loss of clarity of consciousness with complete alienation from the surrounding or with its fragmented and distorted perception while maintaining the usual automated actions.

Epidemiology of the twilight condition. Twitch disorders are the equivalent of epileptic seizures and can occur in people with high convulsive capacity - epilepsy, organic brain pathology and hysterical reactive psychoses.

Clinic (signs) of darkening of consciousness.

Symptoms of a twilight condition

The patient retains orientation in the narrow region of the surrounding area. He correctly assesses the situation and behaves more or less correctly, not being able to perceive and appreciate all that is happening around him. The hallucinatory and delusional experiences of fearful content, which cause the affect of fear, malicious sadness, and aggressive and destructive actions (violence, assault, murder, etc.), are of major importance. Due to the external orderliness of the movements and their unconscious unilateral orientation, the patient's actions are unpredictable and therefore particularly dangerous. Outwardly, human activity seems consistent, but 1-2 questions asked to the patient indicate his complete disorientation: he cannot name his name, is not oriented in time and space, does not know relatives, etc. The

patient's speech is connected, constructed correctly, but he does not answer the questions and does not wait for the answer.

The main signs of dizziness of consciousness are the paroxysmal nature of emergence and termination, the preservation of automated activity during paroxysm, and complete retrograde amnesia after its termination.

Getting out of this state is often critical, with complete amnesia, rarely - lytic.

Twilight states include ambulatory automatism, in which the consciousness is switched off immediately and the patient continues to perform automated, externally ordered actions. Waking up, he does not understand how he ended up on an unfamiliar street, does not remember how and what happened to him.

In childhood and adolescence, cases of somnolence are possible.

Urgent care

In case of psychomotor excitation, it is necessary to ensure the safety of the patient and surrounding people. The patient is isolated in a separate room and only the caregivers remain with him until the arrival of a specialized ambulance team. Psychomotor excitation should be stopped before transportation. To this end, 2-4 ml of 0.5% Sibazone solution (synonyms: Diazepam, Seduxen, Relanium) are injected to the patient intravenously on the background of physical retention. In about 70-80% of cases, this dose is sufficient. If the excitation does not stop in 5-10 minutes, it is possible to repeat the injection of this preparation in the amount of half a dose from the primary one. It is possible to use Aminazine or Tiserzine (25-50 mg), but when using them it is necessary to remember the possible decrease in blood pressure. Good effect is achieved when combining neuroleptics with desensitizing drugs (Dimedrol, Suprastin).

At syndromes of twilight state of consciousness of the patient it is necessary to hospitalize urgently to a psychiatric hospital.

Depression

Diagnosis of depression begins with the manifestation of asthenic affect in the form of a decrease in mood from sadness, to a physical feeling of longing, localized in the heart, which sometimes reach a degree of "physical suffering": patients declare "unbearable pain", "tears the heart", "squeezes like a vice" and the like. Thinking and speech are slow. The whole world is perceived in a gray light. The patient has ghostly ideas of self-blame and self-abasement, which go to the absurdity: a person remembers the insignificant guilt of a long time ago, etc.

Mental and linguistic retardation is manifested by sluggishness, inactivity, and lack of initiative.

Motor inhibition is manifested in the fact that patients prefer to lie down, have difficulty trying to attract them to any activity, lose the sense of correctness in their actions. The highest degree of motor inhibition is a depressive stupor - a state of complete immobility.

Depression is the most common cause of suicide.

Urgent care

1. The use of antidepressants - imipramine (synonyms: melipramine, imisin, depsonil, etc.) at a dose of 1-2 ml of 1.25% solution or amitriptyline in the amount of 2 ml of 1% solution intramuscularly

2. 2. Isolation of the patient in a separate room and close observation in order to prevent self-injury and suicidal attempts.

3. Call the psychiatric team.

At manic-depressive psychosis of the patient it is necessary to hospitalize urgently in a psychiatric clinic.

Signs of suicide in depression

Doctors usually encounter the following groups of suicidants:

1. Those, who were received in the profile somatic department for first aid (the largest group).

2. Those, who made a suicidal attempt during treatment in a somatic hospital.

3. Those, who have made a suicidal attempt in the home.

Emergency care for these suicidal groups is usually somatic, but knowledge of the basics of suicidology is needed by a physician of any profile to identify possible signs of suicidal depression and the onset of preventive treatment.

Signs of suicidal depression may appear in patients undergoing inpatient care and include having suicidal thoughts, insomnia early in the morning, complete loss of appetite and interests, feelings of hopeless despair, inability to express their own thoughts or feelings and progressive social. Patients in this condition are subject to unconditional hospitalization in a psychiatric hospital.

Postpartum depression that develops in the first days after childbirth can also be a cause of impulse suicidal ideation, so in no case can one ignore the dangerous, precursor symptoms that develop: anxiety, loss of appetite, sleep disorders, bizarre obsessions and unreasonable fears about your baby.

If there is a history of postpartum depression, the patient should be monitored and prescribed antidepressants.

Urgent care in the case of suicidal attempt

If the somatic state of the suicidant does not present a danger, he or she is to be admitted to a psychiatric hospital. In the presence of a life threat, suicidants come to the intensive care unit or profile department, depending on the type of suicide: in poisoning - in the department of toxicology, in the case of wounds - in the department of surgery and so on. Regardless of the type of suicidal attempt, emergency care is provided in the following order:

1. Make sure of presence of breathing, pulse in the carotid arteries; if not, begin resuscitation, as in heart failure

2. Eliminate signs of ODN and OSSN, if any.

3. If convulsions stop the convulsive syndrome.

4. In case of injury, if there is external bleeding, stop it.

5. Before transporting the victim to the hospital, it is necessary to exclude the presence of fractures, especially the skull and spine, and to carry out evacuation very carefully.

6. Depending on the type of suicide, specific and symptomatic therapy is performed after eliminating the threat to life. When restoring the consciousness of the patient necessarily consult a psychiatrist to establish a psychiatric diagnosis, coordination of tactics of drug therapy and addressing the place of further treatment.

Side effects and complications of psycho-drug therapy

The collapse occurs mainly when using aliphatic phenothiazine derivatives (Aminazine, Tizerzine, Propazine). It is characterized by a sharp decrease in blood pressure and peripheral circulation disorders. Different from shock with no signs of heart failure).

Clinical manifestations

The skin is pale, cold sweat, adynamia, lower extremities. Pulse frequent, small filling, blood pressure is sharply reduced (may not be determined).

Urgent care

It is necessary to put the patient horizontally on his back, raise his legs. If this is not enough, then intravenously enter 60-150 mg of prednisolone per 10 ml of isotonic sodium chloride solution. If blood pressure is not normalized, then enter drip Reopolyglyukin (Dextran) - 400 ml; if ineffective, add dopamine 5 ml (200 mg) to a solution of Reopolyglukin (Dextran). The resulting solution should be administered at a rate of 60 drops/min. In case of inefficiency, increase the injection rate to 120 drops/ min.

Hospitalization in a specialized department (intensive care department with regard to the main disease).

Paroxysmal extrapyramidal syndrome

It is detected in the initial stages of neurolepsy and is characterized by the occurrence of motor spastic disorders in the following main variants:

- local: environmental crises; oral syndrome - Kulenkampff-Tarnow; torticollis; torsional spasm; tonic reduction of other groups;
- generalized: motor excitation crises; vegetative-extrapyramidal crises.

The duration of paroxysms 15-30 minutes, rarely - several hours. They are motor excitation with anxious-timid coloring affect and narrowing of consciousness.

The motive severity of autonomic disorders are emphasized: profuse sweat, hyper salivation, lacrimation, blood pressure fluctuations, hyperthermia.

Acute extrapyramidal syndrome

Appears at the beginning of treatment with neuroleptics and at poisoning with them, is manifested in the rapid increase in muscle tone and stiffness, the appearance of hyperkinesis, tremor, restlessness, autonomic disorders (hyper salivation, greasy skin), visual disturbances, disorders of accommodation. This symptomatology is accompanied by affective disorders in the form of fear, anxiety, impatience.

Observe: persistence, inflammation, impulsivity of actions with a tendency to aggressive actions.

Urgent care

- Cyclodol 4-6 mg inside;
- solution of Seduxene (Diazepam) 0.5% - 2-4 ml intravenously;
- a solution of Dimedrol (diphenhydramine) 1% - 2 ml intramuscularly;
- Caffeine solution 2% - 2 ml intravenously at 20 ml 40% Glucose solution;
- a solution of Magnesium sulfate 25% - 5-10 ml intramuscularly.

These drugs are injected sequentially at small (10-15 min) intervals until the disappearance of the dyskinetic reaction

RULES AND PRINCIPLES OF APPLICATION OF PHYSICAL RESTRICTION AND INSULATION IN THE PROVISION OF PSYCHIATRIC AID TO PERSONS WITH MENTAL DISORDERS

- the rules of isolation must be approved by the order of the head of the institution;
- apply only in the case of compulsory psychiatric care;
- patients should be examined by a doctor at least once every 3-4 hours;
- duration of single purpose isolation - 8 hours;
- if the isolation period is more than 48 hours, the patient should be examined by a panel of psychiatrists before each new appointment;
- changes in the patient's condition during isolation should be recorded by the staff in the respective logs for at least 4 hours.

RULES OF FIXATION OF PATIENTS

- when there is an excitation;
- when there is at intoxication psychoses;
- for patients with aggressive and autoaggressive behavior;
- duration of fixation - before the start of sufficient action of medicines;
- fixation is prescribed by the treating physician with a reasoned record in the medical records regarding the reasons for its appointment and the symptoms to which it is directed;
- the patient to whom the fixation is applied, the doctor must be examined at least once every 2 hours;
- the need to continue the fixation is evaluated once every 30 minutes;
- the patient should be examined by a panel of psychiatrists for the appropriate appointment at a total duration of 8 hours.

CLINICAL CASES

Patient A. 33 years old.

The patient is admitted by the referral of the general practitioner for the purpose of treatment.

COMPLAINTS: «I decided everything. I have a plan to become president».

ANAMNESIS: Heredity with mental illness is burdened – patient`s uncle suffers from mental retardation. The patient`s parents divorced when the he was 2.5 years old, he was brought up in a religious family. Pregnancy proceeded with the threat of miscarriage. Born on time, with torticollis and left-sided hemiparesis. He was observed by a neurologist for up to 3 years. He attended a kindergarten, in a speech therapy group. He went to school at the age of 6 and studied well. He graduated from the 9th grade school. He worked as a lathe operator, at construction sites, «engaged in furniture», and spent 6 months in Poland. Currently works as a turner. Lives with his wife and son.

He doesn't use alcohol, drugs, doesn't smoke.

He characterizes himself as kind, sympathetic, «hard-working», «always ready to help».

From childhood he was brought up in a family of believers, attends church. Married since 2007, has a son, 4 years old. The mental state changed in May 2015, began to lose weight, worked hard. After the Easter holiday, he became withdrawn, became silent, gloomy, saying «I'm tired». On May 9, he woke up at 2 am, he was scared, began to talk about the resurrection of the dead, began to drink a lot of «holy» water, said that he had hallucinations about his son and wife, fell down, said «I died», then got up and said «I am risen». In the following days (May 10 and 11), he became irritable, rude, shouted at his son, said «you are all in hell ... all died ... I am God, I do what I want». All the time he called «the priest Roman», shouted out torn phrases

of religious content, «we are all burning in hell ... we will rise again», «Christ is risen», «I am God and Satan». Asked forgiveness from loved ones. Sleep was disturbed, «switched off» for a few minutes, prayed fervently, baptized himself, declared, «I feel that they will kill me». On the eve of the first hospitalization, he hit his wife in the face, «for the glory of God, I can hit you» (he had never hit her before). He asked his mother to «hold my hands», twisted her arm, shouted phrases of sexual content, biting, scratching, shouting loudly, hitting those who tried to approach him, bit his wife. On the eve of hospitalization, he began to declare that he was a saint because he fulfilled all religious instructions, said that he would run for the presidency in order to build bridges. Was hospitalized.

PSYCHSTATUS: The patient is in a clear consciousness, oriented correctly all-round. The patient is in a state of motor-speech excitement, he is distracted, fidgety. Appeals to everyone who comes into view. Monologue speech. Asks questions and answers them himself. In essence, he does not answer the doctor's questions, asking counter questions. Contact is unproductive. Spontaneously he says: «They are whispering around the corners, I am outraged by what is happening ... nothing is being done for the country ... I am going to become president, I want to discuss my program with you … I collect proverbs, I want to check: «Do not have 100 rubles, but have 100 friends», while jumping up, hugging the nurse. Declares: «I am working on options for the development of events! I want to become a light!». Thinking is symbolic, slipping, torn, paralogical. Mood with an ecstatic tinge: «I believe in God. I act according to my conscience and I will become a saint!»; «I was fed up with lies and whispering, I want to change everything for the better!».

The patient in the department is restless, does not answer questions, says in a monologue: «There is disorder on the street, roads are not being repaired, the benches are not standing like that… I believe in God, do you? Those who do not believe in God are also believers, only in Satan! I figured everything out!»; «I'm going to a TV show. I will improve everything around! I will become the president!».

The patient was consulted by the associate professor of the Department of Psychiatry, ZSMU: «The patient has a repeated psychotic episode in which there are affective and delusional symptoms with various (including non-congruent) delusional statements (greatness, persecution, impact). The primary episode is also combined with verbal pseudo-hallucinations and elements of mental automatism. So, we can talk about schizoaffective disorder, manic type».

Against the background of an increase in the dosage of drugs, the patient's condition remains unstable. In the department, he rewrites books, writing out banal quotes on sheets of paper, and then demonstrates to other patients, a doctor. He is convinced that he is mentally healthy, and he was «misunderstood». There is no criticism of the disease. Formally he agrees that he behaved defiantly and that he will try to be calmer, although he is still sure that «he did everything right».

DIAGNOSIS:

Schizoaffective disorder. Mixed type. Affective-delusional syndrome. F 25.2.

Patient B. 40 years old.

The patient is admitted by the referral of the general practitioner for the purpose of treatment.

COMPLAINTS: Anxiety, which starts every day at about 17.00 and continues until 21.00, during these states the patient experiences a lump in the throat and compression in the chest area, stiffness inside, tingling in the heart; he cannot go to large supermarkets, stand in line, use public transport - in these situations, anxiety grows and a feeling of fear of death arises.

ANAMNESIS: Heredity is not burdened with mental disorders. Born into a family of workers as the second of twins. In childhood, the patient grew and developed according to his age. I went to school at the age of 7. He graduated from the 9th grade of high school, studied well. Later he graduated from the Marine College and the Marine Institute of Water Transport with a degree in ship mechanic. Labor activity since 18 y.o. He worked in foreign companies under contract, went sailing as a mechanic. «I worked like that for 16 years, until I got sick». The patient was satisfied with the job. He was married once, now he is divorced. Has no children, broke up «because I drank, but we are not officially divorced». Now lives with brother.

The patient describes himself as «a good person, emotional, suspicious, I take everything to heart. When I fell ill, I became very anxious».

He considers himself ill since 2014, when during the flight there was a feeling of fear, increased heart rate, anxiety, fear of death. He tried to relieve anxiety by drinking alcohol, «it became easier, but not for long». After landing, the condition improved on its own. A month later, a similar attack was repeated on the bus – «it became easier when I left the bus.» After that, the frequency of seizures began to increase, as well as their intensity, in connection with which he asked the ship's doctor for help, was written off from the ship's crew, and returned to Zaporizhzhia. Privately he asked for help to «healers», neuropathologists, psychotherapists and psychiatrists. But the patient's condition improved significantly after going to a psychiatric hospital in 2015, he began to go outside himself, is no longer afraid to stay in the apartment himself, categorically denies taking alcohol or alcoholic tinctures. But at the same time, he notes that «the fear of transport and large supermarkets has not gone anywhere». Every day, since now, in the evenings, anxiety grows at about the same time - from 17.00 to 21.00 - it is hard for the patient to endure it. The patient's lifestyle has been reduced to household duties and walking dogs. Lives off previous savings, «already sold a lot». Notes that «there is no full life - I want to completely get rid of anxiety».

PSYCHSTATUS: The patient is in a clear consciousness, oriented correctly all-round, and is available for productive contact. He is emotionally tense, anxious. Waiting for inspection, he walks back and forth along the corridor. After the injection of antihypertensive drugs, he lay down for no more than 5 minutes, and again began to walk along the corridor with the words: «I was already lying down, it's already easier for me». During the conversation, he sits in a tense position, sweat appears on his face above the upper lip. He says that «I am now very worried, therefore my blood pressure is high ... I was worried all week before your consultation». Mood is situationally lowered. No psychotic disorders at the time of examination. Critical to a painful state. Seeking help: «I will do everything as you say». Thinking is logical, consistent, at a normal pace. He does not detect suicidal thoughts. reveals. Suicidal thoughts are not detected.

DIAGNOSIS:

Phobic-anxiety disorder F 40.8

Patient C. 35 years old.

The patient is admitted by the referral of the general practitioner for the purpose of treatment.

COMPLAINTS: «there were seizures again, panic attacks, constant influence from the outside, twin syndrome».

ANAMNESIS: The heredity of mental illness is aggravated - the father suffered from schizophrenia, died in 1995. His brother was treated in a psychiatric hospital three times. Early development was unremarkable. Secondary special

education, graduated from college with a degree in tile tiling. Did not serve in the army. He is married and has 2 children. Lives with family and mother. According to the patient he has 2 traumatic brain injuries in childhood and one in 2005, did not get medical help.

The patient first asked for help from a psychiatrist in 1992, it was diagnosed: «Residual effects of organic lesions of the central nervous system. Neurosis». In 1995 he was treated in a outpatient department with a diagnosis of «neurosis-like enuresis». Later, these states passed. He turned to a psychiatrist again in 2015 and was treated in an inpatient unit with a diagnosis of «Brief psychotic disorder». After discharge, he stopped taking supportive pharmacotherapy, there was a tremor of the hands, dry mouth, stiffness, shortness of breath.

After a while, he stopped coping with work, became confused, sleep disturbed, was suspicious, tense, walked aimlessly around the apartment, spoke absurdities, talked to himself, told his mother that his wife and all people were watching him, that there are 2 worlds and now it is the world of doubles, that «the wife is not the wife, the mother is not the mother,» that he distinguishes voices by the tone of the doubles. Anxiety attacks were noted. He went to a psychiatrist and was hospitalized.

PSYCHSTATUS: The patient is in a clear consciousness, oriented correctly all-round. The patient is available to contact. The background of the mood is lowered, depressed. He is fixed on his condition. Memory is not reduced. Intelligence corresponds to the education received. Thinking is paralogical, with elements of disruption. Suspicious, tense. He said «there is a constant influence from all the people around me, even furniture, there are many thoughts in my head, then emptiness, I did not have time to think, but everyone already knows ... I can already distinguish my wife on the phone by the tone of her voice, if she says «bunny» – everything is OK, and if not, then it means that she is a double ... there is a man's voice on the phone and on the TV, but I don't understand what he is saying».

Emotionally labile, irritable. Has no criticism. In the department, the state is the same, suspicion remains. The patient's behavior is hallucinatory. The mood background is lowered. Periodically becomes whiny. He continues to say that «absolutely everything» affects him. Anxious, fussy, intrusive. He said «it's scary, I no longer understand where my relatives are, and where are strangers who are trying in every possible way to take possession of my brain and lead me to death, it makes me very bad, I got sick of it all». There are no suicidal thoughts.

DIAGNOSIS

Schizophrenia, paranoid form, an episodic course. Hallucinatory paranoid syndrome. Restriction of labor activity of the 1st degree. F20.0

Tasks and tests

Materials for test control (I level)

1. Which syndrome is characterized by true auditory hallucinations?

A. Kandinsky–Clérambault syndrome.

B. Derealization syndrome.

C. Verbal hallucinations.

D. Delirium syndrome.

E. Asthenic syndrome.

2. Which of these drugs is most acceptable in the relief of somatogenous delirium syndrome?

A. Cyclodol.

B. Amitriptyline.

C. Haloperidol.

D. Lithium Salts.

E. Nootropil.

F. Finlepsin.

3. The observation method allows you to identify:

A. Dissimulation.

B. Change in the mental state of the patient.

C. The possibility of aggressive actions.

D. All of the above.

E. None of the above.

4. Syndrome that can be a manifestation of hysteria:

A. Delirium.

B. Oneiroid.

C. Amentia.

D. Twilight state.

E. All of the listed syndromes.

5. The patient is very weak, cannot get out of bed, while agitated, waving his arms, speech is incomprehensible incoherent. This state corresponds to:

A. Delirium.

B. Oneyroid.

C. Amentia.

D. Twilight state.

E. None of the named states.

6. When describing a mental disorder in the history, it is necessary to find out:

A. The age of its existence.

B. Features of development in time.

C. The relationship of the disorder with other mental disorders.

D. All of the above.

E. None of the above.

7. Asthenic syndrome is characterized by all of the above, EXCEPT

A. Physical exhaustion.

B. Mental exhaustion.

C. Fixation amnesia.

D. Affective lability.

8. The classic depressive triad is characterized by:

A. Emotional inhibition.

B. Motor inhibition.

C. Ideational inhibition.

D. All of the above.

E. None of the above.

9. Obsessive syndrome is characterized by:

A. The emergence of feelings, thoughts, memories, drives, motor acts, etc. apart from desire.

B. Consciousness of their morbidity, critical attitude towards them.

C. Powerlessness in confrontation, overcoming at the cost of exhausting suffering.

D. All of the above.

E. None of the above.

10. The depersonalization syndrome is characterized by all of the above, EXCEPT:

A. Disorders of personality self-awareness, alienation of mental properties of personality.

B. Disturbances of consciousness.

C. Feelings of change, loss or self-splitting.

D. Disorders of self-awareness of vitality and activity.

E. Self-awareness disorders.

11. Derealization is characterized by all of the above, EXCEPT:

A. Distortion of the size and shape of perceived objects and space.

B. Feelings of ghostly surroundings.

C. Perception of the outside world as ghostly, indistinct.

D. Loss of a sense of reality.

E. Doubts about the reality of the existence of surrounding objects, people.

12. Hypochondriacal syndrome manifests itself in all of the above, EXCLUDING:

A. Overly exaggerated attention to health.

B. Belief in an existing disease.

C. Depressed mood with senostopathies and thoughts of an incurable disease.

D. Delusional accusation of the existence of a non-existent disease.

E. Varied, extremely painful and painful sensations.

13. Amentive syndrome is NOT characterized by:

A. Lack of focus.

B. Incoherence.

C. Staging delirium.

D. Subsequently amnesia.

E. All above.

14. Manic syndrome is NOT typical for:

A. Speeding up the flow of thoughts.

B. Fast switching of attention.

C. Improving mood.

D. Hyperesthesia.

E. Hypermnesia.

15. In schizophrenia, a syndrome is observed:

A. Korsakov.

B. Apato-abulic.

C. Psychoorganic.

D. Dysmnestic.

E. None of the above.

16. Signs of twilight state of consciousness:

A. Excessive sleepiness.

B. Inadequacy of behavior and facial expressions of the situation.

C. Catatonic lethargy.

D. Quick answers to the questions posed.

E. Obsessions.

17. The presence of automatisms is typical for:

A. Kandinsky-Clerambault syndrome.

B. Paranoid syndrome.

C. Asthenic syndrome.

D. Obsessive-compulsive disorder.

E. Apato-abulic syndrome.

18. Accelerated flow of thoughts is typical for:

A. State of euphoria.

B. Manic syndrome.

C. Eidetism.

D. Depression.

E. Dysphoria.

19. Experimental psychological research in a clinic allows to solve the following tasks:

A. Obtaining data on various disorders of mental processes in a patient for diagnostic purposes.

B. Assessment of the degree of mental disorders.

C. An objective assessment of the dynamics of the mental state during therapy.

D. None of the listed.

E. All of the above.

20. A patient looks around, declares that someone outside the window is calling him, responds to imaginary calls:

A. Reflex (functional) illusions.

B. True auditory hallucinations.

C. Psychosensory disorders.

D. Pseudo-hallucinations.

E. Pareidolic illusions.

Materials for test control (II level)

21. A 32-year-old patient is periodically disturbed by a sudden feeling that the walls and ceiling of the room are about to fall on her. This feeling lasts 2-3 minutes and disappears just as suddenly. Qualify the state:

A. Hallucinosis syndrome.

B. Pareidolic illusions.

C. Special states of consciousness.

D. Sensory automatism.

E. None of the above.

22. A 45-year-old man, a research assistant, became extremely active for no reason, was constantly in high spirits, joked, offered help to others, talked to strangers on the street, talked a lot, was easily distracted and switched to another topic in conversation. Leading syndrome:

A. Manic syndrome.

B. Lacunar dementia.

C. Total dementia.

D. Concentric dementia.

E. Pseudodementia.

23. The patient, at the moment of falling asleep, sees terrible grimacing faces that laugh at him, show him their tongue.

A. Reflex (functional) illusions.

B. Hypnopompic hallucinations.

C. Physical illusions.

D. Hypnagogic hallucinations.

E. Acoasms.

24. The patient is long-spoken, thoughts are superficial, easily distracted, because of this it is not always possible to get an answer to the question, often changes the topic, not having time to finish the previous thought, switches to other topics, while gesticulating abundantly. Qualify the state:

A. Acceleration of thinking (in manic syndrome).

B. Incoherence.

C. Disruption.

D. Mentism.

E. Reasonableness.

25. The patient is disturbed by the constant feeling that his thoughts are flowing independently, regardless of his will. Qualify the state:

A. Disruption.

B. Perseveration.

C. Metaphysical intoxication.

D. Obsessive thoughts.

E. Mental automatisms.

26. A 45-year-old man, an economist, for no reason became extremely active, was constantly in high spirits, joked, flirted with employees, did not keep distance from his superiors, easily made acquaintances with unfamiliar women, was voluminous, easily distracted, quickly jumped from one topic to another. Qualify the syndrome:

A. Manic.
B. Depressive.
C. Lacunar dementia.
D. Cyclothymia.
E. Euphoria.

27. A 32-year-old female patient, a typist, at work suddenly stopped typing, got up and began to take off her clothes. She did not react to comments. After 2 minutes she regained consciousness, surprised to see the clothes she had taken off. Qualify the syndrome:

A. Oneiroid syndrome.
B. Neuroleptic syndrome.
C. Cotard syndrome.
D. Twilight state of consciousness.
E. None of the above.

28. The nurse took the soiled pillow from the patient. The patient continues to lie, raising his head above the pillow. Qualify the syndrome:

A. Catatonic syndrome.
B. Echo symptoms.
C. Active negativism.
D. Passive negativism.
E. Passive (automatic) obedience.

29. The patient states that completely alien thoughts penetrate into his head. He suspects that these thoughts are being imposed on him by his co-worker, who reads them from a distance. Qualify the state:

A. Obsessive thoughts.

B. Mental automatisms.

C. Perseveration.

D. Overvalued idea.

E. Rituals.

30. The patient, looking at his loved ones, declares that he has never seen them before. Qualify the state:

A. Capgra's syndrome.

B. Depersonalization

C. Senestopathies

D. Derealization

E. Pseudo-hallucinations.

31. The patient complains that she has "changed internally", that her feelings and thoughts are not the same as before. Qualify the state:

A. Senestopathies.

B. Depersonalization.

C. Sensory deprivation.

D. Hyperesthesia.

E. Body scheme disorders.

32. High-risk group for inheriting mental illness includes all the listed groups, EXCEPT:

A. Children who have one of the parents.

B. Brothers and sisters of the sick.

C. Uncles and aunts of patients.

D. Parents of patients.

E. Dizygotic twin patients.

33. A 23-year-old boy was detained by the police because of harsh agitation and ridiculous behavior. He ran away from imaginary pursuers, shouted, attacked a policeman. On the way to the hospital, he regained consciousness. There is a smell of alcohol from his mouth. He correctly calls himself, cannot remember anything that happened during the attack. Qualify past psychosis.

A. Oneiroid.

B. Twilight state.

C. Delirium.

D. Status epilepticus.

E. Amentia.

34. A 35-year-old woman turned to a therapist with complaints of malaise, headaches, discomfort behind the breastbone, and lack of appetite. Such disorders can be a manifestation of:

A. Neurasthenia.

B. Depressive syndrome.

C. Alcoholic withdrawal syndrome.

D. Hysteria.

35. A patient complains that inconstantly he has a feeling that the walls of the room bent over and may fall on him:

A. Depersonalization.

B. Hyperesthesia.

C. Psychosensory disorders.

D. Pareidolia.

E. Pseudo-hallucinations.

Situational tasks (III level)

Case 1. A 40-year-old woman presents to her general practitioner complaining of feeling tired and ‘washed-out’. She has had difficulty getting off to sleep for about 4 weeks, but has felt restless during the day. Straightforward, everyday tasks have become a challenge and sometimes provoke a dry mouth and churning stomach, but she occasionally feels tearful. The GP is aware that the woman’s mother died 3 months prior to the presentation. The patient describes no thoughts of self-harm.

1. What is(are) the main syndrome(s)?

2. What information in the history supports the diagnosis, and what other information would help to confirm it?

3. What might the important etiological factors be?

Case 2. You are asked to see a woman on a general medical ward who has been an inpatient for 5 days undergoing investigation for pain in her loin. This was initially thought to be renal in origin, but an intravenous urethrogram was negative for stones and no other cause for her continued pain can be identified. In addition, it has been noted that she has presented to the hospital on a number of occasions over the past year or so complaining of a wide variety of symptoms and different pains for which no physical cause has been identified. The medical team has discussed these findings with the patient and told her that they want to get a psychiatric opinion.

1. What is(are) the main syndrome(s)?

2. What information in the history supports the diagnosis, and what other information would help to confirm it?

3. What might the important etiological factors be?

Case 3. You are asked urgently to assess a 24-year-old woman who has recently moved to a large city to find work. She previously lived in a small rural community, and has had difficulty adapting to city life and finding employment. She gave up her job 2 weeks ago because it was not the sort of thing she was used to. Her boyfriend describes her as becoming ‘increasingly anxious’ throughout the last week, and her conversation increasingly confused and difficult to follow. She has not been sleeping well at night, often staying up doing housework all night and then sleeping during the day. For the 2 days prior to admission her behaviour had become extremely bizarre. She began to talk about people being hidden in the roof of her flat, saying that she could hear them sneezing and coughing, and could smell them as they passed in and out of the building. At one stage she said that she was a goddess who had been chosen to rid the world of evil. Sometimes she seemed happy, sometimes sad, and often very anxious and tense. On the day before admission, she spent hours sitting almost motionless in a chair doing nothing, and then suddenly became agitated, running around and trying to do everything at once.

1. What is(are) the main syndrome(s)?

2. What information in the history supports the diagnosis, and what other information would help to confirm it?

3. What might the important etiological factors be?

Case 4. A 36-year-old teacher is referred to a community mental health team by her general practitioner. She is worried about her physical health, but physical examination and other tests by her general practitioner have found no abnormalities. She describes episodes where her heart pounds, she feels hot and faint, and has an overwhelming need to escape. This first happened during a staff meeting at school, and again while in a large supermarket. Now she is apprehensive about going out in case she experiences another attack.

1. What is(are) the main syndrome(s)?

2. What information in the history supports the diagnosis, and what other information would help to confirm it?

3. What might the important etiological factors be?

Case 5. A 27-year-old woman is brought to the local accident and emergency department by her family. She appears restless, pacing around the waiting room, and her parents say that she has recently been asked to leave her job. She has not slept for several nights, and her speech is rapid and quickly wanders off the point. She had recently purchased an expensive car, and makes references to being offered a new job as chief executive of a major company. She is very reluctant to remain in the A&E department because she has far too much to do and considers it a waste of everyone's time. She believes that she is far too important to be messed around in such a way.

1. What is(are) the main syndrome(s)?

2. What information in the history supports the diagnosis, and what other information would help to confirm it?

3. What might the important etiological factors be?

APPLICATIONS

The applications present tests and scales for validating the most common mental disorders.

Application №1

Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

Instructions: ***Ask the questions in the order listed. Score one point for each correct response within each question or activity.***

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: _____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

(Adapted from Rovner & Folstein, 1987)

Interpretation:

The Mini-Mental State Examination (MMSE) or Folstein test is a 30-point questionnaire that is used extensively in clinical and research settings to measure cognitive impairment. It is commonly used in medicine and allied health to screen for dementia.

A maximum of 30 points can be scored in this test, which corresponds to the highest cognitive abilities. The smaller the test result, the more pronounced the cognitive deficit. According to various researchers, the test results may have the following values:

- severe cognitive impairment – 0-17;
- mild cognitive impairment – 18-23;
- no cognitive impairment – 24-30.

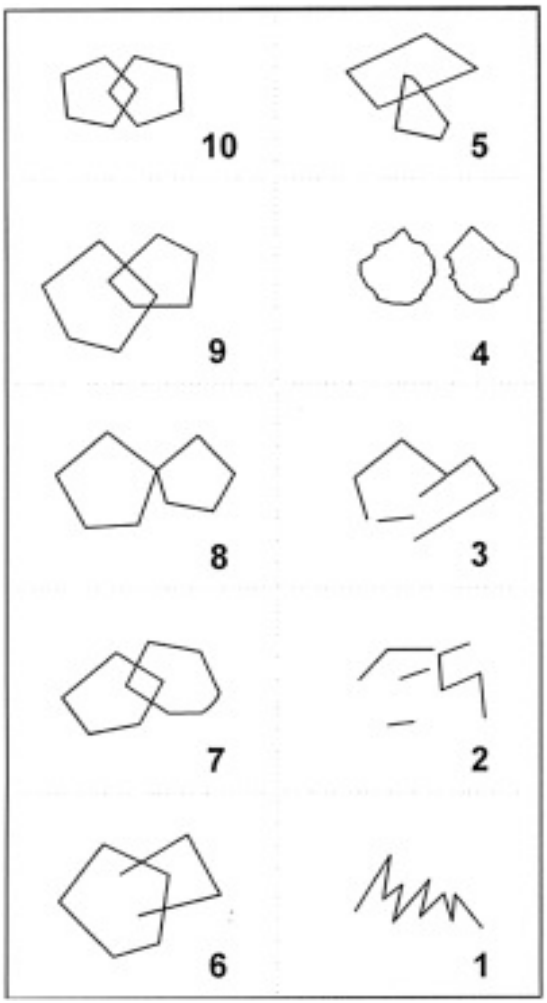


Fig. 11. Examples of validation of images of patients with different levels of dementia.

Hamilton Depression Rating Scale (HAM-D)

Patient Name _____ **Today's Date** _____

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, calculate the patient's score on the first 17 answers.

☐ **1. DEPRESSED MOOD**
(Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
0 = Absent
1 = Sadness, etc.
2 = Occasional weeping
3 = Frequent weeping
4 = Extreme symptoms

☐ **2. FEELINGS OF GUILT**
0 = Absent
1 = Self-reproach, feels he/she has let people down
2 = Ideas of guilt
3 = Present illness is a punishment; delusions of guilt
4 = Hallucinations of guilt

☐ **3. SUICIDE**
0 = Absent
1 = Feels life is not worth living
2 = Wishes he/she were dead
3 = Suicidal ideas or gestures
4 = Attempts at suicide

☐ **4. INSOMNIA - Initial**
(Difficulty in falling asleep)
0 = Absent
1 = Occasional
2 = Frequent

☐ **5. INSOMNIA - Middle**
(Complains of being restless and disturbed during the night. Waking during the night.)
0 = Absent
1 = Occasional
2 = Frequent

☐ **6. INSOMNIA - Delayed**
(Waking in early hours of the morning and unable to fall asleep again)
0 = Absent
1 = Occasional
2 = Frequent

☐ **7. WORK AND INTERESTS**
0 = No difficulty
1 = Feelings of incapacity, listlessness, indecision and vacillation
2 = Loss of interest in hobbies, decreased social activities
3 = Productivity decreased
4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

☐ **8. RETARDATION**
(Slowness of thought, speech, and activity; apathy; stupor.)
0 = Absent
1 = Slight retardation at interview
2 = Obvious retardation at interview
3 = Interview difficult
4 = Complete stupor

☐ **9. AGITATION**
(Restlessness associated with anxiety.)
0 = Absent
1 = Occasional
2 = Frequent

☐ **10. ANXIETY - PSYCHIC**
0 = No difficulty
1 = Tension and irritability
2 = Worrying about minor matters
3 = Apprehensive attitude
4 = Fears

☐ **11. ANXIETY - SOMATIC**
Gastrointestinal, indigestion
Cardiovascular, palpitation, Headaches
Respiratory, Genito-urinary, etc.
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

☐ **12. SOMATIC SYMPTOMS - GASTROINTESTINAL**
(Loss of appetite , heavy feeling in abdomen; constipation)
0 = Absent
1 = Mild
2 = Severe

☐ **13. SOMATIC SYMPTOMS - GENERAL**
(Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)
0 = Absent
1 = Mild
2 = Severe

☐ **14. GENITAL SYMPTOMS**
(Loss of libido, menstrual disturbances)
0 = Absent
1 = Mild
2 = Severe

☐ **15. HYPOCHONDRIASIS**
0 = Not present
1 = Self-absorption (bodily)
2 = Preoccupation with health
3 = Querulous attitude
4 = Hypochondriacal delusions

☐ **16. WEIGHT LOSS**
0 = No weight loss
1 = Slight
2 = Obvious or severe

☐ **17. INSIGHT**
(Insight must be interpreted in terms of patient's understanding and background.)
0 = No loss
1 = Partial or doubtfull loss
2 = Loss of insight

TOTAL ITEMS 1 TO 17: _____
0 - 7 = Normal
8 - 13 = Mild Depression
14-18 = Moderate Depression
19 - 22 = Severe Depression
≥ 23 = Very Severe Depression

☐ **18. DIURNAL VARIATION**
(Symptoms worse in morning or evening. Note which it is.)
0 = No variation
1 = Mild variation; AM ( ) PM ( )
2 = Severe variation; AM ( ) PM ( )

☐ **19. DEPERSONALIZATION AND DEREALIZATION**
(feelings of unreality, nihilistic ideas)
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

☐ **20. PARANOID SYMPTOMS**
(Not with a depressive quality)
0 = None
1 = Suspicious
2 = Ideas of reference
3 = Delusions of reference and persecution
4 = Hallucinations, persecutory

☐ **21. OBSESSIONAL SYMPTOMS**
(Obsessive thoughts and compulsions against which the patient struggles)
0 = Absent
1 = Mild
2 = Severe

Interpretation:

The Hamilton Depression Rating Scale (HAM-D) has proven useful for many years as a way of determining a patient's level of depression before, during, and after treatment. It should be administered by a clinician experienced in working with psychiatric patients.

The patient is rated by a clinician on 17 to 29 items (depending on version) scored either on a 3-point or 5-point Likert-type scale. For the 17-item version, a score of 0–7 is considered to be normal while a score of 20 or higher (indicating at least moderate severity) is usually required for entry into a clinical trial. Questions 18–20 may be recorded to give further information about the depression (such as whether diurnal variation or paranoid symptoms are present), but are not part of the scale. A structured interview guide for the questionnaire is available.

Unstructured versions of the HAM-D provide general instructions for rating items, while structured versions may provide definitions and/or specific interview questions for use. Structured versions of the HAM-D show more reliability than unstructured versions with informed use.

The National Institute for Health & Clinical Excellence of the UK stablished the levels of depression in relation to the HRSD compared with those suggested by the APA:

Not depressed: 0–7

Mild: 8–13

Moderate: 14–18

Severe: 19–22

Very severe: >23

Hospital Anxiety and Depression Scale (HADS)

Tick the box beside the reply that is closest to how you have been feeling in the past week.
Don't take too long over you replies: your immediate is best.

D	A		D	A	
		I feel tense or 'wound up':			**I feel as if I am slowed down:**
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			**I feel restless as I have to be on the move:**
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			**I get sudden feelings of panic:**
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			**I can enjoy a good book or radio or TV program:**
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions

Scoring:

Total score: Depression (D) _____ Anxiety (A) _____

0-7 = Normal

8-10 = Borderline abnormal (borderline case)

11-21 = Abnormal (case)

Interpretation:

Hospital Anxiety and Depression Scale (HADS) was originally developed by Zigmond and Snaith (1983) and is commonly used by doctors to determine the levels of anxiety and depression that a person is experiencing. The HADS is a fourteen-item scale that generates: Seven of the items relate to anxiety and seven relate to depression. Zigmond and Snaith created this outcome measure specifically to avoid reliance on aspects of these conditions that are also common somatic symptoms of illness, for example fatigue and insomnia or hypersomnia. This, it was hoped, would create a tool for the detection of anxiety and depression in people with physical health problems.

Each item on the questionnaire is scored from 0-3 and this means that a person can score between 0 and 21 for either anxiety or depression.

RECOMMENDED BOOKS

1. Current Medical Diagnosis & Treatment / McPhee S. J, Papadakis M. A., Rabow M. W. – New York : McGraw-Hill Medical, 2014. – 832 p.

2. First Aid for the Psychiatry Boards / Azzam A., Yanofski J., Kaftarian E. and Le T. – US: McGraw-Hill Medical, 2010. – 496 p.

3. Introductory Textbook of Psychiatry / Andreasen N. C., Black D. W. – Washington, DC : American Psychiatric Press, 1995. – 1786 p.

4. Kaplan & Sadock's Synopsis of Psychiatry: Behavioral Sciences/clinical Psychiatry. 10th ed. / Sadock B. J., Kaplan H. I., Sadock V. A. – Philadelphia : Wolter Kluwer/Lippincott Williams & Wilkins, 2007. – 1472 p.

5. Manual of clinical psychopharmacology (8th ed.) / Schatzberg A. F., DeBattista C. – American Psychiatric Publishing, 2015. – 744 p.

6. Massachusetts General Hospital Psychiatry Update / Stern T. A., Herman J. B. – New York : McGraw-Hill, 2000. – 678 p.