

MINISTRY OF HEALTH OF UKRAINE
ZAPORIZHZHIA STATE MEDICAL UNIVERSITY

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

**GENERAL PSYCHOPATHOLOGY.
VIOLATION OF EMOTIONS, IMPULSES, VOLITIONAL.
SYNDROMES OF IMPAIRED CONSCIOUSNESS.**

Tutorial
for 4th year students

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S 14 **Safonov D.M.**

General psychopathology. Violation of emotions, impulses, volitional. Syndromes of impaired consciousness: tutorial for 4th year students of International Faculty №2. – Zaporizhzhia, 2021. – 86 p.

The tutorial provides materials on modern ideas about methods of diagnosis main psychopathological syndromes of disturbances of emotions, impulses, volitional and consciousness 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 psychopathological syndromes of emotions, impulses, volitional and consciousness disturbances, 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 methods of diagnosis of this 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.

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INTRODUCTION

Relevance, goals, organizational structure of the lesson

1.1. Relevance of the topic.

A special, very important side of a person's inner life is represented by emotions and volition. Emotions are a reflection by the human brain of any actual need or the likelihood of the possibility of its satisfaction. Subjectively, emotions are manifested in a person's experience of his relationship to the environment and his inner state. Mood disorders are the most common in modern times, 340 million people now suffer from manic or depressive disorder, 15 percent of depressed patients make a suicidal attempt.

Volition is a conscious, purposeful mental activity associated with overcoming obstacles. Volitional disorders and impulse disorders always accompany affective pathology.

Consciousness is considered as the highest function of the brain associated with speech, reflecting in a generalized form the real reality and purposefully regulating human activity. Impairment of consciousness - a state of disorder of consciousness, syndromes of its exclusion - quantitative disorders (coma, stupor, stunning) or stupefaction - qualitative disorders (oneiroid, delirium, twilight state of consciousness).

1.2. Learning objectives of the lesson:

Students must know the definition and characteristics of:

1. Emotions and their classification.
2. Definition of lower and higher emotions.
3. Characteristics of physiological affect.
4. Characteristics of pathological affect, differences from physiological one.

5. Syndromes of quantitative and qualitative emotions disorders.
6. States of impaired mobility of emotions.
7. Characteristics of depressive, manic and dysphoric syndromes.
8. Definition and classification of volition.
9. Definition of volition and effector-volitional activity.
10. States of strengthening of volitional activity.
11. States of weakening and lack of volitional activity.
12. States of distortion of volitional activity.
13. Characteristics of variants of catatonic syndrome.
14. Characteristics of apathetic-abulic syndrome.
15. Characteristics of hebephrenic syndrome.
16. Definition of consciousness, its functions and neurophysiological substrate.
17. Signs of maintaining a clear consciousness.
18. Syndromes of quantitative and qualitative disorders of consciousness.

Students must be able to:

1. Identify symptoms and syndromes of mental illnesses during communication with the patient.
2. Qualify their nature and possible dynamics.
3. Correctly describe the mental state of the patient in the medical records.
4. Carry out differential diagnosis of symptoms and syndromes of emotions, impulses, volitional and consciousness disturbances.
5. Provide medical care in emergencies.

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 disturbances of emotions, impulses, volitional and consciousness and his/her 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. | Organization of classes | | | Academic Journal | 40 |
| 2. | Setting learning goals and motivation | | | "Learning Objectives" | |
| 3. | Control of the initial level of knowledge, skills, abilities: | | | "Actuality" | |
| | 1. Etiological structure and pathogenesis of mental disorders. | I | Level I test control Individual examination | Methodical developments | |
| | 2. Features of diagnosis of patients with mental disorders. | II | | Thematic tables, posters, slides, structural and logical schemes | |
| | 3. Differential diagnosis in psychiatry. | II | Level II test control | Questions for individual examination | |
| | 4. Indications for involuntary hospitalization in a psychiatric hospital. | II | | Test tasks of I, II level | |
| | 5. Supervision, examination and treatment of patients in the clinic. | II | | | |
| II. The main stage | | | | | |

| | | | | | |
|------------------------|--|-----|--|---|-----|
| 4. | 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 examination of the patient. 4. Be able to make a differential diagnosis based on clinical and ancillary laboratory data. | III | Methods of skill formation: professional training, | Algorithms for the formation of practical skills: methodical developments. Neurological hammers. Tables. | 100 |
| | | III | solution of level II tests, typical level III cases | Tests, typical cases of the III level | |
| | | III | professional training in solving atypical clinical cases, level III tasks | Algorithms for the formation of professional skills. Situational atypical tasks. Simulation games. Equipment. | |
| | | IV | | | |
| III Final stage | | | | | |
| 5. | Control and correction of the level of skills and abilities | III | Methods of skill control: | The results of the clinical examination. | 40 |
| 6. | Summarizing the lesson (theoretical, practical, organizational) | | individual control of practical skills and their results. Analysis and evaluation of clinical results, | Level III tasks Level II tests | |
| 7. | Homework (basic and additional literature on the topic) | | solutions of tests, cases | Approximate map for independent work with literature | |

DISTURBANCES OF EMOTIONS

Emotions – a special class of mental states that reflect a person's attitude to the world around him, to other people, to himself and to the results of their activities.

Types of emotions:

Primitive (lower) – experiences associated with the satisfaction or dissatisfaction of physiological needs.

Higher – experiences that arise from the satisfaction of spiritual needs.

Positive – emotions associated with the satisfaction of needs.

Negative – emotions that cause feelings of dissatisfaction and require a change in the situation.

Stenic – emotions that increase human activity.

Asthenic – emotions that suppress the vital functions of the body, reduce the energy of the subject.

Physiological affect is a state of pronounced affect (anger), not accompanied by a clouding of consciousness, but only by a possible narrowing of the range of ideas, concentrating on events associated with the emerging affect; the episode does not end with sleep, severe psychophysical exhaustion and amnesia. In this state, illegal actions are often committed. These persons are recognized as sane, in contrast to those who have suffered a pathological affect.

The experience of a serious danger in a person arises in situations that pose an immediate threat to his life or the life of his loved ones, for example, during natural and man-made disasters, fires, in accidents, hostilities, terrorist attacks, violence by criminals, sexual violence, etc. (Pic. 1).

Variants of affective-shock reactions:

Aggressive behavior aimed at actively eliminating the threat ("hit" reaction). In judicial practice, the states of "sudden strong emotional excitement (affect)" caused by an external threat and leading to the excessive use of force are especially considered in relation to persons who presented such a threat. In these

cases, states that are accompanied by a narrowed, but not clouded consciousness are called physiological affect. It is believed that such a state reduces the ability to self-control and assess the consequences of one's actions, nevertheless, these abilities are not completely lost, therefore, a person who committed an offense in this state is not exempt from criminal punishment. Physiological affect must be differentiated from pathological affect.

Psychomotor agitation, "motor storm" ("run" reaction). It is characterized by motor excitement with unfocused, poorly comprehended actions that could potentially help a person escape from this situation, but often, due to their lack of meaning, carry an additional danger for him. For example, during a fire, some people, succumbing to their emotional state, instead of using the provided escape routes, rush in all directions, sometimes throwing themselves out of windows while safe escape routes from the fire are still available. During the hostilities, situations are described when inexperienced recruits, during the first attack of the enemy, jumped out of the trenches and began to randomly shoot at all people who tried to approach them, including their colleagues. Persons in a state of "motor storm" are especially dangerous in crowded places, when their behavior can quickly "infect" others, causing massive panic and crush.

Motor stupor (immobility), "imaginary death" ("freeze" reaction). Cases when emotions "paralyze" the actions of a person, necessary in order to avoid or minimize the consequences of the danger that threatens him. Unable to cope with the emotions that gripped him, a person remains only a passive observer of the threatening events taking place around him. For example, a mother, having heard the call for help from her drowning son, stops "rooted to the spot", "hands and feet do not obey," looks in horror at how her son is drowning before her eyes, although she is only a few tens of meters away from him.



Pic. 1. Illustration of affect reaction in “The quarrel in the game of cards” (1620-1630) by Adrian Brouwer

Pathological affect is a short-term mental disorder with aggressive behavior and an irritable-spiteful mood against the background of a twilight clouding of consciousness. This state arises in response to intense, sudden mental trauma and is expressed by the concentration of consciousness on traumatic experiences, followed by an affective discharge, followed by general relaxation, indifference and, often, deep sleep. Characterized by partial or complete amnesia. Persons who have committed offenses in this state are recognized as insane.

Differences between physiological and pathological affects

| Physiological affect | Pathological affect |
|--|---|
| Consciousness is not darkened, but narrowed | It is a variant of the twilight clouding of consciousness (often in the form of a hallucinatory delusional variant) |
| Lasts seconds, minutes | Lasts minutes, hours |
| Compliance with the strength of the experience (adequacy to the stimulus) | Inconsistency of the reaction to the strength of the stimulus |
| Occurs immediately in response to the action of a stimulus ("short circuit" reaction) | No "short circuit" response |
| Actions are targeted | Actions reflect psychotic experiences |
| The memory of events in the feeling of affect is preserved | Amnesia of the entire period |
| After – emotional relief | After – terminal sleep |
| Does not exempt from criminal liability, but may be a mitigating circumstance ("a state of strong emotional excitement") | Does exempt from criminal liability |

Sensitivity (emotional hyperesthesia) - increased emotional sensitivity, vulnerability. It can be an innate personality trait, especially pronounced in psychopaths.

Emotional coldness – leveling the expression of emotions in the form of an even, cold attitude to all events, regardless of their emotional significance. It is detected in psychopaths, with schizophrenia.

Emotional dullness – weakness, impoverishment of emotional manifestations and contacts, impoverishment of feelings, reaching the point of indifference. Occurs within the framework of a schizophrenic defect.

Apathy is indifference, a complete absence of feelings, in which desires and impulses do not arise. Sensual dullness is more often observed, in which emotions become dull, poor. The predominant emotion of patients is indifference. It occurs in schizophrenia (defect) and gross organic lesions of the brain, and can also be the leading manifestation of depressive syndrome.

Emotional ambivalence is the simultaneous coexistence of antagonistic emotions that cause inconsistency in thinking and inadequacy of behavior. A symptom that occurs in schizophrenia.

Emotional inadequacy – the emergence of an emotion that does not correspond qualitatively, meaningfully to the stimulus that causes it, the paradoxicality of emotions (a patient with a sad face tells about pleasant impressions). It also occurs in schizophrenia.

Emotional lability is a pathologically unstable mood that easily changes to the opposite due to a change in the situation. Pathologically unstable mood is characteristic of asthenic syndrome, in addition, it can occur within the framework of emotional-volitional disorders in personality pathology.

Explosiveness – heightened emotional excitability, in which the experience of annoyance, anger, up to rage, with aggressive actions easily arises. It may arise for a minor reason. Explosiveness is characteristic of emotional-volitional disorders in personality pathology, organic (traumatic) brain lesions.

Faint-heartedness is a state of easily fluctuating mood for an insignificant reason from tearfulness to sentimentality with tenderness. May be accompanied by moodiness, irritability, fatigue. It is observed with vascular damage to the brain, with somatogenic asthenia.

Hyperthymia is a painfully elevated mood, accompanied by a feeling of joy, strength, energetic upsurge ("joy splashing over the edge"), which sharply reduces the depth and direction of cognitive processes. Hyperthymia is the main symptom of manic syndromes.

Euphoria is a painfully elevated mood, accompanied by a sense of pleasure, comfort, well-being, relaxation, and interferes with cognitive processes. This emotion can be either a normal reaction to happy events or a symptom of substance abuse and certain mental health conditions.

Euphoria is not in itself a medical condition and is in fact one of the most pleasurable aspects of being human. Sexual satisfaction, exciting life events, achievement, and love can all provoke feelings of euphoria. Exercise also causes feelings of euphoria when the body depletes its glycogen stores and then releases endorphins. Occasionally, however, a person's euphoria does not make sense within a particular context. Several conditions and lifestyle choices can contribute to incongruous feelings of euphoria:

Drug use may cause euphoria. Cannabis, heroin, MDMA (also known as ecstasy), and some hallucinogens may cause euphoria. Often, the euphoric feelings wane with increasing use. Drugs that cause feelings of euphoria frequently act directly on dopamine levels (Pic. 2).



Pic. 2. Illustration of euphoria caused by use of psychoactive substances.

Manic states brought about by bipolar or cyclothymia often cause periods of euphoria followed by feelings of depression.

Though rare, some brain disorders and head injuries may cause inappropriate feelings of euphoria. When a tumor or head injury interferes with the body's ability to process negative emotions or alters the production of neurotransmitters, ongoing euphoria may be the result.

Some schizophrenic patients may experience euphoria, particularly if they experience pleasant delusions and hallucinations.

Hypoxia may cause euphoria. This variety of euphoria is common among people who rapidly ascend to high altitudes, such as mountain climbers.

Moria – cheerful excitement with foolishness, childishness, clowning, a tendency to flat and rude jokes; always accompanied by symptoms of intellectual decline. with global dementia.

Ecstasy – hyperthymia with a predominance of delight, up to frenzied admiration, a sense of enlightenment, enlightenment. Often combined with confusion, catatonic manifestations, oneiric confusion.

Hypothymia is a painfully low mood, experienced as sadness, sadness, despondency, depression, depression, grief, a feeling of hopelessness, accompanied by a feeling of physical distress, passivity, helplessness, suicidal thoughts and actions. This type of mood disorder is common in depressive syndromes.

Dysphoria is a painfully low mood, accompanied by an irritable-melancholy-spiteful, gloomy feeling. Arises and ends suddenly. Can last for hours or days. During dysphoria, patients are prone to aggressive actions. Dysphoria is mainly observed in patients with unfavorably current epilepsy, with traumatic and other organic brain lesions.

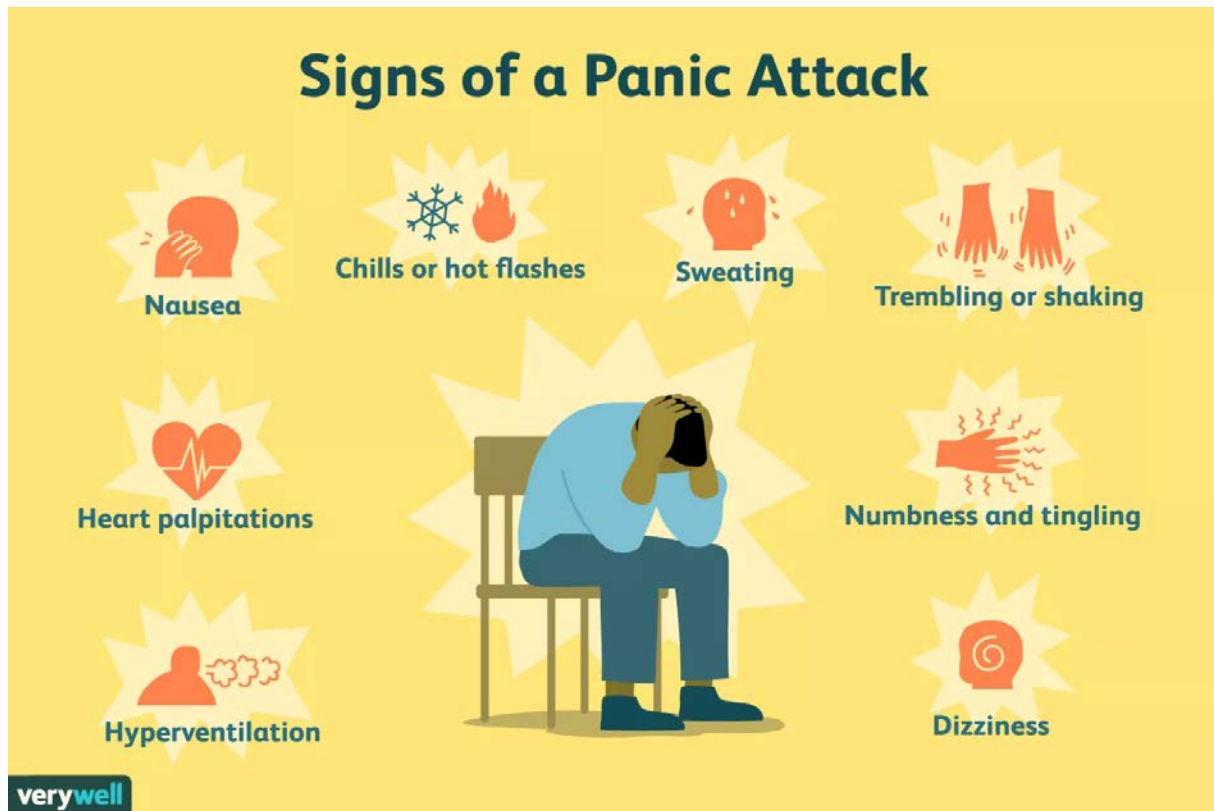
Mild forms of dysphoria look like resentment, picky, grumpy, discontent, sometimes more like sarcasm. Such cases are usually assessed as traits of a certain person. In severe dysphoria, melancholy and anxiety are expressed,

creating a feeling of despair, hopelessness, tension, fear. Hyperesthesia is constantly present - patients react painfully to any stimuli, for example, comments from spouses, colleagues or people they meet by chance, disobedience of children, their own failures and accidental incidents. Anger, also constantly present in dysphoria, in these cases can be interspersed with episodes of rage, states of psychomotor agitation with aggressive, destructive actions. With dysphoria, various impulsive actions, leaving home, alcoholic, sexual excesses, etc. are also possible.

Dysphoria is believed to be an autochthonous disorder that occurs without significant external causes. However, in some cases, its onset may coincide with various psychotraumatic circumstances, while the inconsistency of the severity of the irritation reaction to the occasion, which it followed, draws attention. The onset of dysphoria is usually sudden, lasting from hours to several days. Short-term dysphorias often end as abruptly as they began, protracted dysphorias often end gradually.

Dysphoria is most typical for people with organic brain lesions (for example, those who have suffered a traumatic brain injury, suffering from epilepsy, etc.).

Anxiety is an emotional state or reaction characterized by internal excitement, constriction and tension located in the chest. It is accompanied by a presentiment and timid expectations of impending disaster, pessimistic fears directed to the future. Anxiety is an activating affect. It is part of the structure of neurotic, anxious-depressive, acute delusional, affective-delusional syndromes and clouding of consciousness. It often accompanies depression, but occurs within the framework of individual anxiety disorders, which, when generalized, turn into panic disorders. Anxiety is supported by such cognitive circuits: the heart can stop; it beats too much - I can have a seizure anywhere - I will die as a result of the attack - an increase in anxiety and a repetition of the stereotypical circle (Pic. 3).



Pic. 3. Main symptoms of acute anxiety state (panic attack).

Sometimes anxiety is felt in the body with a welcoming tinge, like itching, internal tremors. Often combined with motor (psychomotor) excitement. As a pathological state, anxiety is irrational and is caused by painful mental experiences, and not by real events. Anxious coloring of experiences is characteristic of psychopathological conditions in old age. With neuroses (anxiety disorders), anxiety is less pronounced, there is no pronounced psychomotor agitation and is accompanied by abundant vegetative manifestations (vegetative anxiety).

Vegetative symptoms in anxiety are associated with the activation of the hypothalamic-pituitary-adrenal system and include physiological changes aimed at increasing the body's readiness for action in connection with the need to overcome impending dangers: muscle tension (up to tremors), increased heart rate and respiration, increased arterial pressure, blood glucose levels, dry mouth,

frequent urination, slowing of intestinal motility (hence constipation) or, conversely, increased urge to defecate, sweating or, conversely, chilliness, etc.

From a physiological point of view, the optimal level of anxiety is necessary for a person as a means of increasing adaptation to changing environmental conditions, mobilizing reserves, preparing to perform actions necessary in future conditions, especially necessary to eliminate the impending danger (see the classic works of Hans Selye on the adaptation syndrome). Whereas an excessively high and excessively low level of anxiety will have a maladaptive meaning, lead to adverse consequences. In psychopathology, cases of anxiety are considered that are inadequate to the situation (arises without objective reasons in neutral, non-threatening conditions) or excessive in strength.

Anxiety differs from fear in its pointlessness. The lack of objectivity during anxiety is especially painful, difficult to endure, since a person in this state does not see any possible rational way out. Fear is always objective, concrete ("fear of this and that"). Nevertheless, it is often difficult to distinguish between fear and anxiety, since a person in a state of anxiety often associates it with some specific circumstances, which, albeit by accident, are always in abundance, therefore such a person, describing his condition, lists many different dangers that come to mind at the moment. On the other hand, people who experience "fear" are not always able to accurately determine what they are afraid of.

Anxiety can be of different severity. In the mildest cases, it is manifested by mild, unclear tension and discomfort. In the future, the tension increases, hyperesthesia joins (increased sensitivity to stimuli - flinching from random noises, loud sounds, etc.), vegetative manifestations, there is an experience of the feeling of an impending threat. With pronounced anxiety, motor anxiety grows, it becomes impossible to sit still, mental activity increases, anxious fears more and more take the form of specific fears - specific experiences of various

(often numerous) threats that await in the future. At the peak of anxiety, pronounced psychomotor agitation is possible, up to the so-called anxious raptus - an attack of motor excitement, during which patients rush from side to side, bite their hands, tear their hair, repeat the same words (anxious verbigations), may commit suicidal attempts (suicide in this case is an attempt to avoid big troubles that supposedly await a person in the future).

Depression is one of the most common disorders occurring in both psychiatric and general medical practice. The basis of the depressive syndrome is the depressive triad, which includes (Pic. 4):

- a) pathological low mood;
- b) ideational inhibition;
- c) psychomotor disorders in the form of general inhibition (although in principle their nature depends on the nature of low mood).

Other depression symptoms can vary from mild to severe and include:

- a) feeling sad or having a depressed mood;
- b) loss of interest or pleasure in activities once enjoyed;
- c) changes in appetite – weight loss or gain unrelated to dieting;
- d) trouble sleeping or sleeping too much;
- e) loss of energy or increased fatigue;
- f) increase in purposeless physical activity (e.g., inability to sit still, pacing, handwringing) or slowed movements or speech (these actions must be severe enough to be observable by others);
- g) feeling worthless or guilty;
- h) difficulty thinking, concentrating or making decisions;
- i) thoughts of death or suicide;

Symptoms must last at least two weeks and must represent a change in your previous level of functioning for a diagnosis of depression.

Also, medical conditions (e.g., thyroid problems, a brain tumor or vitamin deficiency) can mimic symptoms of depression so it is important to rule out general medical causes.

Depression affects an estimated one in 15 adults (6.7%) in any given year. And one in six people (16.6%) will experience depression at some time in their life. Depression can occur at any time, but on average, first appears during the late teens to mid-20s. Women are more likely than men to experience depression. Some studies show that one-third of women will experience a major depressive episode in their lifetime. There is a high degree of heritability (approximately 40%) when first-degree relatives (parents/children/siblings) have depression.

The death of a loved one, loss of a job or the ending of a relationship are difficult experiences for a person to endure. It is normal for feelings of sadness or grief to develop in response to such situations. Those experiencing loss often might describe themselves as being “depressed.”

But being sad is not the same as having depression. The grieving process is natural and unique to each individual and shares some of the same features of depression. Both grief and depression may involve intense sadness and withdrawal from usual activities. They are also different in important ways:

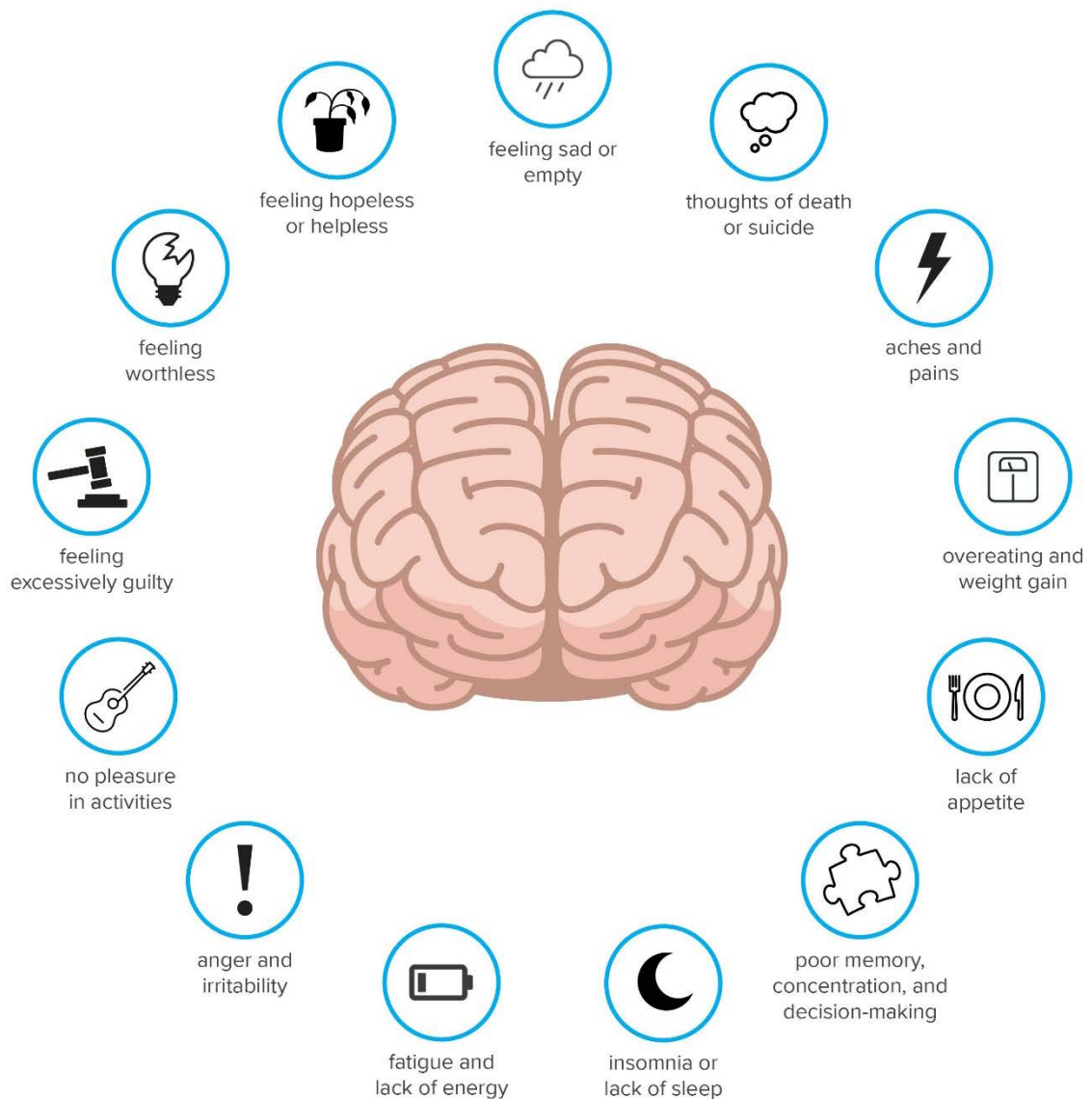
In grief, painful feelings come in waves, often intermixed with positive memories of the deceased. In major depression, mood and/or interest (pleasure) are decreased for most of two weeks.

In grief, self-esteem is usually maintained. In major depression, feelings of worthlessness and self-loathing are common.

In grief, thoughts of death may surface when thinking of or fantasizing about “joining” the deceased loved one. In major depression, thoughts are focused on ending one’s life due to feeling worthless or undeserving of living or being unable to cope with the pain of depression.

Grief and depression can co-exist For some people, the death of a loved one, losing a job or being a victim of a physical assault or a major disaster can lead to depression. When grief and depression co-occur, the grief is more severe and lasts longer than grief without depression.

Common Symptoms of Depression



Pic. 4. Illustration of most common symptoms of depression

Risk Factors for Depression

Biochemistry: Differences in certain chemicals in the brain may contribute to symptoms of depression.

Genetics: Depression can run in families. For example, if one identical twin has depression, the other has a 70 percent chance of having the illness sometime in life.

Personality: People with low self-esteem, who are easily overwhelmed by stress, or who are generally pessimistic appear to be more likely to experience depression.

Environmental factors: Continuous exposure to violence, neglect, abuse or poverty may make some people more vulnerable to depression.

Clinical types of depression

1. Anxious (agitated) depression

Combination of depression and anxiety.

In the triad, instead of inhibition, motor and ideational excitement, characteristic of anxiety states, is often observed: patients go through many options for the dangers that threaten them, actions that could prevent them, etc. Often, they are voluminous, with increased anxiety, they do not find a place for themselves. At the height of anxiety, it is possible to develop a pronounced anxiety excitement with auto-aggressive behavior - anxious raptus.

The deterioration of the condition of patients with an increase in anxiety is usually observed in the evening hours, difficulty in falling asleep is expressed.

Anxiety depression is more common in older people.

The experiences of patients are usually associated with their own health (hypochondriacal ideas) or the financial well-being of their families (fear of impoverishment, stay on the street, etc.). These ideas can reach overvalued and delusional levels.

2. Apathetic depression

Complaints of apathy are characteristic - lack of emotions, indifference and indifference to what is happening around. Usually this “lack of emotions” is painful and alien to the sick (as opposed to apathy as an emotional property), they complain that they cannot and do not want to do anything. It is based on both depressive anhedonia (a diverse array of deficits in hedonic function, including reduced motivation or ability to experience pleasure) and loss of the emotional component of sensations (mental anesthesia), and ideomotor retardation, which reduces the activity of patients.

In some cases, patients are especially burdened by the lack of emotions, a proper response to what is happening around. Such conditions are called painful insensibility, or painful mental anesthesia (*anesthesia psychica dolorosa*).

3. Astheno-depressive syndrome

In addition to low mood in patients, complaints of increased fatigue and unproductiveness in business prevail. Within the framework of depression, initially, such complaints are a consequence of ideomotor retardation, but in the future, the number of cases not completed begins to accumulate, as well as worries about this, sometimes leading the patient to excessive stress and overwork.

Asthenia and depression have many clinical features in common, but differ in their pathogenesis. Fatigue in asthenia is caused by an objective overstrain of the body in connection with debilitating somatic diseases or improper planning by the patient of his work and rest. Depression is usually caused either by an autochthonous change in the exchange of neurotransmitters in the brain, or by psycho-traumatic factors, i.e. the feeling of fatigue and failure in depression is not caused by any excessive objective stress, but arises on its own. Given the different genesis of these conditions, psychiatrists usually try to separate them within the framework of different nosologies (diseases), while doctors of other specialties are often content with only a syndromic assessment, diagnosing asthenic-depressive syndrome.

4. Depression with psychotic symptoms

Depression with delusions and hallucinations. Their content may correspond to the depressive affect (to be congruent to it - the idea of self-deprecation) or inappropriate (to be incongruent to the affect, for example, the idea of persecution).

5. Atypical depression

Atypical depression is characterized by emotional reactivity (mood swings), hypersomnia (increased need for sleep), increased appetite, heaviness in the limbs, sensitivity to rejection in interpersonal relationships.

6. Masked depression (latent, somatized, “depression without depression”) is a depression in which the symptoms of low mood proper are hidden (masked) by some somatic symptoms or other mental disorders.

A person with symptoms of depression may either be unable to sort out and understand his or her emotions, realize that he or she has a depressed mood (“Yes, maybe this is so normal, maybe everyone feels the same way ...”), or finds it difficult to describe them, or may refuse to admit the presence of mental disorders due to fear of going to a psychiatrist, being perceived as "crazy", etc. In this regard, such patients do not receive adequate treatment for a long time, but their emotional state and mental suffering can manifest themselves in the form of other complaints, which represent a "mask" of depression and with which they turn to doctors of various specialties (therefore, such depression is often called somatized).

There are several options for masked depression according to the leading complaints that accompany it:

Algic-senestopathic - manifested by chronic pain (senestopathy and senestalgia), which can have different localization: abdominal, cardialgic, cephalgic, panalgic, etc.

With panic attacks (psychovegetative crises).

With obsessive-phobic manifestations.

With insomnia – persistent insomnia, which cannot be overcome even with high doses of conventional sleeping pills.

With symptoms of addiction, it manifests itself as symptomatic drunkenness (dipsomania) or non-chemical types of addiction.

What signs will help in the diagnosis of masked (somatized) depression?

The patient is treated for a long time, but to no avail, by various doctors.

Doctors do not find any specific somatic disease in the patient or make an unclear diagnosis.

Lack of effect from somatic therapy and good therapeutic effect from antidepressants.

A history of affective disorders in the patient and his family.

Autochthonous and seasonal occurrence of symptoms.

Cotard's syndrome (melancholic paraphrenia, Cotard delusion) is a complex depressive syndrome that includes depressive experiences and hypochondriacal ideas that have the character of enormity and denial. The sick consider themselves to be great sinners, they have no excuse on Earth, because of them all humanity suffers, etc. With a nihilistic delirium of Cotard, patients express hypochondriacal delirium; all their insides, bones rot, nothing is left of them, they are infected with a "terrible" disease and can infect the whole world, etc. Cotard's syndrome is rare, mainly in the clinic of schizophrenia, involuntional melancholy (Pic. 5).

Delusions of negation are the central symptom in Cotard's syndrome. The patient usually denies their own existence, the existence of a certain body part, or the existence of a portion of their body. Cotard's syndrome exists in three stages:

Germination stage: symptoms of psychotic depression and of hypochondria appear;

Blooming stage: full development of the syndrome and delusions of negation; and;

Chronic stage: continued severe delusions along with chronic psychiatric depression.



Pic. 5. Illustration of self-perception of patient with Cotard's syndrome.

Cotard's syndrome withdraws the afflicted person from other people due to neglect of their personal hygiene and physical health. Delusions of negation of self prevent the patient from making sense of external reality, which then produces a distorted view of the external world. Such delusions of negation are usually found in schizophrenia. Although a diagnosis of Cotard's syndrome does not require the patient's having had hallucinations, the strong delusions of negation are comparable to those found in schizophrenic patients

Manic syndrome – represented by the following triad of symptoms:

- a) pathological elevated mood (hyperthymia);
- b) pathological accelerated thinking;
- c) psychomotor agitation.

Patients are optimistic about the present and the future, feel extraordinary vigor, a surge of strength, do not get tired, strive for activity, almost do not sleep, but due to the extreme variability of cognitive processes with pronounced distraction of attention, the activity is chaotic and unproductive. The increase in activity can reach erratic arousal (confused mania) (Pic. 6).



Pic. 6. Main symptoms of mania.

Like depression, manic syndrome is an emotional state, so an elevated mood (hyperthymia) with it should be observed continuously for most of the day for at least a few days, and more often weeks.

Hyperthymia is manifested by a joyful, optimistic mood, a feeling of happiness that cannot be overshadowed by any obstacles and troubles. In

addition to the frequent inconsistency of such a mood with the surrounding situation, the painfulness of hyperthymia lies in the fact that people in this state tend to overestimate their real capabilities - they seem to be able to handle all difficulties, all obstacles are easily surmountable, and possible losses are insignificant. They waste large sums of money (including borrowed money), giving them away to random people, unnecessarily risking their lives (for example, climbing a drain pipe to random lovers or driving a car excessively and aggressively, etc.), overestimating their own physical capabilities, come into conflict with persons superior in strength, which often leads to severe injuries. Ideas of self-revaluation can reach delusional levels (delusions of greatness).

Ideatorial excitement is manifested in the acceleration of thinking, constant multiple words. A patient in a manic state speaks all the time, while his speech has a special expressiveness, pressure, it is difficult to interrupt. Sometimes a heightened mood and ideological excitement, which facilitates the search for rhymes, lead to the fact that a person in this state begins to speak in poetry or sing (especially praising odes dedicated to people of the opposite sex are characteristic). New ideas come to his mind all the time (in case of excessive acceleration of thinking, the so-called jump of ideas develops - not having time to voice one thought, he moves on to another, third, etc.), he easily solves complex intellectual problems, easily remembers and reproduces large volumes of information (hypermnnesia).

Motor excitement is manifested by an increase in motor activity, the inability to sit still, a constant desire to do something, move, and sometimes dance. Together with new ideas and vision of what is happening around, this leads to a desire for change, a desire to change everything around. The people around them, more soberly assessing the possibilities and prospects of such

changes, usually in one way or another seek to stop a person in a manic state, moderate his ardor, dissuade him from implementing his plans, but often these attempts meet only irritation and aggression.

The need for sleep in a manic state is reduced (they may not sleep for several days in a row or sleep for only a few hours). Appetite can be increased, but often patients either do not have time to eat, or they forget about food, being carried away by something, as a result they usually lose weight. Increased sexual desire leads to casual sex, including unprotected, which raises the risk of transmission of genital infections. In addition, the craving for alcohol and other psychoactive substances can be increased. They are used mainly in companies.

Usually, patients in a manic state have a very positive attitude to the emotions they experience, they have no (or partial) criticism of their state, as well as no desire to seek help for the treatment of this condition. They usually turn to a psychiatrist either at the insistence of relatives, or in the event of an offense; they are often detained by the police, from where they are sent for treatment in a psychiatric hospital.

There are a number of clinical variants of manic syndrome:

Classic ("solar") mania – all the components of the "triad" are presented.

Anger mania – all components of the "triad" are represented, irritability, outbursts of anger, including those with verbal and physical aggression, are characteristic (irritability and anger are usually caused by the fact that others refuse to support the patient's ideas, try to limit him in any way, etc.).

Delusional mania – in addition to the "triad" delusional ideas of greatness, overestimation of their own abilities.

Hypomania – a slight manifestation of the manic "triad"

Amimia, hypomimia – absence, weakening of facial expressions, gestures, impoverishment of expressive means of speech, monotony of intonations, extinct, expressionless look.

Hypermimia is an excessive revitalization of the expressive sphere with an abundance of bright and rapidly changing expressive acts. Overproduction of expressive actions is noted, for example, in a state of catatonic excitement: patients laugh loudly, sob, scream, moan, dance, bow, march, salute, take stately poses. It is difficult to determine if the underlying emotion is behind all of this. Describe "pseudo-affective" reactions with imitation of the external expression of affects, arising, as it is believed, as a result of disinhibition of unconditional reflex activity.

With Gilles de la Tourette's syndrome, against the background of hyperkinetic arousal, grimacing, intense gesticulation and demonstrative behavior, cynical swearing is uttered without will.

Expressive actions sometimes have an autonomous character – "violent crying, laughter", as is characteristic of cerebral atherosclerosis.

Patients with the syndrome of mental automatism note that they have "done" mimic and pantomimic acts – "They make me laugh, cry, pretend joy, anger". Involuntary crying, laughter are observed in hysteria ("I sob and cannot stop").

Expressive actions can be dissociated, arising in isolation from the corresponding emotional experiences. Patients note that "Tears roll by themselves and laughter and a smile also arise," while the mood does not change. The revitalization of the expressive sphere is also observed in manic states.

Excessive giggle is typical for cannabis intoxication. Laughter arises for an insignificant reason and has a violent connotation. In temporal lobe epilepsy, focal seizures with expressive automatisms are observed – laughter, sobs.

In depressed patients, moodiness is sometimes also expressed predominantly by expressive actions. So, affective tension is “relieved” for a while if the patient, retiring, can “shout out”. Or he goes to a football match, where there is a reason to shout, not drawing the attention of others. The patient reports that in the morning he cries bitterly, after which he feels relief. Such acts are not addressed to the viewer, they are associated with the need for emotional release.

Paramimia. Perversion of expressive actions. For example, an unpleasant event is reported with a smile, a joyful one with tears. The distortion in the given example concerns innate expressive acts, manifests itself, as it were, at the vital level of expression. Meanwhile, there are culturally conditioned, conventional expressive actions. Expressive acts can have a purely individual character: separate postures, specific gestures, characteristic mimicry. Acquired acts of expression constitute an essential part of an individual's praxis. With organic damage to the cerebral cortex, the appearance of disorders of acquired expressive actions can be expected. So, with atrophic diseases of the brain, some patients lose their understanding of the meaning of expressive acts. A patient with Pick's disease, when making a request, salutes and tries to trip the doctor; leaving the conversation – squats in a curtsy.

Emotional and expression disorders are of great diagnostic value. So, euphoria is observed in alcoholism, progressive paralysis, neurolysis, tumors of the frontal-basal localization. Paroxysmal dysphoric episodes in epilepsy are considered as a mental seizure. Dysphoric reactions are very often detected in exogenous organic lesions of the brain.

Affective instability occurs in neuroses, asthenic states, vascular diseases of the brain; in the latter case, it is also characterized by weakness. In schizophrenia, emotional impoverishment, monotony, loss of affective responsiveness, parathymia, and emotional ambivalence are observed. Mental devastation sometimes reaches the degree of apathy. Emotional dullness is more

common in psychopathy. Explosiveness and affective viscosity are at the core of the emotional changes inherent in epilepsy. Coarsening of the emotional sphere inevitably occurs with toxic and other organic brain damage. Hypotimia, loss of emotional resonance, painful insensibility indicate the presence of depression, and hyperthymia characterizes manic states.

DISTURBANCES OF VOLITION

Volition is a conscious organization and self-regulation by a person of his activities and behavior, aimed at overcoming difficulties in achieving his goals. Volition is a special form of personality activity, a special type of organization of its behavior, determined by its own goal.

Hyperbulia is painfully increased volitional activity. Patients show painfully relieved resolve, in which any idea is immediately implemented, the possibility of correct discussion is reduced, and actions are hasty. Hyperbulia is a characteristic symptom of manic syndrome. In addition, delusional patients can detect hyperbulia when realizing their delusional ideas.



Pic. 7. Art illustration of hypobulia state.

Hypobulia is a painful decrease in the volition, in which the strength of motives, impulses is reduced, it is difficult to determine and maintain any goal. Patients do nothing, are sluggish, passive, sit for a long time or lie in the same position with an indifferent expression on their face (Pic. 7).

The extreme degree of hypobulia is called abulia (lack of volition) and is manifested by the lack of motives, loss of desires, complete indifference and inactivity, almost complete limitation of communication. A decrease in volition power is often combined with a depletion of emotions (up to apathy) and determines the clinic of apato-abulic syndrome (for example, in schizophrenia). Abulia is also found in senile psychosis, depression, asthenia.

Parabulia is a perversion of the volition, represented by various catatonic symptoms:

stupor – general motor retardation, numbness, accompanied by the loss of any contact with others;

mutism – loss of verbal contact with others while maintaining the vocal apparatus, unmotivated refusal to speak;

negativism – meaningless opposition, unmotivated refusal of the patient to perform any actions, sometimes in the form of an opposite action (active negativism);

stereotypy – constant, monotonous repetition of any action (motor stereotypes) or rhythmic, monotonous repetition of a word, phrase (speech stereotypes – verbigeration);

passive obedience – the patient cannot resist the orders of others and completely fulfills them, regardless of the content;

echopraxia – the patient completely repeats all the actions of another person;

echolalia – repetition of all or part of the speech of others, while the patient responds to a question addressed to him by repeating the question or the last words of the question;

catalepsy (wax flexibility) – manifests itself in an increase in muscle tone (this phenomenon develops gradually, starting with the muscles of the neck, shoulders and, then, covers the whole body), as a result of which the patient's body can maintain the position given to it for a long time, even if the position is extremely uncomfortable. The patient himself does not make any movements, but does not resist changing his posture and freezes in it for a long time.

Eating disorders

Bulimia – pathologically increased, excessive appetite, insatiable hunger, "gluttony". It can be observed with organic brain lesions, including sometimes with total dementia, in some cases with depressive conditions, states of anxiety ("stress"), bulimia nervosa (repeated bouts of overeating with excessive concern with controlling body weight; see below), endocrine violations.

Eating inedible (lime, chalk, earth, hair, paper, small objects, etc.) can be observed in persons who are unable to distinguish between edible and inedible objects (small children, patients with severe mental retardation, severe dementia), as one from options for impulsive actions (in patients with schizophrenia, personality disorders), and in fact when the drive changes (in women during pregnancy and children with micronutrient deficiencies, endocrine disorders, in stressful conditions, etc.). This also includes avoiding or limiting the intake of certain types of food (selectivity in food). For example, children with autism spectrum disorders are sometimes extremely selective in food, refuse any new dish, especially if it causes unusual taste and tactile sensations (too hard or, conversely, liquid, spicy or, conversely, bland, etc.).

Anorexia is a lack of hunger, loss of appetite, or deliberate refusal to eat. May be the reason for a decrease in the amount of food eaten or a complete rejection of it. Causes weight loss.

Types:

Somatogenic anorexia – with various somatic diseases: endocrine pathology, tumors – "syndrome of small signs" of cancer, chronic intoxication, aging, etc.

Mental anorexia – observed in various mental illnesses, including depression, catatonia, etc.

Anorexia nervosa is an independent disorder, expressed in a conscious, deliberate restriction in food intake in order to reduce body weight, while weight loss can reach a degree of severe cachexia with a possible fatal outcome. At the heart of the disorder is dysmorphophobia and / or dysmorphomania with a painful conviction of being overweight. The craving for food itself may not be reduced, and refusal from it is motivated only by painful experiences with a desire to lose weight. May be accompanied by bouts of bulimia followed by vomiting of food eaten (Pic. 8).

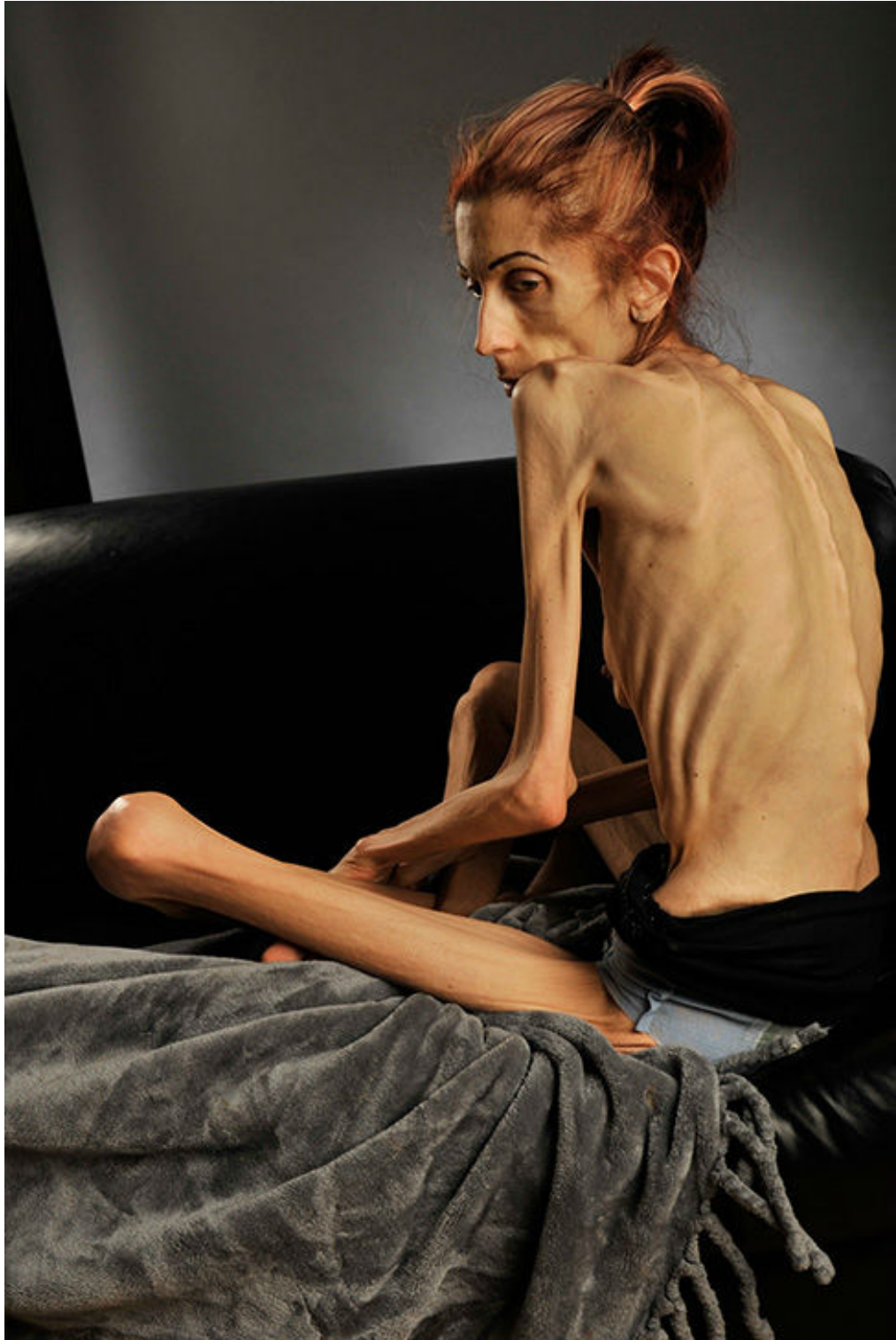
The 11th revision of the International Classification of Diseases (2019) lists the following types of eating disorders:

Anorexia nervosa (BMI <18.5 or -15% of age norm due to deliberate restriction of food intake or weight loss practices; low body weight is key to self-esteem or is misunderstood as normal or even overweight). There can only be a restrictive (food restriction) pattern or an overeating-purging pattern. There are three options for weight loss: weight loss, dangerous weight loss (BMI <14), and recovery with normal weight.

Bulimia nervosa (bouts of uncontrolled overeating of large amounts of food (at least 1 time per week in recent months) with compensatory behavior aimed at preventing weight gain - causing vomiting, taking laxatives, enemas, etc. No weight loss).

Compulsive (psychogenic / paroxysmal) overeating [binge eating disorder] - (bouts of uncontrolled overeating of large amounts of food (at least once a week in recent months) without compensatory behavior, but with distress and guilt).

Avoidance-restriction of food intake (avoidance of food intake, not associated with the experience of being overweight, while entailing a decrease in body weight or metabolic disorders).



Pic. 8. Patient with Anorexia nervosa in terminal state.

Sex drive disorders

Hypersexuality: nymphomania (in women), satyriasis (in men) – manifests itself in constant sexual dissatisfaction, erotic fantasizing, incessant search for new partners, casual sexual intercourse and, in general, a qualitative change in sexual behavior, in which sexuality becomes the main life goal of the individual. It can be observed in manic states, mental retardation, organic brain lesions, endocrine pathology, but it can also be an independent disorder. In ICD-10: increased sex drive (F52.7) and "excessive masturbation" (F98.8). In ICD-11: Compulsive Sexual Behavior Disorder. Close to "sex addiction".

Hyposexuality (hypolybidemia, in women - frigidity, "sexual coldness") – a decrease or loss of sexual desire, which is not secondary to other sexual difficulties (such as lack of erection or pain during intercourse). It may be associated with depression and anxiety, organic brain lesions, endocrine pathology, chronic intoxication (including alcohol, etc.), may be an independent disorder. The ICD-11 distinguishes: hypoactive dysfunction of sexual desire, dysfunction of sexual arousal (in women, in men - erectile dysfunction), orgasmic dysfunction (anorgasmia).

Catatonia is a syndrome of mental disorders in which movement disorders predominate in the form of akinesia (catatonic stupor) or in the form of hyperkinesia (catatonic agitation).

Catatonic stupor is characterized by the presence of increased muscle tone, which develops, as it were, from top to bottom (chewing muscles, cervical and occipital, then the muscles of the shoulders, forearms, hands and, last of all, the muscles of the legs). Hypertonia can appear in the form of stupor or in the form of waxy flexibility (catalepsy). In addition, with a catatonic stupor, negativism, mutism, and passive obedience are revealed (Pic. 9).

Catatonic agitation is characterized by an increase in motor activity, devoid of internal unity and purposefulness, with a desire for movement (as

opposed to a desire for action in manic syndrome), against which symptoms such as stereotypes, echo symptoms, paramimia, negativism, mimicry are noted. May be accompanied by pathos, ecstasy, anger, rage, indifference. As a kind of psychomotor agitation, it is dangerous both for itself and for those around it.



Pic. 9. The patient with catatonic schizophrenia frozen in a strange posture (in catatonic stupor)

Hebephrenic agitation – in the form of lumbarity, foolishness, antics, grimacing, foolish copying of the actions and words of others. Patients come up with extravagant outfits (using linen, newspapers, rags, etc.), pester others with inappropriate and cynical questions, try to interfere with others (throw themselves at their feet, push, grab clothes). Elements of regression of behavior are noted (they eat while standing, without a spoon, spitting and munching). In this state, they are either cheerful, laughing and giggling inappropriately, then whimpering and screaming or crying and howling, then becoming spiteful and

aggressive. More common at a young age with schizophrenia. It is often combined with catatonic syndrome.

DISTURBANCES OF CONSCIOUSNESS

Quantitative disturbances of consciousness

Nubilation – «cloudiness of consciousness», «veil on consciousness». The reactions of patients, primarily speech, slow down. Absent-mindedness, inattention, errors in answers appear. Carelessness of mood is often noted. Such conditions in some cases last minutes, in others, for example, with some initial forms of progressive paralysis or brain tumors, there are long periods.

Stunning – lowering, up to the complete disappearance of the clarity of consciousness and its simultaneous devastation. The main manifestations of stunning are an increase in the threshold of excitability for all external stimuli. Patients are indifferent, the environment does not attract their attention, the questions asked to them are not immediately perceived, and they are able to comprehend only relatively simple ones or only the simplest ones. Thinking is slow and difficult. The vocabulary is depleted. The answers are monosyllabic, perseveration is common. The views are poor and indistinct. Motor activity is reduced, movements are performed by patients slowly; motor awkwardness is noted. Depleted mimic reactions, marked impairment of memorization and reproduction. There are no productive psychopathological disorders. They can be observed in a rudimentary form only at the very beginning of the stun. The stun period is usually completely or almost completely amnesiac.

Somnolence a state of drowsiness, most of the time the patient lies with his eyes closed. There is no spontaneous speech, but the correct answers are given to simple questions. More complex questions are not comprehended. External stimuli can alleviate the symptoms of dullness and drowsiness for a while.

Stupor is a pathological sleep. The patient lies motionless, his eyes are closed, his face is unmoved. Verbal communication with the patient is impossible. Strong stimuli (bright light, strong sound, painful stimuli) cause undifferentiated, stereotyped protective motor and voice responses.

Coma is a complete loss of consciousness with a lack of response to any stimuli. Switching off of consciousness occurs with intoxication (alcohol, carbon monoxide, etc.), metabolic disorders (uremia, diabetes, liver failure), craniocerebral trauma, brain tumors, vascular and other organic diseases of the central nervous system. The Glasgow Coma Scale (see **Appendix**) is a clinical scale used to reliably measure a person's level of consciousness.

Qualitative disturbances of consciousness

Delirious syndrome (delirium) is a hallucinatory clouding of consciousness with a predominance of true visual hallucinations and illusions, figurative delirium, variable affect, in which fear, motor excitement prevails. Delirium – the most common type of clouding of consciousness, can occur in response to any external (exogenous) harm (see reactions of the exogenous type), including in connection with intoxication (psychoactive substances, including alcohol and drugs, drugs, intoxication in infectious diseases, with renal, liver failure, etc.), severe somatic diseases, in the acute period of traumatic brain injury, acute cerebrovascular accident, etc. (Pic. 10).

Usually, the condition occurs quickly (hours, days), diurnal fluctuations in severity are characteristic (undulating course) with worsening at night.

The course depends on the causing reasons. For example, in case of delirium caused by intoxication, the duration is determined by the time spent by toxic substances in the blood.

On average, delirium usually lasts a few days (or possibly only nights), but can vary significantly from hours to weeks or even months (rarely).

Since delirium as a clouding of consciousness is based on impaired cognitive processes (perception, thinking and understanding, attention, memorization), this condition, especially in elderly patients, requires differential diagnosis with dementia. Unlike dementia, delirium develops rapidly, the state of cognitive processes is changeable, like emotional reactions and the psychomotor sphere, deterioration is characteristic of the night time, and

deceptions of perception (illusions, hallucinations) are characteristic. With dementia, the intellectual-mnemonic decline is expressed and persistent, it is characterized by a more or less gradual development. It should be borne in mind that delirium can develop against the background of dementia.



Pic. 10. Illustration of hallucinations of patient in delirium state.

Severe delirium reflects the addition of symptoms of switching off consciousness in connection with the aggravation of the somatic and / or neurological condition of the patient.

Professional delirium – oppression of consciousness leads to the fact that among the experiences of patients only those that are associated with the most automated activity for them remain. Usually this activity is work. These patients are usually no longer able to get out of bed, but they are actively waving their

arms, as if performing a professional activity (for example, a turner seems to be working on his machine, grinding out parts, a driver is driving a car, at times yelling for someone to leave the road, etc.). Since for many persons suffering from alcoholism, the most firmly learned "professional" skill is the situation associated with a feast and drinking alcohol, many of them in this state of experience are associated with this.

Mussitating (muttering) delirium – even greater depression of consciousness leads to the fact that patients only retain excitement within the bed, thinking loses any coherence, patients mumble something indistinctly, speech is incoherent, it is impossible to judge the content of experiences in this state. Usually, patients are practically inaccessible to productive speech contact, sometimes they can only answer the simplest questions (for example, give their name). After coming out of this state, total amnesia is characteristic.

Amentia – sometimes stands out as an independent type of clouding of consciousness, but in fact it is a variant of delirium (confusion) in combination with symptoms of switching off consciousness to the level of stunning. Speech and thinking are incoherent, the face often expresses confusion, chaotic excitement within the bed is noted, they rob themselves, productive contact is impossible, patients are somatically weakened.

An increase in the symptoms of switching off consciousness in delirium indicates the severity of the patient's condition and an unfavorable prognosis.

Oneiroid syndrome (oneiroid clouding of consciousness) is a clouding of consciousness with an influx of involuntarily arising fantastic representations containing modified fragments of what has been seen, read, heard, experienced, sometimes isolated, sometimes intricately intertwined with distortedly perceived details of the environment; emerging pictures - dreams, similar to dreams, usually follow one after the other in a certain sequence so that one event seems to follow from the other, that is, they differ in stage-like nature; persistent

affective (depressive or manic) and movement disorders, including catatonic disorders (Pic. 11).



Pic. 11. Illustration of the patient's experiences in a oneiroid state.

Visual representations and pseudo-hallucinations follow one another so that one situation seems to follow from another (scene-like, dreamlike - just like we see a dream, only this "dream" the patient sees in a state of wakefulness and cannot get rid of it), these images can be intertwined with the details of the environment (for example, the patient feels in the depths of the sea, which is depicted in the photo wallpaper in his room) or perceived in isolation from what surrounds the patient.

Patients feel that they are participants in the action (they are "reincarnated" into heroes of dreams - from any famous historical personalities, for example, in Jeanne D'arc, to completely unnatural characters - the patient

says that he has turned into "the 13th zodiacal constellation of Lenin"), and he is in the "center of the struggle between good and evil." Often this is accompanied by a feeling of enthusiasm (in the expansive version, for example, the patient feels like the savior of the Earth, since he just, while flying in space, stopped a falling meteorite with his hands), bewilderment or complete horror (in the depressive version, the patient is in complete despair, so as she sees how the entire Universe is collapsing before her eyes - "the planets go off their axes and fall on the Sun", "knows" that it is she who is to blame for this).

This state is characterized by detachment from the environment - immersion in their experiences, while the real situation is perceived only partially. It is often possible to note "double orientation" - the patient simultaneously admits that he is physically here (for example, in a hospital), but at the same time his soul, avatar, astral body, etc. are in a completely different world. For example, a patient, upon admission to a hospital, says that she feels as if she is "at the same time" physically in the emergency room of the hospital, and some part of her "at this time is crawling like a snail along the slope of the lunar crater".

Experiences "absorb" patients to a state of motor numbness - manifestations in a wide range from catatonic sub-stupor with periods of immobility (freezing) up to extended catatonic stupor.

After exiting the state, partial amnesia of real events is usually observed, memories of painful experiences are better preserved.

It is observed mainly in schizophrenia. In these cases, the full development of oneiroid usually goes through a number of stages (derealization, illusory, hallucinatory-delusional disorders, etc.), which takes a long time. The duration of the oneiroid is usually weeks.

Twilight clouding of consciousness (twilight consciousness; «twilight») is a sudden and short-term (minutes, hours, days – less often longer periods)

loss of clarity of consciousness with complete detachment from the environment or with its fragmentary and distorted perception while maintaining habitual automated actions.

It is a state of clouded consciousness in which the individual is temporarily unaware of his or her surroundings, experiences fleeting auditory or visual hallucinations, and responds to them by performing irrational acts, such as undressing in public, running away, or committing violence. The disturbance occurs primarily in temporal lobe epilepsy, dissociative reactions, and alcoholic intoxication. On regaining normal consciousness, individuals usually report that they felt they were dreaming and have little or no recollection of their actual behavior.

CLINICAL CASES

Clinical illustration №1

Patient A., a 68 years-old woman, re-enters in the direction of a psychiatrist for treatment in connection with the deterioration of the condition.

COMPLAINTS: "depressed mood, poor appetite, sleep disturbance, irritability, thoughts that I will not be cured."

HISTORY: Heredity, according to the patient, her father suffered from bipolar disorder.

Early development is normal. She finished the university and got an engineer dirge. She has been working for long time as an engineer at the plant. Currently she is a pensioner, does not work. Married, the relationship with husband is good. Has two adult children. Lives with her husband. The family's material and living conditions are satisfactory. Of the past illnesses, she notes colds. History of peptic ulcer of the 12th intestine, uterine fibroids for about three years. She denies Tbc, hepatitis, TBI, skin and veins diseases. Epidemiology is safe. Allergic anamnesis is not burdened. Menstruation from 15 years. Menopause began at the age of 50.

Has no bad habits.

Premorbid personality: She describes herself as "anxious, suspicious, sociable, emotional, executive".

She considers herself ill since 2000, when mood swings from elevated to lowered began to be noted. She was first treated inpatiently in 2002 with a diagnosis of "Mild depressive episode without somatic symptoms." In the future, seven hospitalizations for depressive conditions of varying severity (from mild to severe). Between episodes of depression, there were states of elevation, unusual for the patient's usual state, accompanied by excessive activity, but for such conditions she was not treated. Diagnosis changed to Bipolar Affective Disorder. After discharge in 2013 for 3 years she took

Carbamazepine and felt well. The last hospitalization was about a year ago, when she was experiencing "a decrease in mood, apathy, indecision appeared, there is no joy in life, everything is a burden". Took treatment: Gidazepam, Velaksin, Truxal. Outpatient Velaksin 75mg per day, Lamotrin, Truksal. She notes a deterioration in her condition within 2 weeks, when her mood dropped again, thoughts appeared that "I will not be cured any more." Accompanied by her husband, she was brought to an appointment with a psychiatrist in the outpatient department. Hospitalized in the hospital.

MENTAL STATUS: Clear conscious. She is oriented correctly all-round. Available to the contact. Fixes a gaze, speech at a normal pace. Complains of "depressed mood, I do not want to communicate with anyone, irritability has appeared". The mood background is lowered. Fixed on her state of health, "I was worried at home, I had thoughts that I would not be cured... time had run out and I would be sent to jail". She is hypochondriac, "my whole intestines are clogged, I haven't had a stool for a week, I drink a laxative, but there is no complete cleansing, but what will happen if there is no stool? And what will happen if there is no stool?" She considers herself to be seriously ill, asks "did you still have such seriously ill patients?". The expression on her face is capriciously dissatisfied, "how long I have been treated and nothing helps." She tries to dramatize her condition, but at the same time notes that "after Velaksin I felt a little better, I was doing housework at home, but through force...". Notes daily fluctuations "in the evening it becomes easier." She is demonstrative in her behavior, sighs, walks waddly, periodically looks into the distance through the window, takes the curator by the hand, "are you not sending me to the acute department?" Requires increased attention. Unstable emotional reactions are quickened, from tearfulness to complacency, irritability. Thinking is torpid. Delusions, disorders of perception are not revealed. Denies suicidal thoughts. There is no pronounced ideatorial inhibition. Does not reveal intellectual-

mnesic disorders. Outwardly well-groomed. The criticism of the state is formal. He does not refuse hospitalization or treatment.

The first time in the department: the patient is available to contact, outwardly depressed, speaks in a low voice. He answers the questions on the merits, declares that he does not eat for 2 weeks, because her intestines do not work and she does not recover within 2 weeks. She declares that she tried to tighten a ribbon around her neck in order to hang herself, because: "I didn't want to go to the hospital, I tried it, but it's hard," while sighing heavily, repeating that nothing will help her. In the morning she refused food, said that her intestines were clogged and she was dying of intoxication. With the diagnosis: "Bipolar disorder, current episode of severe depression with psychotic symptoms and suicidal attempt" was transferred to the acute ward.

In the acute ward, the background of the mood is reduced, says, "Look at my intestines, I haven't gone to the toilet for 3 weeks already, I already need to do special procedures for washing the intestines, not only the thick one, but the thin one is already clogged, and soon everything will be on the neck will pick up ... everything swells up and will not work out".

Examined by the associate professor of the Department of Psychiatry of ZSMU: The patient is available to productive contact. Speech at a fairly fast pace. Facial reactions change, sometimes she even smiles, but at the mention of bowel function she instantly becomes sad, with an expression of despair, which is also expressed in her statements. Believes that her intestine is swollen and digests only small part of the food, this problem with intestinal repair has become dominant in her mind and depresses her even more than her depressed mood. The current admission is associated with a suicidal attempt, which she explains, "she didn't want to be a burden to her loved ones," that is, in the clinical picture, a depressive-paranoid syndrome is currently revealed. Delusional ideas about the structure of a hypochondriacal nature, but at the same time, there is a painful belief that these unusual manifestations of bowel

function are associated with the intake of Velaxin. From a conversation with the patient, it was found that Anafranil had a good effect in previous hospitalizations. Assessment of the current condition makes it possible to confirm the diagnosis: "Bipolar disorder, current episode of severe depression with psychotic symptoms with a suicidal attempt."

ADDITIONAL SURVEY DATA:

Neurologist: Initial disorders of cerebral circulation.

Psychologist: the identified symptoms can be attributed to affective-endogenous (endogenous-depressive) register syndrome.

FINAL CLINICAL DIAGNOSIS: Bipolar disorder, current episode of severe depression with psychotic symptoms with suicide attempt. F31.5.

MEDICAL TREATMENT: Clomipramine 25 mg x 2 daily; Risperidone 1 mg in the morning, 1 mg in the evening, Diazepam 2.0 ml im №3.

Clinical illustration №2

Patient B., a 30 years-old man, was re-admitted to a psychiatric hospital for treatment for the second time this year.

COMPLAINTS: «Constant tension, poor appetite, frequent awakening in the middle of the night, despite taking medications, it is difficult to concentrate attention, the world seems to have become flat, has lost perspective, depth, sad and annoying mood, apathy to everything».

HISTORY: Heredity is burdened: the mother's grandmother suffered from schizophrenia. Pregnancy in a mother with toxicosis. Childbirth with stimulation, screamed at once. In 12 hours after birth, the condition worsened (secondary asphyxia). Was transferred to the intensive care unit, was treated with a diagnosis: "Intranatal trauma, posthypoxic encephalopathy. Syndrome of oppression of the central nervous system. Paresis of the right foot». He was treated twice in a neurological hospital, followed up by a neurologist. In childhood, he was mobile, restless, suffered from enuresis, suffered from

jaundice, enterocolitis. He graduated from the 11th grade of secondary school, then the university with a degree in psychology. Does not work. Not married, has no children. Lives with his parents (mother is currently abroad).

From the past diseases: colds, at the age of 12 TBI with concussion (in physical education). Denies viral hepatitis, skin diseases. Epidemiological environment is favorable. Denies an allergy to the medicine.

He uses alcohol sporadically, denies dependence on alcohol, but says that during periods of mental deterioration he uses 200-250 g of cognac "to improve sleep, and a week ago he drank 1 bottle of vodka." Periodically smoked cannabis, currently denies the use of it.

He was first treated in the pediatric department in 2005 with the diagnosis: "Residual-organic lesion of the central nervous system with hyperdynamic syndrome. Enuresis". Repeatedly from 25.10.2005 until 13.12.2005 he was treated in an acute ward, with complains of sleep disturbance, he declared "an insight had come to him," began to think a lot on philosophical topics, and was irritable. In the department, he revealed manic symptoms, was verbose, declared that there was a feeling "that everyone understands all my thoughts... a feeling of happiness." Discharged with a diagnosis of "Acute polymorphic psychotic disorder with symptoms of schizophrenia on a residual organic background." The third hospitalization from 24.02.2009 until 04.03.2009 in the department of neuroses, then he complained of apathy, insomnia, confused day and night, declared that he could not concentrate, "the mood changed in a day up to 3 times." Was discharged with a diagnosis of Bipolar Affective Disorder, current episode of mild depression. He had four hospitalizations since 25.01.2010 to 10.03.2010, and then he complained about the frequent change of mood, declared that "I don't want to do anything, apathy, my mood has dropped, and I watch TV stupidly."

He was found by his father in the bathroom, where he lay motionless, did not answer the question, could not explain anything. Was in the toxicology

department of the city hospital, was discharged a day later. After being discharged from a psychiatric hospital, he took antidepressants irregularly. Since 2010 the patient notes an elevated mood, ability to work. In 2013, while working in the city cleaning service, he “fought against corruption,” clashed with the authorities, and was asked to resign. In 2014 he became interested in politics and started working as a correspondent.

At that time, within 6 months, he tattooed most of his body – on each finger on his hands, on the hands of both hands, in the chest area, on the forearm, he explained – “I was in euphoria then.”

The condition began to deteriorate for no apparent reason at the beginning of December 2017: sleep and appetite worsened, anxiety appeared, he stopped writing articles, “job satisfaction disappeared”. He began to notice fatigue, impotence, difficulty concentrating, lack of desire to do something. He began to take alcoholic drinks every evening in order to “somehow alleviate the state of health.” He turned for help on his own and from 01.29.2018 until 19.02.2018 was undergoing treatment at the psychiatry hospital with a diagnosis of “Bipolar Disorder, current episode of moderate depression without psychotic symptoms.” Discharged in satisfactory condition. After discharge, he took drug therapy: Valprokom, Paroxin, Truxal. He stopped taking Amitriptyline, which explains the real deterioration: “After leaving the department, a day after I felt very bad, a lot of stress, I did not know what to do, and drank a bottle of vodka. The next morning I woke up in a very good mood, almost completely healthy. I didn't drink any more alcohol. But after a few days, the mood began to decrease, the tension increased, and there was irritability. The condition is very unstable. I asked for help”. Hospitalized.

MENTAL STATUS: In a clear mind. He is oriented correctly all-round. Willingly makes contact. Seeking help. He wonders what kind of treatment he will receive. Mimic reactions are lively, posture is free, actively gesticulates. Looks calm, restrained. Notes that “now the state is more mixed than depressive

or manic. I can control myself, but I understand that there is no stability. I need supervision. The colors of the world have become drier, although yesterday the muse came to me and I drew on the computer, while more important things had to be done. " Notes that there is no holistic perception of the surrounding world - "the colors are wrong, the music is wrong, everything has become kind of flat ... I feel that depression does not let me go." Speaking and thinking at a normal pace. Psychomotor retardation is not observed. He speaks evasively about previous hospitalizations, does not reveal his feelings. He emphasizes that in 2010 he did not make a suicidal attempt - "it was such a state that I could not move, and my father was scared and called an ambulance." Denies cravings for alcohol, but no symptoms of dependence and withdrawal have been identified; also denies regular drug use, "once every six months I can smoke weed with friends." Memory, intelligence are not impaired. He categorically denies suicidal thoughts, there is no pessimistic assessment of the future. I am positively disposed towards treatment: "I will tell you about my feelings every day." He is sleepy during the day. In conversation, he is mannered, demonstrative. The condition remains unstable. He is inclined to reasoning, expresses his complaints in a flowery and artistic manner. Comes into contact willingly. A mood tinged with irritation. Denies dependence on alcohol, quits smoking, and "it increases the irritation." The hospital environment does not burden him. Notes that "at the present time the colors have acquired the correct, natural tones, I am thinking about the prospects, but I'm not doing anything yet ...". Continues to complain of depression, bad mood, apathy, irritability. The patient claims that "the state is not changing, I am not very bad now, but not good either ... I cannot feel the same as before, everything is perceived as something flat, apathy has appeared, I do not want anything - neither work nor rest ..." ... The leading complaint at the present time is "a feeling of general tension, anxiety."

During the treatment, the patient's condition remained unstable for a long time. Subdepressive mood was combined with complaints of irritability, agitation and at the same time apathy, light periods of inexpressive "rise" were short-lived. Currently, during the last week, emotional stability has appeared, mood has improved, and plans for further work have appeared. Mood is good. Critical to the disease. Understands the need for drug therapy, is tuned in to a sober lifestyle. During his stay on treatment, he did not drink alcohol. Does not detect psychotic disorders, does not express suicidal thoughts. He can be discharged from the department.

On the background of treatment, side effects, complications were not observed.

ADDITIONAL SURVEY DATA:

Psychologist: the identified symptoms can be attributed to affective-endogenous (endogenous-depressive) register syndrome.

FINAL CLINICAL DIAGNOSIS: Bipolar disorder, current episode of mild depression without physical symptoms. F31.30.

MEDICAL TREATMENT: Fluxen 20mg in the morning, Truxal 25mg at night, Valprokom 300mg x 2 per day.

Clinical illustration №3

Patient C., a 36 years-old man, went to a psychiatric hospital on his own, accompanied by his father, due to a poor mental state.

COMPLAINTS: "... I have depression."

HISTORY: Heredity is not aggravated by mental illness. The father abuses alcohol. The patient was born from the 2nd pregnancy, 2 births, which proceeded without pathology. Early development with little delay. By nature, he was formed with features of sensitivity. The patient went to school with his peers. He had no particular hobbies. He graduated from 11 classes, after which he entered the correspondence department of the university. At the age of 18 he

was drafted into the army. While serving in the army, he suffered "rubella", was treated in a hospital. He was demobilized on a general basis, continued his studies at the college, but left his studies from the 4th year. He began his career at a metallurgical plant. He has no bad habits, although from time to time he smoked "weed" in the company, and, according to his father, from time to time took alcohol. He has a common-law wife and a child of 8 months. The patient's mother died in 2007 from cancer. The patient is a disabled person of the II group.

Past diseases: ARVI, furunculosis and rubella. TVS, TBI, viral hepatitis, STDs denies. Epidemiology is safe. Allergic anamnesis is not burdened.

He has been mentally ill since the fall of 2003, then for no reason he developed rapid fatigue, lethargy, and began to feel the need for frequent rest. At the beginning of December 2003, euphoria suddenly arose, working capacity and sociability increased, the pace of thinking accelerated, began to make unnecessary purchases, and thoughtlessly spend money. Soon there were delusional ideas of persecution, he felt that he was being followed, being watched from neighboring houses. It seemed to him that some TV programs were broadcast specifically for him, he communicated telepathically with the singer Britney Spears, "saw" her winking at him from the TV screen, was going to go to her in America, was waiting for her to visit him. Around him he felt "the struggle of the forces of good and evil - God and the devil", was under the auspices and fought with the devil, who wanted to take over the Earth. He believed that he was entrusted with the mission of protecting the world and destroying all weapons on Earth, and if he did not do this, then time could turn back. He felt the acceleration of the flow of time, "every day the time was turned off a year ago." He was agitated, behaved inadequately at home, constantly changed his clothes. He stated that the world around him had changed, that various "voices" of a commenting nature were communicating with him, the people around him seemed hostile.

In connection with this condition, in 2003 he was first hospitalized in a psychiatric hospital, where disorientation was noted, he believed that he was in a prison where the patients were prisoners and the medical staff were warders. He experienced false recognitions. After the psychosis was cured, a depressive state developed (mood worsened, a feeling of inner emptiness, apathy, joylessness arose, sleep was disturbed, appetite decreased). Took Risperidone at a dose of 2 mg per day, Citalopram, Sertraline. He became a little more active, took part in labor processes, began to take care of himself. After being discharged in 2004, he did not go to work, spent time aimlessly, did not leave the house.

In 2004 he was treated at the VM Bekhterev Institute in Moscow with a diagnosis of "Schizoaffective disorder, atypical depression syndrome." During the treatment, he underwent 9 sessions of electroconvulsive therapy. After being discharged, he felt good, got a job as a security guard at a football club. Remission was observed for 5 years.

A repeated deterioration in 2009, then, against the background of the cessation of taking medications, sleep was disturbed, he became conflicted, for some reason he pounded his fist on the TV, the electric meter, stating that negative energy emanated from them. He began to feel unpleasant smells that emanated from food, left home, wandered down the street, returned, began to smash furniture, broke the glass in the apartment (injured his hand). He became aggressive in his statements about his father, in connection with which he was re-hospitalized and was undergoing treatment with a diagnosis: "Schizoaffective disorder. Manic type." After discharge, he regularly took medications, another deterioration in 2012.

This year he was re-treated at the Institute of VM Bekhterev, Moscow, was discharged with a diagnosis: "F 20.01, depression, asthenic-apathetic syndrome." The course of the disease is episodic, during periods of exacerbation at the height of experiences, throws things out, breaks furniture, feels unpleasant

odors. In total - 9 hospitalizations in a hospital, the last in 2016, when he did not sleep, left home, was ridiculous in his statements, there was an episode when he suddenly began to break furniture at home. Was discharged with a diagnosis of "Schizophrenia, paranoid form, episodic flow with increasing apato-abulic defect. Hallucinatory-paranoid syndrome ". After discharge, he took medications. The condition worsened a week after discharge - sleep disturbance, decreased appetite, apathetic. He independently went to a psychiatric hospital, accompanied by his father. Hospitalized.

MENTAL STATUS: In consciousness, he is oriented all-round correctly. Available to the contact. Calm. He said: "I am depressed, I do not want anything ...". Emotionally lowered. Poor facial expressions. The mood is lowered. He denies deceptions of perception, does not actively express delusional ideas. He says: "I did nothing at home, I just lay there." There are no aggressive tendencies.

First time in the department. The contact is formal. Tense, suspicious. He does not deny his aggressive behavior, states that he broke furniture and electrical appliances, because he felt the influence from them, suspected that he was being watched. Actively expresses delusional ideas of influence. He evasively speaks of the presence of "voices" - "I don't remember ...", but then he said that "I heard both male and female voices in my head, which said to kill myself, kill my father".

On treatment within a week, he came out of psychosis, fully discloses his experiences, is quite critical. He describes the sensations that he felt the influence of the TV, "I became like between heaven and earth, in another dimension, I did not understand what was happening around, as if everything was being done specifically for me and against me ... orders were coming from the TV, people on the street exchanged glances, followed from the cars ... could not figure out what to do. " When talking about his experiences, tears appear in the eyes of the patient, he regrets his behavior (he kicked out his wife and child

and hit his father), asks for help. Interested in how to prevent further exacerbation of the disease.

Emotional-volitional decline, obedience, narrowing of the range of interests came to the fore in the clinical picture of the disease after the relief of psychosis. On dates with his wife and father, he asks for forgiveness. Thinking is consistent, amorphous. There is criticism of the disease. Does not reveal aggressive, autoaggressive tendencies. Configured to take medication. Discharged from the department accompanied by his wife.

On the background of treatment, side effects, complications were not observed.

ADDITIONAL SURVEY DATA:

Therapist: Hypertonic disease II degree, risk II.

FINAL CLINICAL DIAGNOSIS: Schizophrenia, paranoid form, episodic type of course with increasing emotional-volitional decline. Depressive-paranoid syndrome. F 20.01.

MEDICAL TREATMENT: Aminazine 100 mg at night; Zuclopentixol-depot 200 mg / m 1 time in 3 weeks.

Clinical illustration №4

Patient D., a 36 years-old man, went to a psychiatric hospital on his own, accompanied by his father, due to a deterioration in his mental state.

COMPLAINTS: severe weakness, itching hands, feet, "nervous weakness" during the year.

ANAMNESIS: Heredity is not aggravated by mental disorders. He was brought up in a dysfunctional environment "parents often quarreled." Early development was unremarkable. Grew and developed according to age. Higher education, graduated from the Engineering Academy, received the education of an electronic engineer. Labor activity since 1985, worked at the plant until 2001, then in private companies and as a distributor in the market, as an

electrician. Not working since 2006. The patient served in the army. The patient is married for 27 years, has a son of 26 years old, the patient lives with his family. From past illnesses: colds. Viral hepatitis in 1977. TBI, STDs denied. Allergic anamnesis is not burdened.

He was first treated in a psychiatric hospital in 1997 with a diagnosis of "Hypochondriacal neurosis in a psychasthenic personality." Then he believed that "I was sick with something - an infectious disease, cancer." He complained of weakness, headaches, numbness of the limbs; stated that "his wife avoids having sex with him, he was afraid that the family would fall apart, because of this he loses his ability to work at work, I see no way out of this situation." Was discharged in satisfactory condition. Had 2 jobs.

In 2000 he was dismissed from the plant and also lost his job at the company. When looking for another job: "everything did not fit", "could not work with people." During this period, he communicated with neighbors in the hostel, and less with friends. According to his wife, from 2000 to 2006 "something oppressed him, he was not actively looking for work, he stopped working at home, about which there were conflicts." In 2006, his wife bought an apartment and left the hostel with her son. The patient stopped going outside and did not buy anything, twice a week his wife brought food, but he also began to eat this food less, lost 30 kg in 6 months.

Re-hospitalization in 2007 with a diagnosis of "schizotypal disorder with a predominance of ideas of attitudes and apathetic depression." Then he complained "of a very depressed state, mental retardation, bad mood, poor sleep, the body stopped, digestion does not work, constipation, it is difficult to remember." In the department he declared - "I became like inanimate, the nervous system was destroyed, I became inhibited, it seems that everyone would deceive me, the world had somehow changed, there was a feeling that thoughts are known to others, life ended, became unnecessary". On treatment with neuroleptics, antidepressants, a condition with positive dynamics. Discharged in

satisfactory condition with formal criticism. After being discharged, he returned to his wife's apartment.

About a year later, he became irritable, angry, found in ordinary things that which annoyed him, "scandals arose out of nothing." The wife noted episodes when everything was destroyed, in connection with which the neighbors called the police. A year later, the wife and son went to live in a hostel. Over the next 6 months, the patient lived on his own, did not wash, did not shave, and grew a beard to the waist.

From the outpatient card: he did not visit a psychiatrist in the clinic, he did not take medications. The patient's wife and son came to the psychiatrist's appointment and said: "We lived in our son's dorm, because we were hiding, my son and I are afraid of my husband. For more than a year he has not left the house, has not worked, has let himself go, has not washed, has not cut his hair, nails, has let go of his beard, eats the food that I brought. " "He spontaneously becomes spiteful, aggressive towards his family, says not to the point" "evil spirits come from me... I was thrown out of life ". Closes in the room - "you poison me at night." He insults his wife and son, shows aggression towards them, broke doors and furniture. He constantly talks to himself, does not sleep at night. On the eve of hospitalization, he hit his son with a broom, poured tea in his wife's face. In connection with this condition, he was hospitalized forcibly.

He was treated in a psychiatric hospital with a diagnosis of "Schizophrenia, paranoid form, episodic course with a pronounced emotional-volitional defect. Hallucinatory-paranoid syndrome with aggressive behavior. After being discharged from the words of his wife: "He was shaking all the time, did not go anywhere else, was not interested in anything, did not go anywhere, did not communicate with his family for 2 years." Over the past year, he is passive, lack of initiative, complains that his hands are suffering. For the last 3-4 months he has been constantly complaining of weakness, that he has no teeth, poor digestion and possibly heart disease. " Hospitalized.

PSYCHSTATUS: In consciousness, he is oriented all-round correctly. The thinking is consistent in tempo and is not changed. He expresses various complaints about how he was observed by various doctors about weakness, decreased vision, "my legs are suffering", "now I feel good, but before I was psyched, maybe my heart is sick, I went to a therapist, a neurologist, I live quietly , calmly, occasionally attacks of fear, I'm afraid of the future. " In the department passive, lack of initiative, autistic. He lies on his bed all the time, is sociable on dates with his wife, and is active in conversations with the doctor. She reports that during the year "it's hard to do everything, thoughts are different, my legs twist like in rheumatism, my ears ring, I have compensated mitral defect and arachnoencephalitis". He considers himself a sickly person, but there is no clear conviction that he is sick with some incurable disease and he was not diagnosed. These experiences are devoid of affective saturation, liveliness and do not affect the patient's behavior. He calmly says that he did not accept the treatment prescribed by the neurologist because there was no money. Doesn't insist on any examinations and consultations. Emotionally lowered, amimic, but in a conversation he revives in response to a joke. He does not make plans for the future. Does not reveal deceptions of perception. Does not express delusional feelings.

On treatment, his condition improved: he became more active, the number of hypochondriacal complaints decreased, he actively does not present them, and when asked, he says that now it does not bother him much. Does not reveal active delusional hallucinatory symptoms. Emotional-volitional decline comes to the fore. Being on medical leave at the initiative of his wife, he was involved in work. Does not reveal asocial, suicidal tendencies.

FINAL CLINICAL DIAGNOSIS: Residual schizophrenia with a pronounced mixed type defect (asthenic, apato-abulic). F 20.5.

MEDICAL TREATMENT: Triftazin 5 mg 2 times a day, Cyclodol 2 mg in the morning.

Clinical illustration №5

Patient E., a 65 years-old man, went to a psychiatric hospital on his own due to a deterioration in his mental state.

COMPLAINTS: "My wife refuses sex, f***s with all the idiots, and I, Nicholas Ladies'-man, refuses".

History: Heredity aggravated by schizophrenia in a maternal grandfather. He studied well, graduated from college. He served in the army full time. Has a long work experience. Married. Has 2 adult children, lives with his wife and daughter.

Mentally ill since 1975, when he became angry, aggressive, hallucinatory-paranoid symptoms were observed - he experienced auditory hallucinations, expressed delusional ideas that he was being pursued by foreign intelligence, tried to hang himself. He was first treated permanently in 1975, diagnosed with F 20. The course of the disease is continuous. In the clinical picture, oneiroid states, affective-delusional symptoms were noted. More than 20 hospitalizations in a hospital. During the last 11 years he has been attending a day hospital. From 1984 to 1985 he was on compulsory treatment for hooliganism. In 2012, with a suicidal aim at the height of depressive experiences, he drank 46 tablets of Clozapine, was in the intensive care unit. Hospitalization in 2015, then there was a resistance to the therapy. In the clinical picture, hallucinatory, oneiroid symptoms with aggressive tendencies.

A real deterioration within 2 days: does not sleep at night, speaks volumes, sings songs, easily gets annoyed with his wife, accuses her of treason; beat her up. Hospitalized.

MENTAL STATUS: In consciousness, he is oriented all-round correctly. Voluptuous, speech is loud, at an accelerated pace. Brutally, cynically speaks about his wife, declares: "She walks all her life, gets fucked with everyone, but to me, Nicholas Ladies'-man, does not give...". He does not deny that he

"grabbed her by the hair." Scratches on the body explains that he "had a fight with his wife." The mood is elevated, easily affected. Follows instructions after reps. He does not actively express delusional ideas. There is no criticism.

In the department, at first he was long-spoken, motor active, declares: "Give me permission to get married." The mood is unstable, irritable, easily embittered, the feelings are not fully disclosed. He calls himself Nicholas Ladies'-man. Sexually disinhibited; Repeatedly repeats that his wife "did not give", calls her names. Speech at an accelerated pace, thinking with slipping, reacts to remarks for a short time. Laughs loudly, declares: "Again in the hospital, it's all because of my wife ...", "I'm French, and the French don't give up." Sings songs.

Subsequently, he became calmer, in behavior ordered. Thinking is consistent. The mood is uncertain. Spends time sitting in the lobby. Declares: "I was left alone, my wife does not need it." He speaks rudely and cynically about his wife and daughter. He has no real plans for the future. Does not reveal psycho-productive symptoms.

Against the background of the therapy, the state with positive dynamics, sleep and appetite returned to normal, outwardly calm, answers questions to the point. The background of the mood is even, the behavior is ordered. Does not reveal psycho-productive symptoms. Diverse thinking. He was released on home leave, his condition is satisfactory, his relationship with his wife is even. He denies suicidal thoughts, there are no aggressive, auto-aggressive tendencies. May be discharged accompanied by a wife.

ADDITIONAL SURVEY DATA:

Therapist: Chronic bronchitis. Ischemic heart disease. Diffuse cardiosclerosis. ARVI. Chronic iron deficiency anemia.

Dermatologist: Chronic eczema.

Surgeon: Chronic erysipelas.

Neurologist: Cerebral atherosclerosis. Encephalopathy

FINAL CLINICAL DIAGNOSIS: Schizoaffective disorder, mixed type.
The syndrome of angry mania. F 25.2.

MEDICAL TREATMENT: Valprokom 500 mg - 3 times a day.
Aminazine 50 mg at night.

Tasks and tests

Materials for test control (I level)

1. What emotional changes are characteristic of organic personality disorder:

- A. Apathy
- B. Emotional lability
- C. Euphoria and flat, inappropriate jokes
- D. Irritability and / or outbursts of anger and aggression
- E. All of the above

2. For the emotional and volitional sphere of patients with schizophrenia is typical all of the above, except:

- A. Dysphoria
- B. Negativism
- S. Abulia
- D. Ambivalence
- E. Ambitiousness

3. An attack of emotional disorder with a very strong affect of sadness and fear:

- A. Melancholic raptus
- B. Agitation
- C. Pathological affect
- D. Catatonic excitation
- E. All of the above

4. Inhibition, autism, negativism, Dupre's symptom are characteristic of:

- A. Manic stupor

- B. Hallucinatory stupor
- C. Depressive stupor
- D. Epileptic stupor
- E. Catatonic stupor

5. For depressive syndrome, everything is typical, except:

- A. Low mood
- B. Motor retardation
- C. Unstable delusional ideas of a depressive nature
- D. Slowing down the associative process
- E. Detail of thinking

6. In grief, as in depression, there are the same symptoms, except:

- A. Sorrow
- B. Feelings of loss
- C. Loss of self-esteem
- D. Loss of interest in the world around
- E. Impairment of the ability to love

7. Which of the following applies to quantitative disorders of consciousness?

- A. Delirium
- B. Sopor.
- B. Stunning
- D. Amentia.
- E. Twilight dizziness.

8. What criteria indicate a violation of consciousness?

- A. Allopsychic disorientation.

- B. Depression.
- B. Illusions.
- D. Disorders of thinking.
- E. Partial or complete amnesia.

9. What is the difference between coma and sopor?

- A. Incomplete contact.
- B. At a coma protective reflexes are lost.
- B. In a coma, hallucinations appear.
- D. At a sopor there are pathological reflexes.
- E. Coma refers to qualitative disorders of consciousness.

10. Qualitative disorders of consciousness include:

- A. Stupor.
- B. Delirium.
- B. Amentia.
- D. Oneiroid.
- E. Paranoid.

11. What symptoms are NOT characteristic of delirium?

- A. True hallucinations.
- B. Psychomotor arousal.
- B. Autopsychic disorientation.
- D. Pseudohallucinations.
- E. Stupor.

12. What is characteristic of oneiroid?

- A. Pseudohallucinations.
- B. Catatonic stupor.

- B. True hallucinations.
- D. Allo- and autopsychic disorientation.
- E. In duration shorter than delirium.

13. What about the types of twilight confusion of consciousness?

- A. Trans.
- B. Ganzer syndrome.
- W. Absence.
- D. Pathological affect.
- E. Dromomania.

14. In what diseases can twilight state be observed?

- A. Schizophrenia.
- B. Neurasthenia.
- B. Epilepsy.
- D. Hysteria.
- E. Reactive psychoses.

15. In what diseases can delirium be observed?

- A. Alcoholism.
- B. Epilepsy.
- B. Schizophrenia.
- D. Neurasthenia.
- E. flu.

16. False perception of real-life objects is regarded as:

- A. Delirium
- B. Delirium
- C. Illusions

- D. Hallucinations
- E. Pseudohallucinations

17. Placid, silly mood with inappropriate actions, loss feelings of distance and critical appraisal of behavior are called:

- A. Moria
- B. Euphoria
- C. Dysthymia
- D. Dysphoria
- E. Exaltation

18. A disorder with rapid development and daily fluctuation of symptoms, preservation of orientation in the patient's own personality, disorientation in place and time, psychomotor agitation is called:

- A. Twilight clouding of consciousness
- B. Oneiroid
- C. Delirium
- D. Amentia
- E. None of the above

19. Some of the somatic symptoms of depression include:

- A. Decreased mood
- B. Slow down thinking
- C. Increased fatigue
- D. Decreased self-esteem and feelings of guilt
- E. Diurnal fluctuations in the severity of depression

20. The risk of suicide in people with depression is usually highest:

- A. At midnight

- B. Early in the morning
- C. At noon
- D. In the evening
- E. In the morning

21. All of these symptoms are most typical for depression, except:

- A. Decreased mood
- B. Increased fatigue
- C. Decreased libido
- D. Chronic monothematic delusional ideas
- E. Difficulty concentrating

22. How many points on the Glasgow scale correspond to a coma:

- A. 5
- B. 8
- C. 10
- D. 15
- E. All specified

23. Most often, with epilepsy, psychotic disorders with confusion occur in the form of:

- A. Twilight disorder of consciousness
- B. Oneiric confusion
- C. Delirious clouding of consciousness
- D. Amentive confusion
- E. None of the above

24. Anhedonia can be a diagnostic sign:

- A. Manic disorder.

- B. Depressive disorder
- C. Phobic disorder.
- D. Organic damage to the central nervous system.
- E. Epilepsy

25. Typical sleep disturbances in depressed patients:

- A. difficulty falling asleep
- B. superficial sleep
- C. early awakenings
- D. complete lack of sleep
- E. lack of a sense of sleep

Materials for test control (II level)

1. The patient during the meeting with the mother is kind, friendly, caring. Suddenly, against the background of the conversation, she jumped up and hit her mother in the face. She justified this: «I don't know exactly why you became so unpleasant». She immediately apologized for her act. Identify the violation of the patient's volitions:

- A. Dysphoria
- B. Kindness
- C. Depression
- D. Hypotymia
- E. Ambivalence

2. List the diseases that are often accompanied by disorders of consciousness:

- A. Brain injuries.
- B. Brain tumors.

- C. Diabetes mellitus.
- D. Hypertensive disease.
- E. Ischemic heart disease.

3. The twilight state of the acute period of traumatic brain injury is typical

- A. Psychomotor arousal
- B. Disorientation
- C. Stereotyped movements
- D. All of the above
- E. True A) and C)

4. Delirium of the acute period of a craniocerebral trauma is characterized by all listed, except

- A. Development mainly in people who abuse alcohol
- B. Frequent occurrence after stunning or confabulatory confusion
- C. Possibilities of occurrence are acute, in weeks after recovery
- D. Occurrence, usually in the morning and afternoon
- E. Periodic interruption by lucid intervals

5. Oneiroid of the acute period of a craniocerebral trauma is characterized by all listed, except

- A. Preserved memories of psychotic experiences
- B. Experiences of a fantastic nature, alternating with experiences of everyday content
- C. Pleasant-euphoric or ecstatic affect
- D. The presence of metamorphopsies, disorders of the body
- E. Repeated recurrence during the acute period of traumatic brain injury

6. Depression in traumatic illness

- A. More often develop gradually, accompanied by dysphoria and tearing
- B. More often develop acutely
- C. Never accompanied by excessive and delusional hypochondriac disorders
- D. Be sure to be accompanied by a pronounced organic decline until the development of dysnestic dementia with pseudoparalytic symptoms

7. What groups of drugs do not cause depressive disorder:

- A. Antibiotics
- B. Chlorpromazine
- C. Steroid hormones
- D. Antihypertensive drugs
- E. Antineoplastic drugs

8. The non-verbal manifestations of depression are the following, except:

- A. Striving to take up little space in space
- B. Avoiding the gaze of the interlocutor
- C. Slowness of movements
- D. Open pose
- E. Bent back

9. A dreamlike clouding of consciousness, anxiety, movements are limited to bed, mumbling, fingering on the bed, meaningless uncoordinated movements of the limbs is called:

- A. Professional delirium
- B. Mussifying delirium
- C. Oneyroid clouding of consciousness
- D. Syndrome of asthenic confusion
- E. Twilight clouding of consciousness

10. Delirium not associated with substance use most often occurs at the age of:

- A. 20-25 years old
- B. 30-35 years old
- C. After 45 years
- D. After 60 years
- E. At any age

Situational tasks (III level)

Case 1. The patient is 30 years old, the condition developed for no reason: at work he quickly completed all the projects entrusted to him, which he could not finish for several months before, but decided to quit in order to start his own business, which, as he now clearly understood, can be very easily organized. He believed that the products of his company would give a lot of positive emotions to all customers, which would quickly increase turnover and get rich really fast. As he later noted, all thoughts during this period were "crystal clear and accurate", he could keep many questions in his head and solve at once. To start his own business, he took a large loan secured by his apartment, but he did not begin to organize the work of the new company directly. He traveled all over the city all day, "negotiated" with different people, "got to know, talked". To travel around the city, he hired expensive limousines, bought expensive clothes, presented himself as an already established businessman, in order to convince new acquaintances of his financial solvency, he did not spare money on expensive gifts, left huge tips in restaurants. Planned that he would soon get rich, and these expenses seem like a trifle. The mood was very good, joyful, he wanted to do only good to other people, he could buy a huge heap of roses in a flower shop, go out and give them to all the girls he met. Once, having entered a cafe, it seemed to him that it was sad there, he bought a TV in a nearby store

and presented it to the owner of the establishment so that he could turn on "funny music" to visitors, etc. One night he took a car from his father, broke the rules road traffic. According to the patient, he was stopped by police officers, but "very much asked" not to take away the rights, not to bring the case to court, he left the car with policemen, walked home to his parents "for money", but on the way, he spent the rest of his funds on some trifles. "Went to the club to dance", got into a fight there with someone (got a broken jaw) and only in the morning barefoot, undressed and beaten, came to his parents, who called an ambulance.

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. A young married couple turns to a psychiatrist for consultation: she is a doctor, he is a builder, a foreman. In the past, the husband suffered many craniocerebral injuries: in his youth he was engaged in boxing, later, in a state of alcoholic intoxication, he was often irritable, aggressive, initiated fights, in which, due to his medium-sized build, he himself usually received the most severe injuries; several times he was treated with craniocerebral injuries in neurosurgical hospitals, including neurosurgical operations with craniotomy. The wife insisted on consulting a psychiatrist in connection with "cases of her husband's aggression": from time to time, the husband has attacks of aggression, when he beats his wife, he can hit her in the face. Because of bruises on her face, the woman is even forced to miss work. The husband says that "he cannot do anything with himself": usually within a few days, emotional stress begins to build up by itself, does not know "where to put himself", cannot work, because due to stress he is unable to do something one for a long time, everything starts to annoy, breaks down on colleagues. To relieve stress, he uses alcohol, first

beer, then, at the height of his state, vodka in large quantities (“to forget himself”). In a state of intoxication, he becomes especially aggressive, sometimes he simply leaves somewhere on the street in order to "fight", but recently he began to take out aggression more often on his wife. At some point, it is enough for her to make a casual remark (for example, about another alcohol intake), and her husband becomes angry – he silently attacks her with fists. After inflicting beatings, it becomes easier for him, anger passes, he, on the contrary, begins to repent, ask for forgiveness from his wife, begs her not to leave him, promises that this will not happen again, etc. The wife had already tried several times to file an application for divorce, but then succumbed to the persuasions of her husband, believed him, but in the future such excesses were repeated again.

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. A 62-year-old woman, hospitalized for the first time in a psychiatric hospital in connection with a state of anxiety depression, having independently come to her ward in the department, even before receiving the medications prescribed by the doctor, suddenly jumps up, rushes through the entire department to the exit, rushes on the iron doors, then on the bars on the windows, pulls them with such force that he pulls them straight out with pieces of a brick wall, only five people from the medical staff and patients of the department were able to limit the patient's excitement, restrain her physically, and prevent her from throwing herself out of the window. Subsequently, she explained that in the ward she suddenly felt that she would no longer be able to help her family from the hospital to cope with the dangers that threatened her,

that “now everything will certainly end in complete disaster,” therefore she tried to “escape” from the hospital.

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. The 75-year-old mother of a wealthy businessman, due to physical illness and infirmity, was forced to move to her son's house, where she was looked after by a nurse. Observing her son's lifestyle and spending, she became very worried that he would not have enough money for such a life, that she and his family would “stay on the street”, “would die of hunger”; She cried a lot, begged her son to be with her all the time, not to spend money, hid food in her bed, etc. Several times, at the height of anxiety, she left the house and called the neighboring houses, cried at the door, said that she and her son would soon be left without money, that they had nothing to eat, and asked to give her "at least a little bread." Only after the neighbors made a remark to his son that he apparently did not feed his mother well, he decided to contact her with a psychiatrist.

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. Patient B. is a 30-year-old man, unemployed, previously worked as a security guard. Alcoholized from adolescence, after the army began to drink hard for several weeks, high tolerance. The last binge was about a month, stopped drinking 4 days before hospitalization. Against the background of a pronounced alcohol withdrawal syndrome, sleep was disturbed, anxiety

appeared, at night under the window I heard "pornographic music", saw "naked girls on the street." According to the patient's mother, in the morning he spoke without an interlocutor, reported that friends had come to him, that he had caught someone in the kitchen, and that he had chopped all the kitchen furniture with an ax. The mother called an ambulance. Upon admission: disoriented in time (names the month and year, but does not know the date, time of day). He calls himself correctly, understands that he is in a psychiatric hospital. Excited, restless, highly distracting, speaks a lot and willingly, tries to joke. He says that today he had friends who "disappeared and reappeared". Then, unexpectedly, in the kitchen I saw an "alien in black" who was looking for some children, decided that it was an evil, and he himself – a good, began to fight the alien, tried to chop him up with an ax, but since he was disappearing all the time, he only broke all the furniture, and the creature continued to laugh at him. On a clean sheet of paper, after repeated requests, he sees a palm tree and "African animals." The phenomena of alcohol withdrawal syndrome are expressed. In the department, against the background of detoxification therapy and treatment with tranquilizers, he slept overnight, on the second day, the correct orientation was restored, deceptions of perception were not detected, anxiety was arrested. Amnesiac many events of the period of clouding of consciousness, including his admission to the hospital. In the future, a critical attitude to the transferred psychosis appeared.

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?

APPENDIXES


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

Appendix №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.) <div style="text-align: center;">  </div> |
| 30 | | TOTAL |

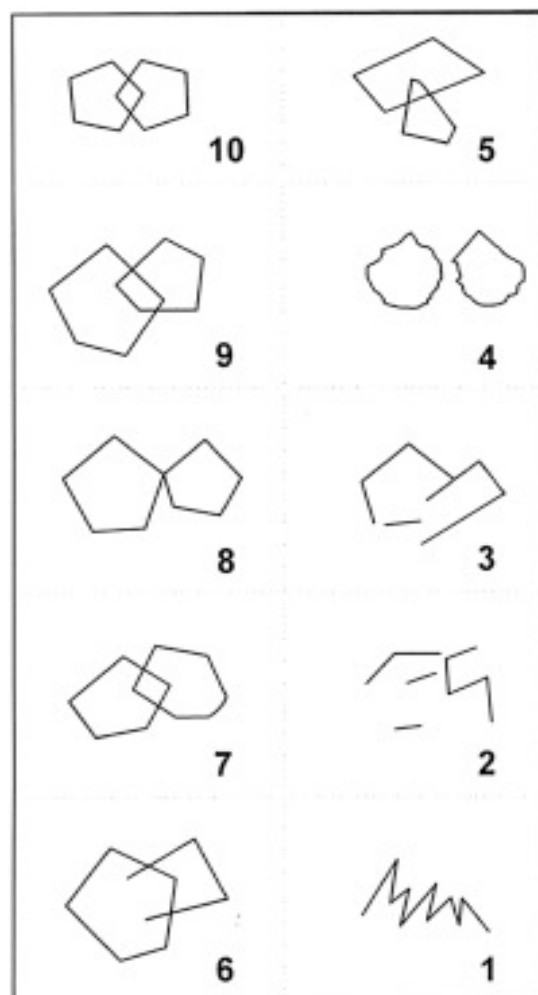
(Adapted from Rovner & Folstein, 1987)

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 (pic. 12):

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



12. Examples of validation of images of patients with different levels of dementia.

The Glasgow Coma Scale

| TABLE 38-2 | | |
|---------------------------|-------------------------------------|--------------|
| Glasgow Coma Scale | | |
| BEHAVIOR | RESPONSE | SCORE |
| Eye opening response | Spontaneously | 4 |
| | To speech | 3 |
| | To pain | 2 |
| | No response | 1 |
| Best verbal response | Oriented to time, place, and person | 5 |
| | Confused | 4 |
| | Inappropriate words | 3 |
| | Incomprehensible sounds | 2 |
| | No response | 1 |
| Best motor response | Obeys commands | 6 |
| | Moves to localized pain | 5 |
| | Flexion withdrawal from pain | 4 |
| | Abnormal flexion (decorticate) | 3 |
| | Abnormal extension (decerebrate) | 2 |
| | No response | 1 |
| Total score: | <i>Best response</i> | 15 |
| | <i>Comatose client</i> | 8 or less |
| | <i>Totally unresponsive</i> | 3 |

Background

Based on motor responsiveness, verbal performance, and eye opening to appropriate stimuli, the Glasgow Coma Scale was designed and should be used to assess the depth and duration coma and impaired consciousness. This scale helps to gauge the impact of a wide variety of conditions such as acute brain damage due to traumatic and/or vascular injuries or infections, metabolic disorders (e.g., hepatic or renal failure, hypoglycemia, diabetic ketosis), etc.

Interpretation

Individual elements as well as the sum of the score are important. Hence, the score is expressed in the form " GCS 9 = E2 V4 M3 at 07:35". Patients with scores of 3-8 are usually considered to be in a coma. Generally, brain injury is classified as:

Severe, GCS < 8–9

Moderate, GCS 8 or 9–12 (controversial)

Minor, GCS \geq 13.

Tracheal intubation and severe facial/eye swelling or damage make it impossible to test the verbal and eye responses. In these circumstances, the score is given as 1 with a modifier attached (e.g. "E1c", where "c" = closed, or "V1t" where t = tube). Often the 1 is left out, so the scale reads Ec or Vt. A composite might be "GCS 5tc". This would mean, for example, eyes closed because of swelling = 1, intubated = 1, leaving a motor score of 3 for "abnormal flexion".

The GCS has limited applicability to children, especially below the age of 36 months (where the verbal performance of even a healthy child would be expected to be poor). Consequently, the Paediatric Glasgow Coma Scale was developed for assessing younger children.

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)

Background

The Hospital Anxiety and Depression Scale (HADS) was devised 30 years ago by Zigmond and Snaith to measure anxiety and depression in a general medical population of patients. It has become a popular tool, for clinical practice and research.

The HADS questionnaire has been validated in many languages, countries and settings including general practice and community settings . It is useful for initial diagnosis and to track progression (or resolution) of psychological symptoms. It is one of the National Institute for Health and Care Excellence (NICE) recommended tools for diagnosis of depression and anxiety

Interpretation

Scores for items in each subscale of the HADS are summed to produce an anxiety score (HADS-A) or a Depression score (HADS-D), or can be added to produce a total score (HADS-T). Each item is rated on a 4-point scale (ranging from 0 = no not at all, to 3 = yes definitely), for a total score ranging from 0-21 for each subscale. A higher score indicates higher distress. A number of items are reverse scored (ranging from 3 = no not at all, to 0 = yes definitely), including two from the HADS-A and four from the HADS-D.

In the original publication, a score of 0 to 7 for either subscale was regarded as in the normal range, a score of 11 or higher indicating probable presence (caseness) of a mood disorder, and a score of 8 to 10 being suggestive of the presence of the state. A recent publication in individuals with stroke determined that an optimal balance is achieved between specificity using a cut-off score of 11 for the total HADS, and 8 for the HADS-D.

Patient Name: _____

Date: _____

Young Mania Rating Scale (YMRS)

Instructions: For each item below, circle the response that best describes how you felt or behaved during the past 48 hours.

- 1. Elevated Mood**
 - 0 Absent
 - 1 Mildly or possibly increased on questioning
 - 2 Definite subjective elevation; optimistic; self-confident; cheerful; appropriate to content
 - 3 Elevated, inappropriate to content; humorous
 - 4 Euphoric; inappropriate laughter, singing
- 2. Increased Motor Activity/Energy**
 - 0 Absent
 - 1 Subjectively increased
 - 2 Animated; gestures increased
 - 3 Excessive energy; hyperactive at times; restless (can be calmed)
 - 4 Motor excitement; continuous hyperactivity (cannot be calmed)
- 3. Sexual Interest**
 - 0 Normal; not increased
 - 1 Mildly or possibly increased
 - 2 Definite subjective increase on questioning
 - 3 Spontaneous sexual content; elaborates on sexual matters; hypersexual by self-report
 - 4 Overt sexual acts (toward patients, staff, or interviewer)
- 4. Sleep**
 - 0 Reports no decrease in sleep
 - 1 Sleeping less than normal amount by up to one hour
 - 2 Sleeping less than normal by more than one hour
 - 3 Reports decreased need for sleep
 - 4 Denies need for sleep
- 5. Irritability**
 - 0 Absent
 - 2 Subjectively increased
 - 4 Irritable at times during interview; recent episodes of anger or annoyance on ward
 - 6 Frequently irritable during interview; short or curt throughout
 - 8 Hostile, uncooperative; interview impossible
- 6. Speech (Rate and Amount)**
 - 0 No increase
 - 2 Feels talkative
 - 4 Increased rate or amount at times, verbose at times
 - 6 Push; consistently increased rate and amount; difficult to interrupt
 - 8 Pressured; uninterruptible, continuous speech
- 7. Language/Thought Disorder**
 - 0 Absent
 - 1 Circumstantial; mild distractibility; quick thoughts
 - 2 Distractible; loses goal of thought; changes topics frequently; racing thoughts
 - 3 Flight of ideas; tangentiality; difficult to follow; rhyming; echolalia
 - 4 Incoherent; communication impossible
- 8. Thought Content**
 - 0 Normal
 - 2 Questionable plans; new interests
 - 4 Special project(s); hyper-religious
 - 6 Grandiose or paranoid ideas; ideas of reference
 - 8 Delusions; hallucinations
- 9. Disruptive/Aggressive Behavior**
 - 0 Absent, cooperative
 - 2 Sarcastic; loud at times, guarded
 - 4 Demanding; threats on ward
 - 6 Threatens interviewer; shouting; interview difficult
 - 8 Assaultive; destructive; interview impossible
- 10. Appearance**
 - 0 Appropriate dress and grooming
 - 1 Minimally unkempt
 - 2 Poorly groomed; moderately disheveled; overdressed
 - 3 Disheveled; partly clothed; garish makeup
 - 4 Completely unkempt; decorated; bizarre garb
- 11. Insight**
 - 0 Present; admits illness; agrees with need for treatment
 - 1 Possibly ill
 - 2 Admits behavior change, but denies illness
 - 3 Admits possible change in behavior; but denies illness
 - 4 Denies any behavior change

Interpretation

The purpose of each item is to rate the severity of that abnormality in the patient. When several keys are given for a particular grade of severity, the presence of only one is required to qualify for that rating. A severity rating is assigned to each of the eleven items, based on the patient's subjective report of his or her condition over the previous forty-eight hours and the clinician's behavioral observations during the interview, with the emphasis on the latter.

Scoring between the points given (whole or half points) is possible and encouraged after experience with the scale is acquired. This is particularly useful when severity of a particular item in a patient does not follow the progression indicated by the keys.

In scoring the YMRS, the following items are graded on a 0 to 8 scale:

- Irritability
- Speech
- Thought content
- Disruptive/aggressive behavior

The following items are graded on a 0 to 4 scale:

- Elevated mood
- Increased motor activity/energy
- Sexual interest
- Sleep
- Language/thought disorder
- Appearance
- Insight

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.
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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.