PSYCHIATRY

Manual for foreign students

ПСИХИАТРИЯ

Учебное пособие

ФГБОУ ВО ВГМУ ИМ. Н. Н. БУРДЕНКО МИНЗДРАВА РОССИИ
Кафедра психиатрии с наркологией

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This manual of psychiatry is intended for the foreign students of the 4th and 5th year of studying. The manual comprises the following parts; general psychopathology, specific Psychiatry, narcology, the questions of curing patients according to nosology, the glossary of psychiatric terms. The material is presented in accordance with ICD-10 and DSM- IV.

The plan of students, literature references and examination questions are included to the manual.

Учебное пособие предназначено для русских студентов всех факультетов, факультета иностранных учащихся (на англ. языке), врачей-ординаторов и аспирантов, углубленно изучающих дисциплину Психиатрия

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Preface

Psychiatry is often inaccurately considered as a branch of medicine that can be understood only by a close circle of specialists. There are many scientific and methodological approaches to diagnostics and treatment of psychiatric disorders. This manual is intended for students who receive training in psychiatry in English. It will help them to study up for examinations as effectively as possible. All diagnostic criteria refer to the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", 4th edition, text revision (DSM-IV-TR), and the most recent edition of "International Classification of Diseases" (ICD-10).

The author hopes for good knowledge and best results of foreign students.

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The plan of studies for the fourth- and fifth-year students

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1. Psychiatry as a branch of medicine. The branches of psychiatry.
2. The right of citizens to psychiatric aid and its guarantees.
3. The grounds for involuntary hospitalization to the psychiatric hospital.
4. Official psychiatric classification systems.
    a. International Classification of Disease (ICD-10).
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5. General terms in the psychiatric classification
    a. Organic brain disorders and functional mental illnesses.
    b. Characteristics of psychosis and neurosis.
    c. Causation in clinical practice.
6. Epidemiology in psychiatry.

LITERATURE

Psychiatry / Ed. J. H. Scully. – 3rd ed. – Hong Kong: Williams & Wilkins. A Waverly Company, 1996. – P. 10–11.

№ 2. General psychopathology

1. Mental state examination.

2. General psychopathology. Disturbances of perception. Hallucinations: classification, clinical picture, nosological nature.

3. Illusions, hallucinations and disturbances of sensory synthesis.

4. The forms of mental disturbances. Delusion.

5. Hallucinatory-delusional syndromes, clinical characteristic. Fregoli's syndrome.

6. The classification of consciousness disturbances. The criteria of the changed consciousness (K. Jaspers). Nosological nature. Delirium.

7. The classification of mood disturbances.

8. Amnesia. Korsakoff's syndrome. The clinical picture of qualitative memory impairment.

LITERATURE

Psychiatry / Ed. J. H. Scully. – 3rd ed. – Hong Kong: Williams & Wilkins. A Waverly Company, 1996. – P. 2–6, 8–9.

Kaplan, Harold. Pocket handbook of clinical psychiatry / H. I.

Kaplan B. J. Sadock. – 2 nd ed. – Baltimore: Williams & Wilkins. A Waverly company, 1996. – P. 10–26.

№ 3. Organic brain syndromes

1. The definition of organic brain syndrome.
2. Causes.
    a. Cerebral conditions.
    b. Systemic conditions.
3. Clinical features.
4. Delirium (acute brain syndrome, acute confusional state). Treatment.
5. Dementia.
    a. Alzheimer's disease.
    b. Vascular dementia.
6. Treatment of dementia syndrome.
7. Pick's disease. Lewy body dementia. AIDS Dementia Complex.
8. Amnestic syndrome.

LITERATURE

Psychiatry / Ed. J. H. Scully. – 3rd ed. – Hong Kong: Williams & Wilkins. A Waverly Company, 1996. – P. 119–137.

Kaplan, Harold. Pocket handbook of clinical psychiatry / H. I.

Kaplan B. J. Sadock. – 2nd ed. – Baltimore: Williams & Wilkins. A Waverly company, 1996. – P. 27–50, 258–260.

№ 4. Mental and behavioural disorders due to psychoactive substance use

1. Epidemiology of drug misuse. Pharmacology.
2. Common terms of drug misuse:
    a. Psychotropic substances.
    b. Addiction.
    c. Dependence.
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3. The classification of mental and behavioural disorders due to the use of psychoactive substances according to ICD-10.
4. The diagnostic criteria of mental and behavioural disorders due to the use of psychoactive substances.
    a. Acute intoxication.
    b. Harmful use.
    c. Dependence syndrome.
    d. Withdrawal state.

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f. Psychotic disorder.

5. Clinical features of mental and behavioural disorders due to the use of psychoactive substances.

6. Characteristics:

a. Wernicke's encephalopathy.

b. Korsakoff's syndrome.

c. Other neurological complications due to the use of psychoactive substances.

7. Treatment misuse.

LITERATURE

Psychiatry / Ed. J. H. Scully. – 3rd ed. – Hong Kong: Williams & Wilkins. Waverly Company, 1996. – P. 141–161.

Kaplan, Harold. Pocket handbook of clinical psychiatry / H. 1.

Kaplan B. J. Sadock. – 2 nd ed. – Baltimore: Williams & Wilkins. A Waverly company, 1996. – P. 51–73.

№ 5. Epilepsy. Clinical picture of mental disturbances in different periods of craniocerebral trauma

1. Epilepsy. Epidemiology, questions of etiology.
2. The classification of the forms of epilepsy.
3. Epileptic paroxysms. Classification. Clinical picture.
4. Pharmacological treatment of epilepsy.
5. Clinical picture of mental disturbances during the remote period of craniocerebral trauma. Medical approaches.

LITERATURE

Psychiatry / Ed. J. H. Scully. – 3rd ed. – Hong Kong: Williams & Wilkins. Waverly Company, 1996. – P. 130–134.

Ayd, Frank. Lexicon of psychiatry, neurology, and the neurosciences / F. J. Ayd. – Baltimore: Williams & Wilkins. A Waverly company, 1995. – P. 249–250.

№ 6. Schizophrenia as a psychotic illness

1. Epidemiology and causation of schizophrenia.
2. Positive and negative symptoms.
3. The classification of schizophrenia according to ICD-10.
4. The diagnostic criteria of schizophrenia (Schneider (1959).

5. Clinical features:
    a. The onset.
    b. Disorders of thoughts' possession and stream.
    c. False beliefs (delusions).
    d. Hallucinations.
6. Differential diagnosis.
7. Choice of a drug.
    a. Characteristics of typical and atypical neuroleptic agents.
    b. Side effects of both typical and atypical neuroleptic agents.

LITERATURE

Psychiatry / Ed. J. H. Scully. – 3rd ed. – Hong Kong: Williams & Wilkins. Waverly Company, 1996. – P. 35–77.

Ayd, Frank. Lexicon of psychiatry, neurology, and the neurosciences / F. J. Ayd. – Baltimore: Williams & Wilkins. A Waverly company, 1995. – 741 p.

Kaplan, Harold. Pocket handbook of clinical psychiatry / H. I.

Kaplan B. J. Sadock. – 2nd ed. – Baltimore: Williams & Wilkins. A Waverly company, 1996. – P.74–96.

№ 7. Personality disorders. Food intake isorders. Sexual dysfunction

1. Personality disorders. Definition. Diagnostic criteria (P. B. Gannushkin).
2. Personality disorders: classification and clinical findings.
3. Types of personality disorders.
    a. Diagnostic criteria (ICD-10).
    b. Diagnostic criteria (DSM-IV).
4. Sociopathic (dissocial) personality disorders.
5. Food intake disorders:
    a. Anorexia nervosa. Clinical features. Treatment.
    b. Bulimia nervosa. Clinical features. Treatment.
6. Sexual dysfunction. Sexual deviations. Causes. Treatment.

LITERATURE

Psychiatry / Ed. J. H. Scully. – 3rd ed. – Hong Kong: Williams & Wilkins. A Waverly Company, 1996. – 318 c. – P. 215–226, 259–271.

Ayd, Frank. Lexicon of psychiatry, neurology, and the neurosciences / F. J. Ayd. – Baltimore: Williams & Wilkins. A Waverly company, 1995. – 741 p.

Kaplan, Harold. Pocket handbook of clinical psychiatry / H. 1.

Kaplan B. J. Sadock. – 2nd ed. – Baltimore: Williams & Wilkins. A Waverly company, 1996. – P. 157–160, 190–204.

Slovenko, Ralph. Psychiatry and Criminal Culpability / R.

Slovenko. – New York: A Wiley Interscience Publication, 1995. – 436 p.

Ross, Colin. Multiple Personality Disorders: Diagnosis, Clinical Features, and Treatment / C. A. Ross. – New York: A Wiley-interscience Publication, 1989. – 382 p.

№ 8. Mental retardation. Mood disorders. Suicide

1. Mental retardation. Causes of mental retardation.
2. Symptoms and classifications of mental retardation.
3. General terms of mood disorders.
4. Epidemiology and frequency of affective disorders.
5. The classification of mood disorders according to ICD-10 and DSM-IV.
6. Clinical features of depressive illnesses.
7. Suicide.
    a. Fatal deliberate self-harm (suicide, completed suicide).
    b. Non-fatal deliberate self-harm (DSH, parasuicide, attempted suicide).
8. Antidepressant medications.
9. Clinical features of mania. Treatment of mania.

LITERATURE

Child and Adolescent Psychiatry: A comprehensive textbook / od, M. Lewis. – 2nd ed. – Baltimore: Williams & Wilkins. A Waverly company, 1996, – 1298 p.

Ayd, Frank. Lexicon of psychiatry, neurology, and the neurosciences / F. J. Ayd. – Baltimore: Williams & Wilkins. A Waverly company, 1995. – 741 p.

Kaplan, Harold. Pocket handbook of clinical psychiatry / H. I.

Kaplan B. J. Sadock. – 2nd ed. – Baltimore: Williams & Wilkins. A Waverly company, 1996. – P. 219–248.

№ 9. Therapy of mental diseases

1. Psychopharmacology:
    a. Neuroleptics and their use in psychiatric practice.
    b. Tranquilizers and their use in psychiatric and therapeutic practice.
    c. Antidepressants and their use in psychiatric and therapeutic practice.
    d. Nootropics and their use in psychiatric and therapeutic practice.
    e. Mood stabilizers.
2. Psychotherapy. The value of psychotherapy in various diseases. Methods of psychotherapy.

3. Side effects and complications caused by the use of psychotropic agents. Medical approaches to the elimination of side effects and complications.

4. Side effects of typical and atypical neuroleptic agents.

5. Treatment of epilepsy.

6. Electroconvulsive therapy (ECT). Indications. The mode of action. Contraindications. Myths.

LITERATURE

Psychiatry / Ed. J. H. Scully. – 3rd ed. – Hong Kong: Williams & Wilkins. A Waverly Company, 1996. – 318 p.

Ayd, Frank. Lexicon of psychiatry, neurology, and the neurosciences / F. J. Ayd. – Baltimore: Williams & Wilkins. A Waverly company, 1995. – P. 237–239.

Kaplan, Harold. Pocket handbook of clinical psychiatry / H. I.

Kaplan B. J. Sadock. – 2nd ed. – Baltimore: Williams & Wilkins. A Waverly company, 1996. – P. 266–323.

Further readings:

- American Psychiatric Association (1994). Diagnostic and Statistical Manual o Mental Disorders (4th ed.) (DSM-IV). Washington, DC: American Psychiatri Association.
- World Health Organization (1992). The ICD-10 Classification of Mental and Behavioural Disorders. Geneva: WHO. http: / / www3.who.int / icd / currentversion / ft-icd.htm.

Psychiatry. The right of citizens to psychiatric aid and its guarantees

Psychiatry as a branch of medicine. Problems of psychiatry.
The branches of psychiatry. Basic terms in psychiatric classification.

Psychiatry is a branch of medicine that deals with mental, emotional and behavioural disorders.

Problems of psychiatry:

1. Diagnostics of mental disorders.
2. Study of clinical picture, etiopathogenesis and outcome of mental diseases.
3. Epidemiology of mental disorders.
4. Medicamental influence on clinical picture of mental diseases.
5. The methods of mental pathology treatment.
6. The methods of mental pathology prophylaxis.
7. Organization of psychiatric help.

The branches of psychiatry:

1. General psychopathology – studies the basic laws of clinical picture, diagnosis, therapy and prophylaxis of mental disorders.
2. Specific psychiatry – studies certain mental diseases.
3. Age psychiatry.
4, Organizational psychiatry.
5. Forensic psychiatry – deals with the questions of sanity and capacity for acting.
6 Psychopharmacotherapy – studies the use of medicinal substances for mental disorders treatment.
7. Social psychiatry – studies the influence of social factors (education, work etc.) on the development of mental disorders.
8. Addictology (narcology) – studies the influence of psychotropic substances on a personal state.
9. Transcultural psychiatry – studies the difference of mental pathologies in different countries, cultures.
10. Sexology – studies the sexual activity.
11. Suicidology – studies suicide and parasuicide.
12. Military psychiatry – studies posttraumatic stress disorders, psychopathology of wartime.
13. Ecological psychiatry – studies the influence of ecological factors on mentality.
14. Psychotherapy – studies the treatment of borderline mental disorders using verbal and behavioral influence.

The basic terms in psychiatric classification.

Organic and functional

Psychiatric conditions are sometimes divided into organic brain disorders and inctional mental illnesses. Organic conditions are caused by identifiable physical thology affecting the brain, directly or indirectly, and include, for example, learning disabilities and the dementias. Functional conditions have usually been attributed to some kind of psychological stress.

Psychosis and neurosis

These terms have largely been removed from the international classifications but are still used in clinical practice.

Psychoses (*for example, schizophrenia, a bipolar affective disorder*) are characterized by the following:

- severe course of illness;
- symptoms of abnormal experiences, such as delusions and hallucinations;
- loss of insight, the subjective experience is mistaken for external reality.

Neuroses (for example, anxiety disorders, depression) may be characterized as follows:

- more common;
- often less severe;
- symptoms are regarded as an exaggeration of the normal response to stress.

The right of citizens to psychiatric aid and its guarantees

The abstracts from the Law of the Republic of Belarus "About the right of citizens to psychiatric aid and its guarantees":

1. People suffering from mental disorders have all rights and freedom of a citizen stipulated by the Constitution of the Republic of Belarus.

2. All people suffering from mental disorders have the right to psychiatric help. *The grounds for hospitalization to the psychiatric hospital are:*

- symptoms of a mental disorder and the psychiatrist's decision on examination and admission for treatment or the court's decision;
- the necessity of psychiatric or forensic medical examination.

Psychiatric help is rendered in case of a person's voluntary consent, except for the cases separately stipulated in the Law mentioned above.

Clause 30. The grounds for involuntary hospitalization to the psychiatric hospital without person's consent.

1. the court's decision;
2. examination or treatment of a person are possible only at the hospital;
3. the disorder is severe and can lead to:
    - immediate danger to himself or society;
    - helplessness (disability to satisfy the basic vital needs);
    - the risk of self-harm due to the disturbed mental condition of a patient if left without psychiatric aid.

CHAPTER 1. Clinical examination of a psychiatric patient

The psychiatric case history. International Classification of Disease (ICD-10).
Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV).
Global assessment of functioning (Axis V, DSM-IV). General psychopathology.

1.1. The psychiatric case history

I. Psychiatric history.

A. *Identifying information*. Age, sex, marital status, race, referral source.

B. *The main complaint.* The reason for consulting, which is usually a direct complaint from the patient.

C. *The history of present illness.*

1. Current symptoms: the date of onset, duration and course of symptoms.
2. Previous psychiatric symptoms and treatment.
3. Recent psychosocial stressors: stressful events that may have contributed to the patient's current presentation.
4. The current reason.
5. This section provides the evidence that confirms or excludes relevant diagnoses.
6. The historical evidence in this section should be relevant to the current presentation.

D. *Past psychiatric history.*

1. Previous and current psychiatric diagnoses.
2. The history of psychiatric treatment, including outpatient and inpatient treatment.
3. The history of psychotropic medications use.
    3.1. Substances abuse history: alcohol, cocaine, heroin, marijuana, amphetamines, barbiturates, hallucinogens, and prescribed medications, such as opioids or benzodiazepines.
    3.2. In case if alcohol present, screen for abuse or dependence asking if the following signs took place: attempts to cut down, anger, guilt, eye-openers, blackouts, shakes, seizures, or delirium took place. Ask about the amount of substance used, money spent daily, weekly, or monthly. Also find out about the way of usage (inhaled, intranasal, or intravenous).
4. The history of suicidal attempts and cases of potential lethality.

E. *Past medical history.*

1. Current and / or previous medical problems.
2. The type of treatment, including prescription and over-the-counter medications, home remedies.

F. *Family history.* Relatives with the history of psychiatric disorders, suicides or suicidal attempts, alcohol or substance abuse.

G. *Social history.*

1. The source of income.

2. The level of education, relationships history (including marriages, sexual orientation, number of children); individuals who currently live with a patient.

3. Support network.

4. Current alcohol or illicit-drugs usage.

5. Occupational history.

H. *Developmental history.* Family structure during childhood, relationships with parents and siblings; developmental milestones, relationships with peers, school performance.

II. The examination of a present mental status. Historical information should not be included into this section.

A. *General appearance and behavior.*

1. Grooming, hygiene level, characteristics of dressing.

2. Unusual physical characteristics or movements.

3. Attitude. The ability to interact with an interviewer.

4. Psychomotor activity. Agitation or retardation.

5. The degree of eye contact.

B. *Affect.*

1. Definition. The external range of expression, described with terms of quality, range and appropriateness.

2. The types of affect

a. Flat. The absence of all or most affect.

b. Blunted or restricted. The moderately reduced range of affect.

c. Labile. Multiple abrupt changes with affect.

d. Full or wide range of affect. Generally appropriate.

C. *Mood.* Internal emotional tonus of a patient (i.e., dysphoric, euphoric, angry, euthymic, anxious).

D. *Thought process.*

1. The use of language. Quality and quantity of speech. The tone, associations and fluency of speech should be noted.

2. Common thinking disorders:

a. Pressured speech. Rapid speech, which is typical for patients with maniacal disorders.

b. Poverty of speech. Short responses, such as “yes or no.”

c. Blocking. Sudden cessation of speech, often in the middle of a statement.

d. Flight of ideas. Accelerated thoughts that jump from idea to idea are typical for mania.

e. Loosening of associations. Illogical shifting between unrelated topics.

f. Tangentiality. Thoughts that wanders away from the original point.

g. Circumstantiality. Unnecessary digression, which eventually reaches the point.

h. Echolalia. Echoing of words and phrases.

i. Neologisms. Invention of new words by a patient.

j. Clanging. Speech is based on sounds, such as rhyming and punning without logical connection.

k. Perseveration. Repetition of phrases or words in the flow of speech.

I. Ideas of reference. Interpreting unrelated events as having direct reference to a patient, for instance, believing that television is talking specifically to him / her.

E. *Thought content.*

1. Definition, Hallucinations, delusions and other perceptual disturbances.

2. Common thought content disorders:

a. Hallucinations. False sensory perceptions, which may be auditory, visual, tactile, gustatory or olfactory.

b. Delusions. Fixed, false beliefs firmly held to in spite of contradictory evidence.

i. Persecutory delusions. A false belief that the others are trying to cause harm, or spying with intent to cause harm.

ii. Erotomanic delusions. A false belief that a person, usually of a higher status, is in love with a patient.

iii. Grandiose delusions. A false exaggerated belief of self-worth, power, knowledge, or wealth.

iv. Somatic delusions. A false belief of a patient that he / she has a physical disorder or defect.

c. Illusions. Misinterpretation of reality.

d. Derealization. involving the outer environment.

e. Depersonalization. The feeling of unreality, such as if one is “outside” his body and observes himself.

f. Suicidal and homicidal ideation. Suicidal and homicidal ideation requires further elaboration with comments about intents and planning (including means to carry out the plan).

F. Cognitive evaluation.

1. Consciousness level.

2. Orientation: name, place and date.

3. Attention and concentration: repeat five digits forwards and backwards or spell a five-letter word (“world”) forwards and backwards.

4. Short-term memory: the ability to recall three objects after five minutes.

5. Storage of knowledge: the ability to name previous five presidents, five large cities, or historical dates.

6. Calculations. Subtraction of serial 7s, simple math deductions.

7. Abstraction. Interpretation of proverbs.

G. *Insight*. The ability of a patient to display an understanding of his current problems, and the ability to realize the implication of these problems.

H. *Judgment.* The ability to make sound decisions regarding everyday's activities. Judgment is best evaluated by assessment of a patient's history of decisions, actions, rather than by asking hypothetical questions.

III. Diagnosis. Psychiatry adheres to a biopsychosocial model in which psychiatric problems are understood from biological, psychological, and social point of view.

Differential diagnosis: Include all psychiatric, medical, and neurological possibilities.

IV. Treatment plan. This section should discuss pharmacologic treatment and other psychiatric therapy, including hospitalization.

V. General medical screening of a psychiatric patient. A thorough physical and neurological examination, including basic screening laboratory analysis to exclude physical conditions, should be completed.

A. Laboratory evaluation of a psychiatric patient:

1. CBC with differential.
2. Blood chemistry (SMAC).
3. Thyroid function panel.
4. Screening test for syphilis (RPR or MHA-TP).
5. Urinalysis with drug screening.
6. Urine pregnancy test for females of childbearing potential.
7. Alcohol level in blood.
8. Serum levels of medications.
9. Hepatitis C test in at-risk patients.
10. HIV test in high-risk patients.

B. A more extensive work-up and laboratory analysis may be indicated based on clinical findings.

1.2. ICD-10 (World Health Organization, 1992)

The 10th edition of " / international Classification of Disease" (ICD-10), prepared by the World Health Organization, covers all the branches of medicine and includes the classification of mental

and behavioral disorders. This is the official classification of the diseases used in the Republic of Belarus. The classification of psychiatric diseases includes:

F00-F09 Organic, including symptomatic, mental disorders.

F10-F19 Mental and behavioural disorders due to psychoactive substance use.

F20-F29 Schizophrenia, schizotypal and delusional disorders.

F30-F39 Mood (affective) disorders.

F40-F48 Neurotic, stress-related, and somatoform disorders.

F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors.

F60-F69 Disorders of adult personality and behavior.

F70-F79 Mental retardation.

F80-F89 Disorders of psychological development.

F90-F98 Behavioural and emotional disorders with onset usually in childhood or adolescence.

F99 Unspecified mental disorders.

All of the main categories listed above have a number of subdivisions.

Diagnostic criteria for each condition are presented in the ICD. Some conditions relevant to psychiatry, such as suicide and poisoning, are classified in other sections of the ICD, for example, 'factors influencing health status and contact with health services', Z00-Z99 codes.

1.3. "Diagnostic and statistical manual of mental disorders", 4th edition, (DSM-IV)

comprises the official classification system of the American Psychiatric Association, and is used in the UK. Diagnosis is made across five separate axes to delineate primary psychiatric disorders and substance abuse, personality disorders and mental retardation, general medical illness, psychosocial stressors, and global functioning. This multiaxial system supports an approach to understanding a patient, which includes medical, psychiatric, and social aspects.

DSM-IV is a multiaxial system with **five axes:**

Axis I: Clinical syndromes.

Axis I: Developmental disorders and personality disorders.

Axis III: Physical disorders and conditions.

Axis IV: Severity of psychosocial stressors.

Axis V: Global assessment of functioning.

Every syndrome is defined by a set of practical criteria. Common Axis I disorders: depression, anxiety disorders, bipolar disorder, phobias, and schizophrenia. Common Axis II disorders: personality disorders and mental retardation. Common Axis III disorders: brain injuries and other medical / physical disorders which may aggravate existing diseases or present symptoms similar to other disorders.

1.4. Global Assessment of Functioning (Axis V, DSM-IV)

Table 1.4.1. Global Assessment of Functioning (Axis V, DSM-IV)

Score *Description of functioning*

91–100 Superior functioning in a wide range of activities, everyday problems seem to be under control, is sought out by others because of his or her many positive qualities. There are no abnormal symptoms.

81–90 Absent or minimal symptoms (mild anxiety), good functioning in all spheres, interested in and involved to a wide range of activities, socially active, generally satisfied with life, everyday problems or concerns are controlled (an occasional argument with family members).

71–80 If symptoms are present, they are short-term and normal reactions to psychosocial stressors (difficulties with concentrating after having arguments); slight changes in social, occupational functioning, or school performance (a temporary worsening of school performance). 3

61–70 Some mild symptoms (depressed mood or mild insomnia) OR difficulties in social, occupational, or school functioning (occasional truancy, or theft within the household), but generally functioning is quite normal, some meaningful personal relationships.

51–60 Moderate symptoms (flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulties in social, occupational, or school functioning (few friends, conflicts with peers or coworkers).

41–50 Serious symptoms (suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (no friends, unable to keep a job).

31–40 Some impairment in reality testing or communication (speech is at time: illogical, obscure, or irrelevant) OR major impairment in several areas such as work or school, family relations, judgment, thinking, or mood (depressed person avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

21–30 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (sometimes incoherent, grossly inappropriate behavior, suicidal, preoccupation) OR inability to function in almost all areas (stays in bed all day; no job, home, or friends).

11–20 Some danger of hurting self or others (suicide attempts without cle expectation of death; frequently violent; manic excitement) O! occasionally fails to maintain minimal personal hygiene (smear feces) O! gross impairment in communication (largely incoherent or mute).

1–10 Persistent danger of severely hurting self or others (recurring violence) O persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

1.5. General psychopathology

The general psychopathology studies signs, sets of symptoms, laws of occurrence and development of mental diseases.

The spheres of mental activity:

1. perception;
2. thinking;
3. memory;
4. emotions;
5. will;
6. consciousness;
7. intelligence.

DISTURBANCES OF PERCEPTION

Perception is a reflection of the environmental validity in its external communications and attitudes.

Sensation is an initial mental activity. The sensation precedes the process of perception. The sensation is the initial mental activity because has the emotional coloring.

Perception is the sum of not mechanical complex sensations.

There are the following frustrations of perception:

- Hallucinations.
- Illusions.
- Senesthopathies..
- Metamorphopsies

Hallucination – imaginary perception (without object).

There are various classifications of hallucinations. According to sense organs:

visual,	tactile,
kinesthetic,	gustatory,
acoustic,	olfactory,
visceral,	complex.

According to the level of complexity:

1. Elementary.
   - Visual analyzer: photopsia – sparks, lightnings, brilliant lines;
   - Acoustic analyzer: acoasm – elementary sounds (knock, singing, hum); phonemes – verbal hallucinations (calls).

2. Simple.

Visual and acoustical hallucinations arise on a background of the changed consciousness.

- Visual analyzer: panoramic hallucinations.
- Acoustic analyzer: commenting or imperative voices.

3. Complex (combined) hallucinations – arise, for example, in alcoholic delirium.

Also **true and false hallucinations** are distinguished.

True – the projection “outside” (in environmental space); hallucinations are bright, and vivacity of hallucinatory images is kept. The feeling of “perception from outside” is absent.

False (pseudohallucinations) – the projection "inside", brightness of hallucinatory images is absent. The feeling of “perception from outside” is typical.

Hypnological hallucinations.

‘These hallucinations occur just before falling asleep and affect a surprising number of people. The hallucinations can last from seconds to minutes; during this period the subject usually remains aware of the true nature of the images. Hypnological hallucinations are sometimes associated with brainstem abnormalities.

Peduncular hallucination.

Peduncular means pertaining to the peduncle, which is a neural tract running to and from the Pons on the brain stem. These hallucinations occur most often in the evening, but not during drowsiness as in the case of hypnological hallucination. The subject is usually fully conscious and can interact with the hallucinatory characters for extended periods of time. As in the case of hypnological hallucinations, insight into the nature of the images remains intact. The false images can occur in any part of the visual field, and are rarely polymodal.

Illusions.

‘They are perverted perception of really existing objects. The subject is perceived, but his valid essence disappears.

The following types of illusions are distinguished: visual, acoustical, gustatory, etc. illusions. Allocate: affective illusions – arise on the background of action change.

'The action is a strongly expressed short-term emotional condition.

Functional illusions – an illusion of not existing objects on the background of existing in reality objects (a sound of time, hum of a passing trolley bus).

DISTURBANCES OF THINKING

Thinking disorders can be assessed to the certain degree by judging the appearance: clothes, ornaments, make-up, strange movements and views. As a tule, people with disordered thinking productivity draw, compose and write a lot. A psychiatrist receives the basic information, certainly, during immediate verbal contact with a patient.

Thinking disorders are divided by several aspects:

1. Form

o Loosening of associations
o Derailment
o Incoherence
o Circumstantiality
o Tangentiality
o Echolalia
o Neologisms
o Verbigeration

2. Process

o Blocking
o Perseveration
o Poverty of content
o Poor abstraction
o Over-inclusion

3. Content:

Delusions:
A. By Topic:
o Persecutory
o Grandiose
o Somatic
o Religious
o Other
B. By Credibility:
o Non-bizarre (believable),
o Bizarre (unbelievable)

4. Thought Control:

a. Thought broadcasting
b. Thought insertion
c. Thought withdrawal

Delusion is commonly defined as a fixed false belief and is used in everyday language to describe a belief that is false, fanciful or derived from deception. Delusions typically occur in the context of neurological or mental illness, although they are not tied to any particular disease and have been found to occur in the context of many pathological states (both physical and mental). However, they are of particular diagnostic importance in psychotic disorders and particularly in schizophrenia, mania and in the episodes of bipolar disorders.

Although non-specific concepts of madness have been around for several thousand years, the psychiatrist and philosopher Karl Jaspers was the first to define the three main criteria for a belief to be considered delusional in his book "General Psychopathology". The criteria are the following:

- certainty (held with absolute conviction);
- incorrigibility (not changeable by compelling argument or proof to the contrary);
- impossibility or falsity of content (implausible, bizarre or patently untrue).

These criteria still hold their importance in modern psychiatric diagnosis. In the most recent edition of "Diagnostic and Statistical Manual of Mental Disorders" *delusion is defined as "a false belief based on incorrect inference about external reality that is firmly sustained despite what almost*

everybody else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary". The helief is not one ordinarily accepted by other members of the person's culture or subculture (e. g., it is not an article of religious faith).

There is some controversy over this definition, as 'despite what almost everybody else believes! implies that a person who believes something and others do Hot, is a candidate for delusional thought. Indicators of delusion (Munro, 1999):

1. The patient expresses an idea or belief with unusual persistence or force.
2. That idea appears to exert an undue influence on his or her life, and the way of life is often altered to an inexplicable extent.
3. Despite his / her profound conviction, there is often a quality of secretiveness or suspicion when the patient is questioned about it.
4. The individual tends to be humorless and oversensitive, especially about the belief.
5. There is a quality of centrality: no matter how unlikely it is that these strange things are happening to him, the patient accepts them relatively unquestioningly.
6. An attempt to contradict the belief is likely to arouse an inappropriately strong emotional reaction, often with irritability and hostility.
7. The belief is, at least, unlikely.
8. The patient is emotionally over-invested in the idea and it overwhelms other elements of his psyche.
9. The delusion, if acted out, often leads to behaviors which are abnormal and / or out of character, although perhaps understandable in the light of the delusional beliefs.
10. Individuals who know the patient will observe that his belief and behavior are uncharacteristic and alien.

Types of delusion:

- Erotomanic type (see erotomania): delusion that another person, usually of a higher status, is in love with the individual.
- Grandiose type: delusion of inflated worth, power, knowledge, identity, or special relationship with a famous person (see Jerusalem syndrome, Megalomania, Messiah complex)
- Jealousy type: delusion that the individual's sexual partner is unfaithful (see delusional jealousy).
- Persecutory type: delusion that the person (or someone to whom the person is close) is being malevolently treated in some way.
- Somatic type: delusions that the person has some physical defect or general medical condition.

A diagnosis of 'mixed type' or 'unspecified type' may also be given if the delusions fall into several or none of these categories respectively.

DISTURBANCE OF MEMORY

Amnesia (from Greek Apvnota) is a condition in which memory is disturbed. In simple terms it is the loss of memory. The causes of amnesia are organic or functional. Organic causes include damage of the brain, due to the trauma or disease, or use of certain (generally sedative) drugs. Functional causes are psychological factors, such as defense mechanisms (hysterical post-traumatic amnesia). Amnesia may also be spontaneous, in the case of transient global amnesia. This global type o amnesia is more common in middle-aged to elderly people, particularly males, an usually lasts less than 24 hours.

Forms of amnesia:

- In anterograde amnesia, new events present in the immediate memory are no transferred to the permanent as long-term memory. The subject will not be able t remember anything that occurs after the onset of this type of amnesia for more than brief period following the event.
- Retrograde amnesia is the distinct inability to recall some memory or memories o} the past, beyond ordinary forgetfulness.

The terms are used to categorize patterns of symptoms, rather than to indicate particular cause or etiology.

An example of mixed retrograde and anterograde amnesia may be a motorcyclis| unable to recall driving his motorbike prior to his head injury (retrograde amnesia), nor can he recall the hospital ward where he is told he had conversations with famil over the next two days (anterograde amnesia).

Types / causes of amnesia:

Post-traumatic amnesia is generally due to a head injury (e. g. a fall, a knock on the head). Traumatic amnesia is often transient, but may be permanent of either anterograde, retrograde, or mixed type. The extent of the period covered by the amnesia is related to the degree of injury and may give an indication of the prognosis for recovery of other functions. Mild trauma, such as a car accident that results in no more than mild whiplash, might cause the occupant of a car to have no memory of the moments just before the accident due to a brief interruption in the short / long-term memory transfer mechanism. The subject may also lose knowledge of who people are, they may remember events, but will not remember their faces.

Dissociative amnesia results from a psychological cause as opposed to direct damage to the brain caused by head injury, physical trauma or disease, which is known as organic amnesia. Dissociative amnesia can include:

- Repressed memory refers to the inability to recall information, usually about stressful or traumatic events in persons' lives, such as a violent attack or rape. The memory is stored in long term memory, but access to it is impaired because of psychological defense mechanisms. People retain the capacity to leam new information and there may be some later partial or complete recovery of memory. This differs from anterograde amnesia caused by amnestics such as benzodiazepines or alcohol, where an experience was prevented from being transferred from temporary to permanent memory storage: it will never be recovered, because it was never stored in the first place. Formerly known as "Psychogenic amnesia"
- Dissociative fugue is also known as a fugue state. It is caused by psychological trauma and is usually temporary, unresolved and therefore may return.
- Posthypnotic amnesia – when past memories are unable to be recalled.
- Lacunar amnesia – the loss of memory regarding one specific event.
- Childhood amnesia (also known as infantile amnesia) is the common inability to remember events from one's own childhood.

DISTURBANCE OF CONSCIOUSNESS

Frustration of consciousness arises not only in patients with mental disorders, it can also occur, for example, in children with infections. Impairment of consciousness may develop in drug-addicts or individuals sniffing glue.

Classification of consciousness frustration:

1. A set of symptoms of the switched off consciousness. The following stages are allocated: obnubilation, sopor, coma – the consciousness is absent.

2. A set of symptoms of the changed consciousness – the consciousness is kept, but in new quality – patients behave unusually. Then subject does not remember or hardly remembers, what happened to him at the moment of the event. Experiences are bright, externally – not clear.

Criteria of the changed consciousness (by K. Jaspers)

a) 4) detachment from the real world;
b) 6) impairment of orientation;
c) h) amnesia – specific to each variant.

Jaspers has described the stages of delirium development.

There are 4 basic forms of stupefaction: a delirious stupefaction, oneiric stupefaction, amental stupefaction, and twilight stupefaction.

Diagnostic criteria. According to the DSM-IV, the «catatonic features" specifier can be applied if the clinical picture is predominated by at least two of the following:

- motor immobility as evidenced by catalepsy (including waxy flexibility) or stupor;
- excessive motor activity (purposeless, not influenced by external stimuli);
- extreme negativism (motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism;
- peculiarities of voluntary movement as evidenced by posturing, stereotyped movements, prominent mannerisms, or prominent grimacing;
- echolalia or echopraxia.

Subtypes:

Stupor is a motionless, apathetic state in which one is oblivious or does not react to external stimuli. Motor activity is nearly non-existent. Individuals in this state make little or no eye contact with others and may be silent and rigid. One might remain in one position for a long period of time, and then go directly to another position immediately after the first position.

Catatonic excitement is a state of constant purposeless agitation and excitation. Individuals in this state are extremely hyperactive although the activity seems to lack purpose.

CHAPTER 2. Axis I: Clinical syndromes

Schizophrenia. Categorization of mood disorders.
Fatal deliberate self-harm (suicide) and non-fatal deliberate self-harm (parasuicide).
Dementia. Delirium – an acute organic syndrome.
Mental and behavioural disorders due to the use of psychoactive substances.

2.1. Schizophrenia

Schizophrenia is a disorder characterized by apathy, absence of initiative (avolition), and affective blunting. These patients have alterations in thoughts, perceptions, mood, and behavior. Many schizophrenics display delusions, hallucinations and misinterpretations of reality.

Often there is a history of declining social and educational function which precludes significant achievements (sometimes in spite of early promise). The chronic course of the condition and the major disruptions caused by periods of more severe symptoms also make it less likely that a person with schizophrenia will achieve as much as his peers. Until relatively recent time there have been few specific treatments of the disorder, and even today the prognosis is at best guarded.

Nonetheless, there are notable exceptions to the rule: people who have battled with the disorder and achieved success in their chosen fields, for example, in the sphere of Art – Vaslov Fomich Nijinsky (1891–1950), the God of the Dance, whose personal account is to be found in his autobiography The Diary of Vaslov Nijinksy (1999); in sport – Lionel Aldridge (1941–1998), a member of Vince Lombardi's legendary Green Bay Packers of the 1960s, who played in two Super Bowls, and, until his death, gave inspirational talks on his battle against paranoid schizophrenia; in the sphere of popular music, Roger (Syd) Barrett (1946) of "Pink Floyd" and Peter Green (1946) of "Fleetwood Mac".

Perhaps, the most famous, due to a recent academy award-winning dramatisation of his life, is the mathematician John Forbes Nash Jr. (1928), who was awarded the 1994 Nobel Prize in Economic Science for his work on game theory. His life story (upon which the film was based) is recorded by Sylvia Nasar in the book "A Beautiful Mind" (1998).

I. DSM-IV Diagnostic criteria for schizophrenia.

A. Two or more of the following symptoms present for one month:

1. Delusions.
2. Hallucinations.
3. Disorganized speech.
4. Grossly disorganized or catatonic behavior.
5. Negative symptoms (i.c., affective flattening, alogia, avolition).

B. Decline in social and / or occupational functioning since the onset of illness.

C. Continuous signs of illness for at least six months with at least one month of active symptoms.

D. Schizoaffective disorder and mood disorder with psychotic features have been excluded.

E. The disturbance is not due to substance abuse or a medical condition.

F. If the history of autistic disorder or pervasive developmental disorder is present, schizophrenia may be diagnosed only if prominent delusions or hallucinations have been present for one month.

II. Clinical features of schizophrenia.

A. A prior history of schizotypal or schizoid personality traits or disorder is often present.

B. Symptoms of schizophrenia have been traditionally categorized as either positive or negative. Depression and neurocognitive dysfunction are gaining acceptance as terms to describe two other core symptoms of schizophrenia.

<u>1. Positive symptoms:</u>

a. Hallucinations are most commonly auditory or visual, but hallucinations can occur in any sensory modality.

b. Delusions.

c. Disorganized behavior.

d. Thought disorder is characterized by loose associations, tangentiality, incoherent thoughts, neologisms, thought blocking, thought insertion, thought broadcasting, and ideas of reference.

2. Negative symptoms:

a. Poverty of speech (alogia) or poverty of thought content.

b. Anhedonia.

c. Flat affect.

d. Loss of motivation (avolition).

e. Lack of attention.

f. Loss of social interest.

3. Depression is common and often severe in schizophrenia and can compromise functional status and response to treatment. Atypical antipsychotics often improve depressive signs and symptoms, but antidepressants may be required.

4. Cognitive impairment. Cognitive dysfunction (including attention, executive function, and particular types of memory) contribute to disability and can be an obstacle in long-term treatment. Atypical antipsychotics may improve cognitive impairment.

C. The presence of tactile, olfactory or gustatory hallucinations may indicate an organic etiology such as complex partial seizures.

D. Sensorium is intact.

E. Insight and judgment are frequently impaired.

F. No sign or symptom is pathognomonic of schizophrenia.

III. Epidemiology of schizophrenia.

A. The lifetime prevalence of schizophrenia is one percent.

B. The onset of psychosis usually occurs in the late teens or early twenties.

C. Males and females are equally affected, but the mean age of onset is approximately six years later in females. Females frequently have a milder course of illness.

D. The suicide rate is 10-13%, similar to the rate that occurs in depressive illnesses. More than 75% of patients are smokers, and the incidence of substance abuse is increased (especially alcohol, cocaine, methamphetamine and marijuana).

E. Most patients follow a chronic downward course, but some have a gradual improvement with a decrease in positive symptoms and increased functioning. Very few patients have a complete recovery.

F. The lifespan of patients with schizophrenia is approximately 10 years shorter compared to the general population. This is thought to lifestyle (poor nutrition, lack of exercise, smoking), decreased access to medical care and higher suicide rate.

IV. Classification of schizophrenia.

A. *Paranoid type*. Schizophrenia is characterized by a preoccupation with one or more delusions or frequent auditory hallucinations, the absence of prominent disorganization of speech, disorganized or catatonic behavior, or flat or inappropriate affect.

B. *Disorganized type*. Schizophrenia is characterized by prominent disorganized speech, disorganized behavior, and flat or inappropriate affect.

C. *Catatonic type*. Schizophrenia is characterized by at least two of the following motoric immobility, excessive motor activity, extreme negativism or mutism peculiar voluntary movements such as bizarre posturing, echolalia or echopraxia.

D. *Undifferentiated type* Schizophrenia meets criteria for schizophrenia, but it cannot be characterized as paranoid, disorganized, or catatonic type.

E. *Residual type* Schizophrenia is characterized by the absence of prominent delusions, disorganized speech and grossly disorganized or catatonic behavior and continued negative symptoms or two or more attenuated positive symptoms.

V. Differential diagnosis of Schizophrenia.

A. *Psychotic disorder due to a general medical condition, delirium, or dementia.*

Included would be CNS infections, thyrotoxicosis, lupus, myxedema, multiple strokes, HIV, hepatic encephalopathy, and others.

B. *Substance-induced psychotic disorder.*

Amphetamines and cocaine frequently cause hallucinations, paranoia, or delusions. Phencyclidine (PCP) may lead to both positive and negative symptoms.

C. *Schizoaffective disorder.*

Mood symptoms are present for a significant portion of the illness. In schizophrenia, the duration of mood disorder symptoms is briefly compared to the entire duration of the illness.

D. *Mood disorders with psychotic features*.

1. Psychotic symptoms occur only during major mood disturbance (mania or major depression).

2. Disturbances of mood are frequent in all phases of schizophrenia.

E. Delusional disorder. Non-bizarre delusions are present in the absence of other psychotic symptoms.

F. Schizotypal, paranoid, schizoid or borderline personality disorders.

1. Psychotic symptoms are generally mild and brief in duration.

2. Patterns of behavior are life-long, with no identifiable time of onset.

G. Brief psychotic disorder. Duration of symptoms is for one day to one month.

H. Schizophreniform disorder. The criteria for schizophrenia are met, but the duration of illness is less than six months.

VI. Indications for hospitalization.

1. Psychotic symptoms prevent a patient from fulfilling his basic needs.
2. Suicidal ideation, often secondary to psychosis, usually requires hospitalization.
3. Patients who are a danger to themselves or others require hospitalization.
4. Patients with command hallucinations to harm themselves or others should be evaluated for hospitalization, especially with a history of acting under the effect of hallucinations.

Case example.

Anamnesis: Finished 4 classes of primary school before the II World War, then continued education. Worked in the sphere of accounting. Was married, has one daughter, the husband died about 5 years ago. Resides with the daughter's family.

Now she is a pensioner and disabled of 2 group due to myocardial infarction (2000).

In childhood she was down with meningitis, suffers from poor hearing, underwent operation on duodenum ulcer. Has been under psychiatric observation since January 2008, when according to the daughter's deliverance the psychiatric inspection was carried out in connection with inadequate behavior: the patient closed the door of the bedroom, loudly shouted that the daughter and her husband were smothering a child.

She told a psychiatrist that «my daughter with my son-in-law want to make a psychopath of me. They fabricated that I have hallucination, but I am healthy».

21.05.08. The patient's daughter applied to psychiatrist with such complains:

inadequate behavior expressed in shouting and attempts to save the little girl Natasha that is being raped in their bedroom. That day the patient was hospitalized to the Grodno State Clinical Centre ''Psychiatry-Narcology" from the police station where she reported about the little girl Natasha being a hostage in the room № 21. At the admission department shouted loudly, then suddenly became silent "Wait Natasha, I am busy now." Because of poor hearing communication was extremely difficult.

Psychic status 22.05.08: Consciousness is clear, correctly oriented. The contact is available only in a written form. Answers the questions in essence. The voice is loud and ringing. The mood is unstable, worries about Natasha. The patient told that her daughter has been living with a man for 20 years (denies the fact of marriage); the daughter's name is Natasha. The patient is certain that her daughter has brought to her apartment a little girl Natasha 17 years old, a pupil of the 7" class, living at the address: Pushkin St. The son-in-law closed Natasha in the room, and constantly rapes the child: "Poor Natasha came to me, I wanted to feed her with soup, but he closed her, she was a virgin, now he comes anytime he wants and rapes her, Natasha asks me to rescue her". In the course of conversation the patient reported that son-in-law forces her daughter too. "For 8 hours on end, 1 knock the door but it does not help". The patient saw and heard Natasha, explained

that her daughter named Natasha and the little girl Natasha are different people. The woman explained her hospitalization as incorrect because “my daughter wants to make a psychopath of me to own my apartment”. Demonstrated the bruises on her body wit words: "These are daughter's leg beats" or "I have undergone 7 operations on my head”. Thinking is inconsequent, viscous, and delirious ideas are obvious. Self-criticism is absent. Attention is switched with difficulty, memory remained, available mathematical operations, classification of subjects. The patient names different countries and their capitals correctly, spatial orientation in Grodno preserves.

Denies suicidal thoughts. Denies that hears the Natasha’s voice in hospital but is certain that the little girl needs her help.

2.2. Categorization of Mood disorders:

A. Mood episodes are comprised of periods when the patient exhibits symptoms of a predominant mood state. Mood episodes are not diagnostic entities. Mood disorders are clinical diagnoses defined by the presence of characteristic mood episodes.

B. Mood episodes are classified as follows:

1. Types of Mood Episodes
    a. Major depressive episode.
    b. Manic episode.
    c. Mixed episode.
    d. Hypomanic episode.

C. Mood disorders are classified as follows:

1. Types of **Mood Disorders**
    a. Depressive disorders.
    b. Bipolar disorders.
    c. Other mood disorders.

Major depressive episodes

Major depressive episodes are characterized by persistent sadness, often associated with somatic symptoms, such as weight loss, sleeping problems and decreased energy.

I. DSM-IV. Diagnostic criteria:

A. At least five of the following symptoms for at least two weeks duration.

B. Must be a change from previous functioning.

C. At least one symptom is depressed mood or loss of interest or pleasure.

1. Pervasive depressed mood.
2. Pervasive anhedonia.
3. Significant change in weight.

4. Sleep disturbance.
5. Psychomotor agitation or retardation.
6. Pervasive fatigue or loss of energy.
7. Excessive guilt or feeling of worthlessness.
8. Difficulty with concentrating.
9. Recurrent thoughts of death or thoughts of suicide.

D. Symptoms must cause significant social or occupational dysfunction or significant subjective distress.

E. Cannot be caused by a medical condition, medication or drugs.

F. Symptoms cannot be caused by bereavement.

II. Clinical features of depressive episodes.

A. Occasionally no subjective depressed mood is present; only anxiety and irritability are displayed.

B. Feelings of hopelessness and helplessness are common.

C. Decreased libido is common.

D. Early morning awakening with difficulty or inability to fall back asleep is typical.

E. Psychomotor agitation can be severe.

F. Patients may appear demented because of poor attention, poor concentration, and indecisiveness.

G. Guilt may become excessive and may appear delusionally.

H. Obsessive rumination about the past or specific problems is common.

1. Preoccupation with physical health may occur.

J. Frank delusions and hallucinations may occur, and they are frequently nihilistic in nature.

K. Family history of mood disorder or suicide is common.

Manic episodes

I. DSM-IV Diagnostic criteria.

A. At least one week of abnormally and persistently elevated, expansive or irritable mood (may be less than one week if hospitalization is required).

B. During the period of mood disturbance, at least three of the following have persisted in a significant manner (four if mood is irritable):

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep.
3. The patient has been more talkative than usual or feels pressure to keep talking.
4. Flight of ideas jumping from topic to topic) or a subjective sense of racing thoughts.
5. Distractibility.

6. Increased goal-directed activity or psychomotor agitation.
7. Excessive involvement in pleasurable activities with a high potential for painful consequences (i.e., sexual indiscretion).

C. Does not meet criteria for a mixed episode.

D, Symptoms must have cause marked impairment in social or occupational functioning, or have required hospitalization to prevent harm to self or others, or psychotic features are present.

E. The symptoms cannot be caused by a medical condition, medication or drugs.

II. Clinical features of manic episodes

A. The most common presentation is excessive euphoria, but some patients may present with irritability alone.

B. Patients may seek out constant enthusiastic interaction with others, frequent using poor judgment in those interactions.

C. Increased psychomotor activity can take the form of excessive planning an participation, which are ultimately nonproductive.

D. Reckless behavior with negative consequences is common (e. g., shopping sprees, excessive spending, sexual promiscuity).

E. Inability to sleep can be severe and persist for days.

F. Lability of mood is common.

G. Grandiose delusions are common.

H. Speech is pressured, loud and intrusive, and difficulty to interrupting these patients is common. Flight of ideas can result in gross disorganization an incoherence of speech.

1. Patients frequently lack insight into their behavior and resist treatment.

J. Patients may become grossly psychotic, most frequently with paranoid features.

K. Patients may become assaultive, particularly if psychotic.

L. Dysphoria is common at the height of a manic episode, and the patient ma' become suicidal.

2.3. Fatal deliberate self-harm (suicide) and non-fatal deliberate self-harm (parasuicide)

Fatal deliberate self-harm (suicide, completed suicide) and non-fatal deliberate self-harm (DSH, parasuicide, attempted suicide) are separate phenomena which overlap to some degree. Both medical and social factors are involved in their aetiology, prevention, and management.

Suicide is an act of self-harm, undertaken with conscious self-destructive intent, with a fatal outcome.

Frequency. There are between 3000 and 5000 suicides in the Republic of Belarus per year; this is about 34 per 100 000 population. Official statistics have tended to underestimate the true rate because only cases with proven evidence of intent, such as a suicide note, were given suicide

verdicts by the coroner. Some deaths given ‘accident’ or ‘undetermined’ verdicts in the past were probably suicides However, coroners may have become more ready to give suicide verdicts in recent years when the evidence points in that direction.

Methods that are most easily available are most likely to be used, and media publicity about a suicide is often followed by other deaths by the same method, Methods can be thought of as violent (hanging or jumping) and non-violent (drugs and other forms of poison). Males and mentally disordered persons tend toward violent methods; females toward non-violent. Hanging / strangling / suffocation and gassing by car exhaust fumes (carbon monoxide) are now the most common methods taken overall, although poisoning (often by medicinal drugs) remains the commonest method in women. Other methods include drowning, shooting, cutting, jumping, and burning.

Epidemiology.

- Temporal trend: the number of suicides in the UK and some other countries has declined somewhat in recent years (McClure, 2000), partly due to the detoxifying of the household gas supply (natural rather than coal gas) and motor vehicle exhaust fumes (introduction of catalytic converters) (McClure, 2000). Attempts have been made to relate this reduction to contemporaneous increases in antidepressant prescribing rates (e. g. Hall et al., 2003), but this is impossible to prove.
- Age: the rate increases with age, but suicide in young men (age 15–24) has recently become more frequent.
- Sex: suicide is more than twice as common in men than women.
- Marital status: divorced people have the highest rates, followed by the widowed and single, and the married at the lowest.
- Social class: the highest rates are at both extremes of the social scale.
- Occupation: high-risk groups include doctors, veterinary surgeons, pharmacists, and farmers.
- Residential circumstances: inner-city areas with a mobile population have high rates. Psychiatric inpatients, those recently discharged from such hospitals, and prisoners are all at high risk.
- Nationality: there are large differences between the suicide rates of different countries. These are partly real, due, for example, to religious and cultural variation, but some apparent differences result from differing methods of ascertainment. High tates are found in Greenland, Hungary, Austria, Denmark, Japan, Germany, and jastern Europe. Low rates are found in Eire, Italy, Spain, Greece, and the Netherlands.

- National circumstances: suicide rates fall in wartime. High suicide rates are found in association with economic depression, unemployment, and high divorce rates.

Causes. Psychiatric disorder is present immediately before death in up to 90 per cent of cases, as indicated by the 'psychological autopsy' technique of interviewing those who knew the dead person. Depressive illness, often inadequately treated, is the commonest diagnosis, especially in older people. Alcohol and drug misuse are also common, especially in the young. Personality disorder often coexists. 'Rational' suicide, by people without evidence of mental disorder, presumably in hopeless situations, seems to be rare in Western societies. Follow-up of psychiatric patient populations indicates that in 5–15 per cent of subjects with mental illness, personality disorder, and / or drug or alcohol problems, suicide will be the cause of death. Risk of suicide is raised in all mental disorders, not just depression.

Other causes:

- stressful circumstances, including life events such as bereavement, and long-term social difficulties such as unemployment.
- social isolation in those who live alone and / or lack confiding relationships.
- physical illness: raised suicide rates are found in association with certain physical conditions, including epilepsy, other neurological disorders, peptic ulcer, renal failure on dialysis, and AIDS.
- neurochemistry: deficiency of 5-HT has been linked to suicidal behaviour in some studies.

Prevention.

Some preventive strategies aim to improve the management of individuals at high risk; others to reduce factors associated with suicidality in society as a whole. Reduction of suicide rates, both for the general population and for psychiatric patients, is among the targets in the government's 'Health of the Nation' strategy. It is important to remember that not only depression but also all mental disorders (apart possibly from learning disability and dementia) carry an increased risk of suicide (Harris and Barraclough, 1997). Psychiatric patients who have voiced suicidal thoughts, have a past history of suicide attempts should be considered at high risk.

Other strategies:

- counseling services (the confidential telephone helpline for despairing).
- restricting availability of methods, (catalytic converters for cars; controls on sale and possession of medicines, guns).
- physical considerations such as making psychiatric wards as safe as possible (for example, by removing potential ligature points, from which a patient might hang himself) and

preventing public access to bridges or cliffs from which others have jumped to their death.

- educational programmers; for example, efforts to improve the recognition and management of potentially suicidal patients in general practice, or to dissuade young people from suicidal behavior.

Non-fatal deliberate self-harm (DSH) is deliberate overdose or self-injury without a fatal outcome. Most such acts are not determined attempts at self-killing, and therefore the previous terms 'parasuicide' and 'attempted suicide' are less frequently employed. The term 'deliberate self-harm' (DSH) has become preferred, because it is neutral and gives a clearer description. Accidental injuries and acts intended to cause pleasure are excluded from the definition of DSH. Factitious disorder involves a form of self-injury, such as self-injection with pus to produce fever. The intended outcome is to deceive health-care professionals into thinking that a person is unwell and needs care.

Frequency. Exact frequency is impossible to determine because milder case: may not be referred to hospital, or even present to health services at all, Community surveys indicate a lifetime prevalence of up to 5 per cent for DSH.

Methods. About 90 per cent of DSH cases are self-poisonings, often b painkillers bought without prescription, such as paracetamol, and / or prescribe psychotropic drugs; they are often accompanied by alcohol. Others are by more violent methods, such as self-cutting or burning by cigarette ends.

Epidemiology.

- Age: highest in the late teens and early twenties.
- Sex: twice as common in women.
- Social conditions: highest rates are in social classes IV and V, and in inner-city areas with a high incidence of social problems.

Motives. Up to 10 per cent of episodes of DSH are serious suicide attempts that failed. In other cases, the reported motivation is to escape from an intolerable situation or state of mind, an appeal for help, or an attempt to influence another person. Some patients cannot explain their motivation. Motivation is frequently multiple, mixed, and complex and changeable. Patients often say that they wanted to dle when they did the act, but that this coexisted with other motives and feelings, sich as a need to get out of an impossible situation.

Causes:

- Life events and social difficulties: about 70 per cent of these acts follow a distressing event, usually involving disharmony with another person. Long-term social problems, such as family or economic difficulties, are common.

- Psychiatric disorder: there is clearly a high prevalence of mental disorder among DSH patients, but it is difficult to generalize. All types of mental disorder are seen, including psychosis occasionally. Symptoms of low mood are common (over 50 per cent of cases), but most do not have a pervasive clinical depressive illness at follow-up. Personality disorder and substance misuse are also common (perhaps over 25 per cent).

Assessment. Before a valid psychosocial assessment can be carried out, the patient must have had time to recover from the immediate effects of the self-harm, such as drowsiness or confusion after an overdose. Three aspects require special attention:

- whether there was serious suicidal intent, as indicated by:
  - the subject claiming to have wanted to die and to regret survival;
  - a premeditated act preceded by making arrangements for death, leaving a suicide note, and taking precautions against discovery;
  - use of a method that the subject believed would be fatal;
  - features associated with completed suicide, such as older age and social isolation.
- whether psychiatric illness requiring treatment and social problems are present.

It is not feasible, or necessary, for all cases to be assessed by a psychiatrist. Junior medical staff, nurses, and social workers in the general hospital can be trained to identify patients needing psychiatric referral.

Prognosis. About 20 per cent repeat deliberate self-harm the next year, and around 1 per cent die by suicide the next year (nearly a 100-fold increase over the general population suicide rate). Up to 10 per cent die by suicide eventually.

Prevention. Primary preventive strategies are similar to those described above for completed suicide. Psychiatric treatment, social work, and counselling have been evaluated for secondary prevention in people who have already made an attempt.

“ SAD PERSONS ” – scale for assessment and management of suicidal ideation.

S ex-male

A ge> 60 years old

Depression

P revious attempts

E thanol abuse

R ational thinking loss (delusion, hallucination, hopelessness)

S uicide in family

O rganized plan

N o spouse (no support systems)

S erious illness, intractable pain

- Score (total number of risk factors present):

0–2 consider sending home with family

3–4 close follow up, consider hospitalization

5–6 strongly consider hospitalization

7–10 hospitalize

Case example 1. A 22-year-old man was brought to the doctor by his girlfriend, who complained that over the previous few weeks he had become increasingly 'moody and withdrawn', and had been drinking too much. The doctor, who had known him for years, was struck by his gaunt and miserable appearance, but was nevertheless surprised when, after his partner left the consulting room, the patient broke down in tears. There was a clear history of depressed mood, loss of interest in things which he usually found pleasurable, poor sleep with terminal insomnia, poor appetite with weight loss, and inability to concentrate, leading to problems at work. The doctor noting a positive family history of bipolar affective disorder in the father, made a diagnosis of depressive illness. After the consultation, the doctor realized that he had not yet assessed suicidal risk, and decided to call on the patient on the way home.

Mild depression is more common, and the symptoms are more like an exaggeration of ordinary unhappiness. Somatic symptoms are not prominent, and delusions and hallucinations do not occur. There may be marked tearfulness, anxiety, irritability and difficulty getting to sleep. It is, however, probably an over-diagnosed condition these days, especially in general practice. This is not to criticize our colleagues in primary care. Patients have been encouraged to take their emotional difficulties to doctors; in previous eras, they might have been seen as tired and given a tonic, and in later times as anxious, and given benzodiazepines. Currently, the social and medical culture guides doctors and patients toward a diagnosis of depression and the prescription of an antidepressant. The key point is the mood; the patient has to have a true depression of mood; that is, persistent low mood unrelieved by circumstances.

If this is not present, depression is not present either. A natural reaction, an adjustment disorder, or dysthymia, is more likely.

Case example 2. Anamnesis: The patient is a young woman aged 22, the second child of the 5-children clergyman's family. She got basic education, finished the pedagogical college. At present time she is a 3rd year student of the university. Other diseases: colds. She had strict upbringing. Parents forbade her going to disco parties and meetings with her friends. In adolescence she made superficial self cuts of the left forearm because of «brawls with parents» two times. In 2007 became pregnant from the 5 years elder man, with whom had relationship for a year. Then made abortion outside the hospital. After this for the first time had noticed changes in her psychic state: she ceased relations with this man; avoided any communications; was simply laying in bed staring

at ceiling. Such general state continued for a month, no apply for medical help was made. The sense of guilt about the performed deeds increased.

She agitated, when meeting pregnant woman or children. Later her mood became smooth and she started communications with friends. Then she started cohabiting with a male elder from her for 6 years. They wanted to get married but the patient noticed oddity in her behavior: mood drops, unmotivated deeds, for example: lighting candles everywhere at home, attempts to jump from a bridge, spontaneous wishes for hanging. Over the last 2 months the woman noticed the gradual reduction of spirit, anorexia, insomnia, unwillingness. Fear of death appeared. «Some strange bumps arised on my head on nervous soil, I am seriously ill and will die». Occasionally suicidal thoughts appeared, but without concrete actions. She had pour progress in college, became bad-tempered «all people irritated», lack of attention and memory reduction appeared. She applied for medical help, was examined by a psychiatrist of the Grodno State Clinical Centre "Psychiatry-Narcology" and hospitalized to the women psychiatric department.

Psychic status on 15.04.08. Wears black clothes. Easy to contact. Answers the questions curtly. Is oriented comprehensively correct. Consciousness is normal. The back-ground of spirit is abated. Complains of insomnia for the last 2 nights, lack of appetite, bad temper. Defines herself as a punk. Told in details about her relationships with men, parents. Said that used «grass»2–3 times, several times «nasvay», at present smokes one pack of cigarettes per day. Delirium and hallucinations are not detected. Thinking is consecutive, a bit slack. Attention is labile. Denies suicide thoughts. At the department easily found common language with people of the same age. Agreed to pass the treatment at the Grodno State Clinical Centre "Psychiatry-Narcology".

2.4. Dementia

Dementia is characterized by chronic and progressive deterioration of selective mental functions. Dementia can be classified as cortical or subcortical. Cortical dementia includes the disturbance of 'higher functions', such as dysphasia, agnosia, and apraxia. In subcortical dementia, these functions are preserved, but the patient is forgetful, slow and apathetic; may show marked emotional lability with sudden outbursts of laughter or rage.

There are three types of cortical dementia:

(1) primary degenerative dementia (e. g., Alzheimer's), accounting for about 50–60% of cases;

(2) atherosclerotic (multi-infarct) dementia, 15–20% of cases (this figure is probably low because of the tendency to overuse the diagnosis of Alzheimer's dementia);

(3) mixtures of the first two types or dementia due to miscellaneous causes, 15–20% of cases (see also Geriatric Disorders).

Examples of primary degenerative dementia are Alzheimer's dementia (most common) and Pick, Creutzfeldt-Jakob, and Huntington dementias (less common).

I. DSM-IV Diagnostic criteria for dementia

A. The development of multiple cognitive deficits manifested by:

1. Memory impairment.

2. One or more of the following:

   a. Aphasia (language disturbance).

   b. Apraxia (impaired ability to carry out purposeful movement, especially the use of objects).

   c. Agnosia (failure to recognize or identify objects).

   d. Disturbance in executive functioning (abstract thinking, planning and carrying out tasks).

B. The cognitive deficits cause significant social and occupational impairment and represent a significant decline from a previous level of functioning.

C. The deficits are not the result of delirium.

IL. Clinical features of dementia

A. The memory impairment involves difficulty in learning new material and / or forgetting previously learned material. Early signs may consist of losing belongings or getting lost more easily.

B. Once the dementia is well established, patients may have great difficulty performing activities of daily living such as bathing, dressing, cooking, or shopping.

C. Poor insight and impaired judgment are common features of dementia.

1. Patients are often unaware of their deficits. 2

2. Patients may overestimate their ability to safely carry out specific tasks.

3. Disinhibition can lead to poor social judgment, such as making inappropriate comments.

D. Psychiatric symptoms are common and patients frequently manifest symptoms of anxiety, depression, and sleep disturbance.

E. Paranoid delusions (especially accusations that others are stealing items) an hallucinations (especially visual) are common.

F. Delirium is frequently superimposed upon dementia because these patients and more sensitive to the effects of medications and physical illness.

III. Epidemiology of dementia

A. The prevalence of dementia increases with age. Three percent of patients over 65 years old have dementia, but after age 85, 20% of the population is affected.

B. Alzheimer's type dementia is the most common type of dementia, comprising 50–60% of all cases. Vascular dementia is the second most common cause of dementia, accounting for 13% of all cases.

IV. Classification of dementia

A. Alzheimer's Type Dementia

1. The patient meets basic diagnostic criteria for dementia but also:
    a. Gradual onset and continued cognitive decline.
    b. Cognitive deficits are not due to another medical condition of substance.
    c. symptoms are not caused by another psychiatric disorder.
2. Alzheimer's Disease is further classified as:
    a. Early or late onset.
    b. With delirium, delusions, depressed mood, or uncomplicated.
3. The average life expectancy after onset of illness is 8–10 years.

A. National Institute of Neurological and Communicative Disorders and Stroke (NINCDS), Alzheimer's Disease and Related Disorders Association (ADRDA) criteria.

Probable Alzheimer's disease:

- Criteria include: the presence of dementia, deficits in at least two areas of cognition, progressive deterioration, no clouding of consciousness, age between 40 and 90, absence of systemic disorders.
- Diagnosis is supported by: progressive deterioration of individual cognitive function, impaired activities of daily living, family history of dementia, normal lumbar puncture, electroencephalogram, and evidence of atrophy (or progression) on CT scan.
- Features consistent with the diagnosis: plateaus in the course of the disease, associated psychiatric symptoms, neurological signs, seizures, normal CT scan.
- Diagnosis unlikely if: sudden onset, focal neurological signs, seizures or gait disturbance early in the disease.

Possible Alzheimer's disease:

- Diagnosis can be made in the presence of atypical features; in the presence of a systemic disease (not considered to be the cause of dementia); in the presence of a single progressive cognitive deficit.

Definite Alzheimer's disease:

- Criteria are the clinical criteria for probable Alzheimer's disease plus histological evidence of the disorder.

B. Vascular dementia (previously multi-infarct dementia).

The patient meets basic diagnostic criteria for dementia but also has:

a. Focal neurological signs and symptoms or laboratory evidence of cerebrovascular disease (eg, multiple infarctions or MRI scan).
b. Vascular dementia is further classified as with delirium, delusions, depressed mood, or uncomplicated.
c. Unlike Alzheimer's disease, changes in functioning may be abrupt, and the long-term course tends to have a stepwise pattern. Deficits are highly variable depending on the location of the vascular lesions, leaving some cognitive functions intact.

C. Dementia due to other general medical conditions.

1. Meets basic diagnostic criteria for dementia, but there must also be evidence that symptoms are the direct physiological consequence of a general medical condition.

2. AIDS-related dementia:

a. Dementia caused by the effect of the HIV virus on the brain.
b. Clinical presentation includes psychomotor retardation, forgetfulness apathy, impaired problem solving, flat affect, social withdrawal.
c. Frank psychosis may be present.
d. Neurological symptoms are frequently present.

3. Dementia caused by head trauma.

Dementia caused by head trauma usually does not progress. The on notable exception is dementia pugilistica, which is caused by repeated trauma (e. g., boxing).

4. Dementia caused by Parkinson's disease.

Dementia occurs in 40-60% of patients with Parkinson's disease. The dementia is often exaggerated by the presence of major depression.

5. Dementia caused by Huntington's disease.

a. Dementia is an inevitable outcome of this disease.
b. Initially, language and factual knowledge may be relatively preserved, while memory, reasoning, and executive function are more seriously impaired.
c. Occasionally, dementia can precede the onset of motor symptoms.

6. Dementia caused by Pick's disease.

a. The early phases of the disease are characterized by disinhibition apathy, and language abnormalities because Pick's disease affects the frontal and temporal lobes.
b. Later stages of the illness may by clinically similar to Alzheimer' disease. Brain imaging studies usually reveal frontal and / or temporal atrophy.

7. Dementia caused by Creutzfeldt-Jakob disease.

a. Creutzfeldt-Jacob disease is a subacute spongiform encephalopathy caused by a prion.

b. The clinical triad consists of dementia, involuntary myoclonic movements, and periodic EEG activity.

8. Lewy body dementia.

a. Characterized by decline in cognition along with fluctuating levels of attention and alertness. Recurrent, well-formed visual hallucinations are also common.

b. Lewy body dementia is associated with repeated falls, transient loss of consciousness, syncope, neuroleptic sensitivity, delusions and hallucinations.

D. Substance-induced persisting dementia.

1. Meets basic diagnostic criteria for dementia but also:

a. The deficits persists beyond the usual duration of substance intoxication or withdrawal.

b. There is evidence that the deficits are related to the persisting effects of substance use (specify which drug or medication).

2. When drugs of abuse are involved, most patients have, at some time in their lives, met criteria for substance dependence.

3. Clinical presentation is that of a typical dementia. Occasionally patients will improve mildly after the substance use has been discontinued, but most display a progressive downhill course.

E. Dementia due to multiple etiologies. This diagnosis is applicable when multiple disorders are responsible for the dementia.

2.5. Delirium – acute organic syndrome

Delirium (acute brain syndrome, acute confusional state) is a clouding of consciousness – that is, reduced awareness of the environment – accompanied by abnormalities of cognition, perception, thought, and mood, due to organic cause. The lcohol withdrawal syndrome (delirium tremens) is a common example, but delirium may be due to any acute condition affecting the brain.

The cardinal feature is a reduced level of consciousness, although mild degrees of this can be easy to miss in clinical practice. The patient is confused and disoriented, often restless, overactive, and fearful, but sometimes underactive and withdrawn. Inattention, including reduced ability to focus or shift attention, is common. Illusions; hallucinations of visual, auditory, or tactile type; and changeable paranoid delusions may be present. Severity fluctuates, usually being worse at night.

I. DSM-IV Diagnostic criteria for delirium.

A. Disturbance of consciousness with reduced ability to focus, sustain or shift attention.

B. The change in cognition or perceptual disturbance is not due to dementia.

C. The disturbance develops over a short period of time (hours to days) and fluctuates during the course of the day.

D. There is clinical evidence that the disturbance is caused by a general medical condition and / or substance use or withdrawal.

II. Clinical features of delirium.

A. Delirium is characterized by impairments of consciousness, awareness of environment, attention and concentration. Many patients are disoriented and display disorganized thinking. A fluctuating clinical presentation is the hallmark of the disorder, and the patient may have moments of lucidity during the course of the day.

B. Perceptual disturbances may take the form of misinterpretations, illusions or frank hallucinations. The hallucinations are most commonly visual, but other sensory modalities can also be misperceived.

C. Sleep-wake cycle disturbances are common, and psychomotor agitation can be severe, resulting in pulling out of IVs and catheters, falling, and combative behavior. The quietly delirious patient may reduce fluid and food intake without overtly displaying agitated behavior.

D. Failure to report use of medications or substance abuse is a common cause of withdrawal delirium in hospitalized patients. Infection and medication interaction or toxicity is a common cause of delirium in the elderly.

E. Injuries may occur when the patient is delirious and agitated and unrecognized delirium may result in permanent cognitive impairment.

F. The incidence of delirium in hospitalized patients is 10–15%, with higher rates in the elderly. Other patients at risk include those with CNS disorders, substance abusers, and HIV-positive patients. G. Post-discharge morbidity and mortality is higher in patients who experience delirium compared to those who do not.

III. Classification of delirium.

A. Delirium due to a general medical condition (specify which condition).

B. Delirium due to substance intoxication (specify which substance).

C. Delirium due to a substance withdrawal (specify which substance).

D. Delirium due to a multiple etiologies (specify which conditions).

E. Delirium not otherwise specified (unknown etiology or due to other causes such as sensory deprivation).

IV. Differential diagnosis of delirium.

A. *Dementia*

1. Dementia is the most common disorder that must be distinguished from delirium. The major difference between dementia and delirium is that demented patients are alert without the disturbance of consciousness characteristic of delirious patients.

2. Information from family or caretakers is helpful in determining whether there was a preexisting dementia.

B. Psychotic disorders and mood disorders with psychotic features. Delirium can be distinguished from psychotic symptoms by the abrupt development of cognitive deficits including disturbance of consciousness. In delirium, there should be some evidence of an underlying medical or substance-related condition.

C. Malingering. Patients with malingering lack objective evidence of a medical or substance-related condition.

Differential for delirium:

I – Infectious (encephalitis, meningitis, UTI, pneumonia)

W – Withdrawal (alcohol, barbiturates, benzodiazepines)

A – Acute metabolic disorder (electrolyte imbalance, hepatic or renal failure)

T – Trauma (head injury, postoperative)

C – CNS pathology (stroke, hemorrhage, tumour, seizure disorder, Parkinson's)

H – Hypoxia (anemia, cardiac failure, pulmonary embolus)

D – Deficiencies (vitamin B 12, folic acid, thiamine)

E – Endocrinopathies (thyroid, glucose, parathyroid, adrenal)

A – Acute vascular (shock, vasculitis, hypertensive encephalopathy)

T -Toxins, substance use, medication (alcohol, anesthetics, anticholinergics, narcotics)

H – Heavy metals (arsenic, lead, mercury)

2.6. Mental and behavioural disorders due to psychoactive substance use

Drug misuse implies the use of drugs outside social, medical, or legal norms.

A psychoactive drug or psychotropic substance is a chemical substance that acts primarily upon the central nervous system where it alters brain function, resulting in lemporary changes in perception, mood, consciousness and behaviour. These drugs may be used recreationally to purposefully alter one's consciousness, as entheogens for ritual or spiritual purposes, as a tool for studying or augmenting the mind, or therapeutically as medication.

Classification of substances – mnemonic – **CHEAP COCAINE**

Cocaine

H allucinogens

E thanol

A mphetamines, sympathomimetics

P hencyclidine (PCP)

C affeine

O pioids

C annabis

A nxiolytics / hypnotics / sedatives

I nhalants

N icotine

E cstasy, gamma hydroybutyrate, ketamine (new designer drugs)

- *Addiction*: dependence on drugs with consequent detriment to social, physical, or economic function.
- *Dependence:* psychological dependence is a strong desire to take a certain drug to produce pleasure or relieve distress. Physical dependence is indicated by the development of bodily symptoms if the drug is withdrawn.
- *Tolerance:* physical adaptation to a drug, leading to a need for increasing dosage to achieve the same effect. Tolerance often precedes the development of physical dependence.

F10 – F19 – Mental and behavioural disorders due to psychoactive substance use.

Classification of Mental and behavioural disorders due to psychoactive substance use according to ICD-10.

F10 – Mental and behavioural disorders due to use of alcohol.

F11 – Mental and behavioural disorders due to use of opioids.

F12 – Mental and behavioural disorders due to use of cannabinoids.

F13 – Mental and behavioural disorders due to use of sedative hypnotics.

F14. – Mental and behavioural disorders due to use of cocaine.

F15 – Mental and behavioural disorders due to use of other stimulants, including caffeine.

F16 – Mental and behavioural disorders due to use of hallucinogens.

F17 – Mental and behavioural disorders due to use of tobacco.

F18 – Mental and behavioural disorders due to use of volatile solvents.

F19 – Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances.

F1x.0 *Acute intoxication.* A transient condition following the administration of alcohol or other psychoactive substance, resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psychophysiological functions and responses.

Flx.1 *Harmful use.* A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected drugs) or mental (e. g. episodes of depressive disorder secondary to heavy consumption of alcohol).

Flx.2 *Dependence syndrome.* A central descriptive characteristic of the dependence syndrome is the desire to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco.

Diagnostic guidelines.

A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:

(a) a strong desire or sense of compulsion to take the substance;

(b) difficulties in controlling substance-taking behavior in terms of its onset, termination, or levels of use;

(c) a physiological withdrawal state;

(d) evidence of tolerance, such that increased doses of the psychoactive substances are required in order to achieve effects originally produced by lower doses;

(e) progressive neglect of alternative pleasures or interests because of psychoactive substance use;

(f) persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning;

Flx.3 *Withdrawal state.* Withdrawal state is one of the indicators of dependence syndrome (see F1x.2) and this latter diagnosis should also be considered.

- Physical symptoms vary according to the substance being used.
- Psychological disturbances (e. g. anxiety, depression, and sleep disorders) are also common features of withdrawal.

The diagnosis of withdrawal state may be further specified by using the following five-character codes: F1x.30 Uncomplicated, Fix.31 With convulsions.

F'1x.4 *Withdrawal state with delirium.*

Onset usually occurs after withdrawal of alcohol. In some cases the disorder appears during an episode of heavy drinking, in which case it should be coded here. Prodromal symptoms typically include insomnia, tremulousness, and fear.

The classical triad of symptoms includes clouding of

1. consciousness and confusion,
2. vivid hallucinations and illusions affecting any sensory modality,
3. marked tremor.

F1x.40 Without convulsions.

F1x.41 With convulsions.

Flx.5 *Psychotic disorder*. A cluster of psychotic phenomena that occur during or immediately after psychoactive substance use (usually within 48 hours) and are characterized by:

- vivid hallucinations (typically auditory, but often in more than one sensory modality),
- misidentifications,
- delusions (often of a paranoid or persecutory nature),
- psychomotor disturbances, and an abnormal affect, which may range from intense fear to ecstasy.

Diagnostic guidelines.

The diagnosis of psychotic state may be further specified by the following five-character codes:

F1x.50 Schizophrenia-like.

Flx.51 Predominantly delusional.

F1x.52 Predominantly hallucinatory (includes alcoholic hallucinosis).

F1x.53 Predominantly polymorphic.

F1x.54 Predominantly depressive symptoms.

F1x.55 Predominantly manic symptoms.

F1x.56 Mixed.

F1x.6 *Amnesic syndrome.*

A syndrome associated with chronic prominent impairment of recent memory; remote memory is sometimes impaired, while immediate recall is preserved.

Confabulation may be marked but is not invariably present.

Flx.7 Residual and late-onset psychotic disorder.

A disorder in which alcohol- or psychoactive substance-induced changes of cognition, affect, personality, or behavior persist beyond the period during which a direct psychoactive substance-related effect might reasonably be assumed to be operating.

Specific substance-related disorders according DSM-IV:

I Alcohol, Sedatives, Hypnotics, and Anxiolytics.

A. Diagnostic criteria for intoxication.

1. Behavioral and psychological changes are present.

2. One or more of the following: slurred speech, incoordination, unsteady gait, nystagmus, impaired attention or memory, stupor or coma.

B. Clinical features of intoxication.

1. Amnesia is often present.

2. Behavioral disinhibition (aggressive or sexual activity) is a common finding.

3. Dependence is associated with the development of tolerance to sedative effects. Because the brainstem develops tolerance to the respiratory depressant effects more slowly, the risk for respiratory depression is increased, as users require higher doses to achieve a "high."

C. Addiction.

1. Tolerance develops to sedative effects.

2. Tolerance to brainstem depressant effects develops more slowly. As users require higher doses to achieve a "high," the risk for respiratory depression is increased.

D. Withdrawal from alcohol and other sedatives.

1. Detoxification may be necessary after prolonged use of central nervous system depressants, or when there are signs of abuse or addiction.

2. Sedatives associated with withdrawal syndromes include alcohol, benzodiazepines, barbiturates, and chloral hydrate.

E. Detoxification of patients dependent on alcohol, sedatives or hypnotics.

1. Provide a supervised stepwise dose reduction of the drug or substitute a cross-tolerant, longer-acting substance (diazepam), which has less risk of severe withdrawal symptoms.

2. The cross-tolerated drug is given in gradually tapering doses. To prevent withdrawal symptoms, the dose of medication should be reduced gradually over 1–2 weeks.

II. *Cocaine.*

A. Diagnostic criteria for intoxication.

1. Psychological or behavioral changes, such as euphoria, hyperactivity, hypersexuality, grandiosity, anxiety, or impaired judgement, are present.

2. Two or more of the following: tachycardia or bradycardia, mydriasis (dilated pupils), high or low blood pressure, chills or perspiration, nausea or vomiting, weight loss, agitation or retardation, weakness, arrhythmias, confusion, seizures, coma, respiratory depression, dyskinesias, or dystonia.

B. Clinical features of cocaine abuse.

1, Irritability, poor concentration, insomnia, and personality change are common. Intoxication can result in euphoria, impulsive behavior, poor judgement, and perceptual disturbances.

2. Physical sequelae include seizures, nasal congestion and bleeding, cerebral infarcts, and arrhythmias.

3. Chronic use is associated with paranoid ideation, aggressive behavior, depression, and weight loss.

C. Addiction. Psychological dependence is frequent. Tolerance develops with repeated use.

D. Withdrawal is characterized by depression, hypersomnia, anhedonia, anxiety, fatigue, and an intense craving for the drug; withdrawal generally remits in 2–5 days. Drug craving may last for months.

III. Opioids.

The group includes natural derivatives of opium (opiates) and synthetic surrogates (opioids).

The principal narcotic of abuse is heroin (metabolized to morphine), which is not used as a legitimate medication.

A. Diagnostic criteria for intoxication.

1. Behavioral or psychological changes, such as euphoria, followed by dysphoria, psychomotor retardation, impaired judgement, or impaired social or occupational functioning.

2. Pinpoint pupils (meiosis).

3. One of the following: drowsiness, coma, slurred speech, or impairment in attention or memory.

B. Clinical features of opioid abuse.

1. Initial euphoria is followed by apathy, dysphoria, and psychomotor retardation. Overdose can result in coma, respiratory depression, and death.

2. IV use is associated with risk of AIDS, skin abscesses, and bacterial endocarditis.

C. Addiction. Tolerance and dependence develops rapidly.

D. Withdrawal.

1, Intensity of the withdrawal syndrome is greatest with opiates that have a short half-life, such as heroin. Heroin withdrawal begins eight hours after the last use, peaks in 2-3 days and can last up to 10 days.

2. Diagnosis of withdrawal requires the presence of three or more of the following: dysphoria, nausea, vomiting, muscle aches, lacrimation, rhinorrhea, mydriasis, piloerection, sweating, diarrhea, yawning, fever, and insomnia.

Grades of withdrawal are categorized from 0 to 4:

- grade 0 includes craving and anxiety;
- grade 1, yawning, lacrimation, rhinorrhea, and perspiration;
- grade 2, previous symptoms plus mydriasis, piloerection, anorexia, tremors, and hot and cold flashes with generalized aching;
- grades 3 and 4, increased intensity of previous symptoms and signs, with increased temperature, blood pressure, pulse, and respiratory rate and depth.

IV. Phencyclidine abuse.

A. Diagnostic criteria for intoxication.

1. Behavioral changes.

2. At least two of the following: nystagmus, hypertension or tachycardia, slurred speech, ataxia, decreased pain sensitivity, muscle rigidity, seizure or coma, hyperacusis,

B. Clinical features of phencyclidine abuse.

1. Behavior changes include violence, belligerence, hyperactivity, catatonia, psychosis, anxiety, impairment of attention or memory, difficulty communicating.
2. Perceptual disturbances include paranoia, hallucinations, and confusion.
3. Physical examination: fever, diaphoresis, mydriasis.
4. Toxicology: PCP can be detected in urine for up to 5 days after ingestion.

C. Addiction: No evidence of physical dependence occurs, but tolerance to the effects can occur.

D. Withdrawal: Signs of depression can occur during withdrawal.

V. *Amphetamine / Methamphetamine (Speed, Crystal, Crank).*

A. Diagnostic criteria for amphetamine intoxication.

1. Behavioral or psychological changes such as euphoria, rapid speech, hyperactivity, hypervigilance, agitation, or irritability.

B. Clinical features.

1. Euphoria and increased energy is common in new users,

2. Development of delusions or hallucinations are not unusual in chronic heavy users.

C. Addiction: Physical tolerance develops, requiring increasing doses to achieve usual effect. Psychological dependence is frequent.

D. Amphetamine withdrawal.

1. Generally resolves in one week and is associated with increased appetite, vivid dreaming, fatigue, anxiety, hypersomnia, insomnia, psychomotor agitation or retardation.

2. Depression and suicidal ideation can develop.

VI. *Nicotine.*

A. Intoxication does not occur,

B. Clinical features

1. Craving is often prominent.

C. Addiction: Tolerance develops rapidly.

D. Diagnostic criteria for withdrawal

1. After abrupt cessation or reduction in the amount of nicotine used, four or more of the following occur within 24 hours: dysphoria, insomnia, irritability, anxiety, poor concentration, restlessness, decreased heart rate, increased appetite.

CHAPTER 3. Axis II: Developmental disorders and personality disorders

'Normal' personality. Personality disorders. Cluster A personality disorders. Cluster B personality disorders. Cluster C personality disorders. Mental retardation.

3.1. 'Normal' personality. Personality disorders

Personality disorder should be diagnosed only if the personality traits consistently impair well-being, personal relationships, or work, or lead to dependence on drugs or alcohol.

The distinction between personality disorder and psychiatric illness can be difficult, however, for the following reasons:

- The same patient may have both.
- Personality disorders may only be obvious during times of stress.
- Patients are often unable to describe the difference between their current symptoms and their usual personalities.

In domestic psychiatry development of the doctrine about psychopath – first of all with Peter Gannushkin's researches and representatives of his school. Gannushkin P. B. for the first time has described the diagnostic criteria of a psychopath:

1. totality of pathological character traits (the psychopath always and everywhere the psychopath);
2. relative stability;
3. social desadaptation.

3.2. General characteristics of personality disorders

A. Personality traits consist of enduring patterns of perceiving, relating to, and thinking about the environment, other people and oneself.

B. A personality disorder is diagnosed when personality traits become inflexible, pervasive and maladaptive to the point where they cause significant social or occupational dysfunction or subjective distress. Patients usually have little or no insight into their disorder.

C. Personality patterns must be stable and date back to adolescence or early adulthood. Therefore, personality disorders are not generally diagnosed in children.

D. Patterns of behavior and perception cannot be caused by stress, another mental disorder, drug or medication effect, or a medical condition.

DSM-IV groups the personality disorders into three clusters:

- *Cluster A: odd-eccentric*, including paranoid, schizoid, and schizotypal personality disorder.
- *Cluster B: dramatic-emotional-erratic*, including antisocial, borderline, histrionic and narcissistic personality disorder.

- *Cluster C: anxious-fearful*, including avoidant, dependent and obsessional compulsive personality disorder.

Personality disorder	Clinical findings
Paranoid	Defensive, oversensitive, secretive, suspicious, hyperalert, with limited emotional response.
Schizoid	Shy, introverted, withdrawn, avoids close relationships.
Obsessive-compulsive	Perfectionist, egocentric, indecisive, with rigid thought patterns and need for control.
Histrionic (hysterical)	Dependent, immature, seductive, egocentric, vain, emotionally labile.
Schizotypal	Superstitious, socially isolated, suspicious, with limited interpersonal ability, eccentric behaviors, and odd speech.
Narcissistic	Exhibitionist, grandiose, preoccupied with power, lacks interest in others, with excessive demands for attention.
Avoidant	Fears rejection, with poor social endeavors and low self-esteem.
Dependent	Passive, over accepting, unable to make decisions, lacks confidence, with poor self-esteem.
Antisocial	Selfish, callous, promiscuous, impulsive, unable to learn from experience, has legal problems.
Borderline	Impulsive; has unstable and intense interpersonal relationships; is suffused with anger, fear, and guilt; lacks self-control and self-fulfillment; has identity problems and affective instability; is suicidal (a serious problem-up to 80% of hospitalized 'borderline patients make an attempt at some time during treatment, and the incidence of completed suicide is as high as 5%); aggressive behavior, feelings of emptiness, and occasional psychotic decompensation. This group has a high drug abuse rate, which plays a role in symptoms. There is extensive overlap with other diagnostic categories, particularly mood disorders and posttraumatic stress disorder.

3.2. Cluster A personality disorders

Paranoid, schizotypal and schizoid personality disorders are referred to as cluster A personality disorders. Patients with these disorders have a preference for Social isolation. There is

also an increased incidence schizophrenia in first-degree compared to the general population. Patients with cluster A personality disorders often develop schizophrenia. They are considered part of the schizophrenia-Spectrum disorders, possibly milder variants of schizophrenia.

Paranoid personality disorder

1. DSM-IV Diagnostic criteria.

A. A pervasive distrust and suspiciousness of others is present without justification, beginning by early adulthood, and is manifested by at least four of the following:

1. The patient suspects others are exploiting, harming, or deceiving him.

2. The patient doubts the loyalty or trustworthiness of others.

3. The patient fears that information given to others will be used maliciously against him.

4. Benign remarks by others or benign events are interpreted as having demeaning or threatening meanings.

5. The patient persistently bears grudges,

6. The patient perceives attacks that are not apparent to others, and is quick to react angrily or to counterattack.

7. The patient repeatedly questions the fidelity of his spouse or sexual partner.

II. Clinical feature.

A. The patient is often hypervigilant and constantly looking for proof to support his paranoia. Patients are often argumentative and hostile.

B. Patients have a high need for control and autonomy in relationships to avoid betrayal and the need to trust others. Pathological jealousy is common.

C. Patients are quick to counterattack and are frequently involved in legal disputes. These patients rarely seek treatment.

III. Epidemiology.

A. The disorder is more common in first-degree relatives of schizophrenics compared to the general population.

B. Patients with the disorder may develop schizophrenia.

C. The disorder is more common in men than women.

IV. Differential diagnosis.

A. Delusional disorder. Fixed delusions are not seen in personality disorders.

B, Paranoid schizophrenia. Hallucinations and formal thought disorder are not seen in personality disorder.

C. Personality change due to a general medical condition and substance-related disorder. Acute symptoms are temporally related to a medication, drugs or a medical condition. The longstanding patterns of behavior required for a personality disorder are not present.

Schizoid personality disorder

I, DSM-IV Diagnostic criteria.

A. A pervasive pattern of social detachment with restricted affect, beginning by early adulthood and indicated by at least four of the following:

1. The patient neither desires nor enjoys close relationships, including family relationships.
2. The patient chooses solitary activities.
3. The patient has little interest in having sexual experiences.
4. The patient takes pleasure in few activities.
5. The patient has no close friends or confidants except first-degree relatives.
6. The patient is indifferent to the praise or criticism of others.
7. The patient displays emotional detachment or diminished affective responsiveness.

II. Clinical features.

A. The patient often appears cold and aloof, and is uninvolved in the everyday concerns of others.

B. Patients with SPD are often emotionally blunted, and these patients generally do not marry unless pursued aggressively by another person.

C. These patients are able to work if the job allows for social isolation.

III. Epidemiology.

A. Schizoid personality disorder is more common in first-degree relatives of schizophrenics compared to the general public.

B. Patients with schizoid personality disorder may develop schizophrenia.

C. Schizoid personality disorder is a rare disorder, which is thought to be more common in men than women.

IV. Differential diagnosis of schizoid personality disorder.

A. Schizophrenia. Hallucinations and formal thought disorder are not seen in personality disorders. Patients with schizoid personality disorder may have good work histories, whereas schizophrenic patients usually have poor work histories.

B. Schizotypal personality disorder. Eccentricities and oddities of perception, behavior and speech are not seen in schizoid personality disorder.

C. Avoidant personality disorder. Social isolation is subjectively unpleasant for avoidant patients. Unlike schizoid patients, avoidant patients are hypersensitive to the thoughts and feelings of others.

D. Paranoid personality disorder. Paranoid patients are able to express strong emotion when they feel persecuted. Schizoid patients are not able to express strong emotion.

E. Personality change due to a general medical condition and substance-related disorder. Acute symptoms are temporally related to a medication, drugs or a medical condition. The longstanding patterns of behavior required for a personality disorder are not present.

Schizotypal personality disorder

I, DSM-IV Diagnostic criteria.

A. A pervasive pattern of discomfort with and reduced capacity for close relationships as well as perceptual distortions and eccentricities of behavior, beginning by early adulthood.

At least five of the following should be present:

1. Ideas of reference: interpreting unrelated events as having direct reference to the patient (e. g., belief that a television program is really about him).
2. Odd beliefs or magical thinking inconsistent with cultural norms (eg, superstitiousness, belief in clairvoyance, telepathy or a "sixth sense").
3. Unusual perceptual experiences, including bodily illusions.
4. Odd thinking and speech (eg, circumstantial, metaphorical, or stereotyped thinking).
5. Suspiciousness or paranoid ideation.
6. Inappropriate or constricted affect.
7. Behavior or appearance that is odd, eccentric or peculiar.
8. Lack of close friends other than first-degree relatives.
9. Excessive social anxiety that does not diminish with familiarity.

II. Clinical features.

A. These patients often display peculiarities in thinking, behavior and communication.

B. Discomfort in social situations, and inappropriate behavior may occur.

C. Magical thinking, belief in "extra sensory perception," illusions and derealization are common.

D. Repeated exposure will not decrease social anxiety since it is based on paranoid concerns and not on self-consciousness.

E. The patient may have a vivid fantasy life with imaginary relationships.

F, Speech may be idiosyncratic, such as the use of unusual terminology.

G. These patients may seek treatment for anxiety or depression.

III. Epidemiology.

A. This disorder is more common in relatives of schizophrenics compared to the general population.

B. Patients with schizotypal personality disorder may develop schizophrenia.

C. The prevalence is approximately 3% in the general population.

IV. Differential diagnosis.

A. Schizoid and avoidant personality disorder. Schizoid and avoidant patients will not display the oddities of behavior, perception, and communication of schizotypal patients.

B. Schizophrenia. No formal thought disorder is present in personality disorders. When psychosis is present in schizotypal patients, it is of brief duration.

C. Paranoid personality disorder. Patients with paranoid personality disorder will not display the oddities of behavior, perception and communication of schizotypal patients. Unlike schizotypals, paranoid patients can be very verbally aggressive and do not avoid conflict.

D. Personality change due to a general medical condition and substance-related disorder. Acute symptoms are temporally related to a medication, drugs or a medical condition. The longstanding patterns of behavior required for a personality disorder are not present.

3.3. Cluster B personality disorders

Antisocial, borderline, histrionic and narcissistic personality disorders are referred to as cluster B personality disorders. These disorders are characterized by dramatic or irrational behavior. These patients tend to be very disruptive in clinical settings.

Antisocial personality disorders

1. *DSM-IV Diagnostic criteria.*

A. Since age 15 years, the patient has exhibited disregard for and violation of the rights of others, indicated by at least three of the following:

1. Failure to conform to social norms by repeatedly engaging in unlawful activity.
2. Deceitfulness: repeated lying or “conning” others for profit or pleasure.
3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, such as repeated physical fighting or assaults.
5. Reckless disregard for the safety of self or others.
6. Consistent irresponsibility: repeated failure to sustain consistent work or honor financial obligations.
7. Lack of remorse for any of the above behavior

B. A history of some symptoms of conduct disorder before age IS years as indicated by:

1. Aggression to people and animals.
2. Destruction of Property.
3. Deceitfulness or theft.
4. Serious violation of rules.

II. Clinical features of antisocial personality disorder:

A. Interactions with others are typically exploitative or abusive.

B. Lying, stealing, fighting, fraud, physical abuse, substance abuse, and drunk driving are common.

C. Patients may be arrogant, but they are also capable of great superficial charm.

D. These patients do not have a capacity for empathy.

III. Epidemiology:

A. The male-to-female ratio is 3:1.

B. APD is more common in first-degree relatives of those with the disorder.

IV. Differential diagnosis:

A. Adult antisocial behavior. This diagnosis is limited to the presence of illegal behavior only. Patients with adult antisocial behavior do not show the Pervasive, long-term patterns required for a personality disorder.

B. Substance-related disorder, Substance abuse is common in antisocial personality disorder, and crimes may be committed to obtain drugs or to obtain money for drugs. Many patients will meet criteria for both diagnoses.

C. Narcissistic personality disorder. Narcissistic patients also lack empathy and are exploitative, but they are not as aggressive or deceitful as antisocial patients.

D. Borderline personality disorder. These patients are also impulsive and manipulative, but they are more emotionally unstable and they are less aggressive.

The manipulativeness of borderline patients is aimed at getting, emotional – gratification rather than aimed at financial motivations.

Borderline personality disorder

I. DSM-IV Diagnostic criteria.

A pervasive pattern of unstable interpersonal relationships, unstable self-image, unstable affects, and poor impulse control, beginning by early adulthood, and indicated by at least five of the following:

1. Frantic efforts to avoid real or imagined abandonment.

2. Unstable and intense interpersonal relationships, alternating between extremes of idealization and devaluation.

3. Identity disturbance: unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e. g., spending, promiscuity, substance abuse, reckless driving, binge eating).

5. Recurrent suicidal behavior, gestures or threats; or self-mutilating behavior.

6. Affective instability (e. g., sudden intense dysphoria, irritability or anxiety of short duration).

7. Chronic feelings of emptiness.

8. Inappropriate, intense anger or difficulty controlling anger.

9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

II. Clinical features of borderline personality disorder.

A. The clinical presentation of BPD is highly variable. Chronic dysphoria is common, and desperate dependence on others is caused by inability to tolerate being alone.

B. Chaotic interpersonal relationships are characteristic and self-destructive or self-mitigatory behavior is common.

C. A childhood history of abuse or parental neglect is common.

III, Epidemiology.

A. The female-to-male ratio is 2:1. The disorder is five times more common in first-degree relatives.

B. The prevalence is 1–2%, but the disorder occurs in 30-60% of psychiatric patients.

IV. Differential diagnosis.

A. Adolescence. Normal adolescence with identity disturbance and emotional lability shares many of the same characteristics of BPD; however, the longstanding pervasive pattern of behavior required for a personality disorder is not present.

B. Histrionic personality disorder. These patients are also manipulative and attention seeking, but they do not display self-destructiveness and rage. Psychosis and dissociation are not typically seen in histrionic patients.

C. Dependent personality disorder. When faced with abandonment, dependent patients will increase their submissive behavior rather than display rage as do borderline patients.

D. Personality change due to a general medical condition and substance-related disorder. Acute symptoms are temporally related to medications, drugs, or a medical condition.

Histrionic personality disorder

1. *DSM-IV Diagnostic criteria.*

A. A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood, as indicated by five or more of the following:

1. The patient is not comfortable unless he is the center of attention.
2. The patient is often inappropriately sexually seductive or provocative with others.
3. Rapidly shifting and shallow expression of emotions are present.
4. The patient consistently uses physical appearance to attract attention.
5. Speech is excessively impressionistic and lacking in detail.
6. Dramatic, theatrical, and exaggerated expression of emotion is used.
7. The patient is easily influenced by others or by circumstances.
8. Relationships are considered to be more intimate than they are in reality.

II. Clinical features of histrionic personality disorder.

A. The patient is bored with routine and dislikes delays in gratification.

B. The patient begins Projects, but does not finish them (including relationships).

C. Dramatic emotional "performances" of the patient appear to lack sincerity.

D. These patients often attempt to control relationships with seduction, manipulation, or dependency.

E. The patient may resort to suicidal gestures and threats to get attention.

A mnemonic that can be used to remember the criteria for histrionic personality disorder is

PRAISE ME

- P – provocative (or seductive) behavior
- R – relationships, considered more intimate than they are
- A – attention, must be at center of
- I – influenced easily
- S – speech (style) – wants to impress, lacks detail
- E – emotional lability, shallowness
- M – make-up – physical appearance used to draw attention to self
- E – exaggerated emotions – theatrical

III. Epidemiology.

A. The prevalence of HPD is 2–3%.

B. Histrionic personality disorder is much more common in women than men.

C. These patients have higher rates of depression, somatization and conversion disorder compared to the general population.

IV. Differential diagnosis.

A. Borderline personality disorder.

1. While patients with Borderline Personality can also be sensation-seeking, impulsive, superficially charming, and manipulative, they also have identity disturbance, transient psychosis, and dissociation which are not seen in histrionic patients.

2. Some patients meet criteria for both BPD and HPD.

B. Antisocial personality disorder.

1. Antisocial patients are also sensation-secking, impulsive, superficially charming, and manipulative.

2. Histrionic patients are dramatic and theatrical but typically lack histories of antisocial behavior.

C. Narcissistic personality disorder.

1. Narcissists also seek constant attention, but it must be positive in order to confirm grandiosity and superiority.

2. Histrionics are less selective and will readily appear weak and dependent in order to get attention.

D. Personality change due to a general medical condition and substance-related disorder. Acute symptoms are temporally related to medication, drugs, or a medical condition.

Narcissistic personality disorder

I. DSM-IV Diagnostic criteria.

A. A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy. The disorder begins by early adulthood and is indicated by at least five of the following:

1. An exaggerated sense of self-importance.

2. Preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love.

3. Believes he is "special" and can only be understood by, or should associate with, other special or high-status people (or institutions).

4. Requires excessive admiration.

5, Has a sense of entitlement.

6. Takes advantage of others to achieve his own ends.

7. Lacks empathy.

8. The patient is often envious of others or believes that others are envious of him.

9. Shows arrogant, haughty behavior or attitudes.

II. Clinical features.

A. Patients with narcissistic personality disorder exaggerate their achievements and talents, and they are surprised when they do not receive the recognition they expect.

B. Their inflated sense of self results in a devaluation of others and their accomplishments. Narcissistic patients only pursue relationships that will benefit them in some way.

C. These patients feel very entitled, expecting others to meet their needs immediately, and they can become quite indignant if this does not happen. These patients are self-absorbed and unable to respond to the needs of others. Any perception of criticism is poorly tolerated, and these patients can react with rage.

D. These patients are very prone to envy anyone who possesses knowledge, skill or belongings that they do not possess. Much of narcissistic behavior Serves as a defense against very poor self-esteem.

III. Epidemiology.

A. The prevalence of NPD is less than 1% in the general population and up to 16% in clinical populations.

B. The disorder is more common in men than women. Studies have shown a steady increase in the incidence of narcissistic personality disorder.

IV. Differential diagnosis.

A. Histrionic personality disorder. Histrionic patients are also attention seeking, but the attention they seek does not need to be admiring. They are more highly emotional and seductive compared to patients with NPD.

B. Borderline personality disorder. These patients also tend to idealize and devalue others, but narcissistic patients lack the unstable identity, self-destructive behavior, and abandonment fears that characterize borderline patients.

C. Antisocial personality disorder. Interpersonal exploitation, superficial charm, and lack of empathy can be seen in both antisocial personality disorder and narcissistic personality disorder. However, antisocial patients do not require constant admiration nor do they display the envy seen in narcissistic patients.

D. Personality change due to a general medical condition and substance-related disorder, All symptoms are temporally related to medication, drugs or a medical condition.

3.4. Cluster C Personality disorders

Avoidant, dependent and obsessive-compulsive personality disorders are referred to as cluster C personality disorders. These patients tend to be anxious and their personality pathology is a maladaptive attempt to control anxiety.

Avoidant personality disorder

I DSM-IV Diagnostic criteria.

A. A pervasive pattern of social inhibition, feelings of imadequacy and hypersensitivity, beginning by early adulthood, and indicated by at least four of the following:

1. The patient avoids occupational activities with significant interpersonal contact due to fear of criticism, disapproval or rejection.
2. Unwilling to get involved with people unless certain of being liked.
3. Restrained in intimate relationships due to fear of being shamed or ridiculed.
4. Preoccupied with being criticized or rejected in social situations.
5. Inhibited in new interpersonal situations due to feelings of inadequacy.
6. The patient views himself as socially inept, unappealing or inferior to others.
7. Reluctance to take personal risks or to engage in new activities because they may be embarrassing.

II. Clinical features.

A. The patient is usually shy and quiet and prefers to be alone. The patient usually anticipates unwarranted rejection before it happens.

B. Opportunities to supervise others at work are usually avoided by the patient.

These patients are often devastated by minor comments they perceive to be critical.

C. Despite self-imposed restrictions, avoidant personality disorder patients usually long to be accepted and be more social.

III, Epidemiology.

A. The male-to-female ratio is 1:1.

B. Although adults with avoidant personality disorder were frequently shy as children, childhood shyness is not a predisposing factor.

IV. Differential diagnosis.

A. Social phobia, generalized type shares many features of avoidant personality disorder. Patients may meet criteria for both disorders. The two disorders may only be differentiated by a life-long pattern of avoidance seen in patients with avoidant personality disorder.

B. Dependent personality disorder. These patients are also hypersensitive to criticism and crave acceptance, but they will risk humiliation and rejection in order to get their dependent needs met. Patients may meet the criteria for both disorders.

C. Schizoid personality disorder. These patients also avoid interactions with others and are anxious in social settings; however, schizoid patients do not fear criticism and rejection. Avoidant patients recognize that social isolation is abnormal.

D. Panic disorder with agoraphobia. In patients with panic disorder with agoraphobia, avoidance occurs after the panic attack has begun, and the avoidance is aimed at preventing another panic attack from occurring.

Dependent personality disorder

I. DSM-IV Diagnostic criteria.

A. A pervasive and excessive need to be cared for. This need leads to submissive, clinging behavior, and fears of separation beginning by early adulthood and indicated by at least five of the following:

1. Difficulty making everyday decisions without excessive advice and reassurance.

2. Needs others to assume responsibility for major areas of his life.

3. Difficulty expressing disagreement with others and unrealistically fears loss of support or approval if he disagrees.

4. Difficulty initiating projects or doing things on his or her own because of a lack of self-confidence in judgment or abilities.

5. Goes to excessive lengths to obtain nurturance and support, to the point of volunteering to do things that are unpleasant.

6. Uncomfortable or helpless when alone due to exaggerated fears of being unable to care for himself.

7. Urgently seeks another source of care and support when a close relationship ends.

8. Unrealistically preoccupied with fears of being left to take care of himself.

II. Clinical features.

A. Patients will endure great discomfort in order to perpetuate the caretaking relationship. Social interaction is usually limited to the caretaker network.

B. These patients may function at work if no initiative is required.

A mnemonic that can be used to remember the criteria for dependent personality disorder is **DEPENDENT**

- D – Difficulty making everyday decisions
- E – Excessive lengths to obtain nurturance and support from others
- P – Preoccupied with fears of being left to take care of self
- E – Exaggerated fears of being unable to care for himself or herself
- N –Needs others to assume responsibility for his or her life
- D –Difficulty expressing disagreement with others
- E – End of a close relationship is the beginning of another relationship
- N – Noticeable difficulties in initiating projects or doing things on his or her own
- T – "Take care of me" is his or her motto

III, Epidemiology.

A. Women are affected slightly more than men.

B. Childhood illness or separation anxiety disorder of childhood predispose patients to dependent personality disorder.

IV. Differential diagnosis.

A. Avoidant personality disorder: Avoidant patients are more focused on avoiding shame and rejection rather than getting needs met. Some patients may meet criteria for both disorders.

B. Borderline personality disorder: Borderline patients react with rage and emptiness when feeling abandoned. Dependent patients react with more submissive behavior when feeling abandoned.

C. Histrionic personality disorder. These patients are also needy and clinging, and they have a strong desire for approval, but these patients actively pursue almost any kind of attention. They tend to be very flamboyant, unlike dependent patients.

D. Personality change due to a general medical condition and substance-related disorder: acute symptoms are temporally related to a medication, drugs or a medical condition.

Obsessive-compulsive personality disorder.

I. DSM-IV Diagnostic criteria.

A. A pervasive pattern of preoccupation with orderliness, perfectionism and control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and indicated by at least four of the following:

1. Preoccupied with details, rules, lists, organization or schedules, to the extent that the major point of the activity is lost.

2. Perfectionism interferes with task completion.

3. Excessively devoted to work and productivity to the exclusion of leisure activities and friendships.

4. Over conscientiousness, scrupulousness and inflexibility about morality, ethics, or values (not accounted for by culture or religion).

5. Unable to discard worn-out or worthless objects, even if they have no sentimental value.

6. Reluctant to delegate tasks to others.

7. Miserly spending style toward both self and others.

8. Rigidity and stubbornness.

II. Clinical features.

A. Obsession with detail can paralyze decision making.

B. Tasks may be difficult to complete. These patients prefer logic and intellect to feelings, and they are not able to be openly affectionate.

C. These patients are often very "frugal" with regard to financial matters.

III. Epidemiology.

A. The prevalence of OCPD is 1% in the general population and up to 10% in clinical populations.

B. The male-to-female ratio is 2:1.

C. Obsessive-compulsive personality disorder is more frequent in first-degree relatives.

IV. Differential diagnosis.

A. Obsessive-compulsive disorder (OCD). Most patients with OCD do not meet criteria for OCPD, although the two conditions can coexist.

B. Personality change due to a general medical condition and substance-related disorder. Acute symptoms are temporally related to a medication, drugs, or a medical condition. The longstanding patterns of behavior required for a personality disorder are not present.

3.5. Mental retardation

Mental retardation is a condition diagnosed before the age of 18 years that includes below-average general intellectual function, and a lack of the skills necessary for daily living.

Causes. Mental retardation affects about 1–3% of the population. There are many causes of mental retardation, but doctors find a specific reason in only 25% of causes. A family may suspect mental retardation if the child's motor skills, language skills, and self-help skills do not seem to be developing, or are developing at a far slower rate than the child's peers. Causes of mental retardation can be roughly divided into several categories:

- Infections (present at birth or occurring after birth):
  - o Congenital CMV
  - o Congenital rubella
  - o Congenital toxoplasmosis
  - o Encephalitis
  - o HIV infection
  - o Listeriosis
  - o Meningitis
- Chromosomal abnormalities:
  - o Chromosome deletions
  - o Chromosomal translocations (a gene is located in an unusual spot on a chromosome, or located on a different chromosome than usual)
  - o Defects in the chromosome or chromosomal _ inheritance (for example, fragile X syndrome)
  - o Errors of chromosome numbers (such as Down syndrome)
- Environmental:
  - o Deprivation syndrome
- Genetic abnormalities and inherited metabolic disorders:
  - o Adrenoleukodystrophy
  - o Phenylketonuria
  - o Rett syndrome
  - o Sanfilippo syndrome
  - o Tay-Sachs disease
  - o Tuberous sclerosis
- Metabolic:
  - o Congenital hypothyroid
  - o Hypoglycemia (poorly regulated diabetes mellitus)
  - o Reye syndrome
  - o Hyperbilirubinemia (very high bilirubin levels in babies)
- Nutritional – Malnutrition.
- Toxic:
  - o Intrauterine exposure to alcohol, cocaine, amphetamines, and other drugs
  - o Lead poisoning
  - o Methylmercury poisoning
- Trauma (before and after birth):
  - o Intracranial hemorrhage before or after birth
  - o Lack of oxygen to the brain before, during, or after birth
  - o Severe head injury
- Unexplained (this largest

o Galactosemia
o Hunter syndrome
o Hurler syndrome
o Lesch-Nyhan syndrome

category is for unexplained occurrences of mental retardation).

Symptoms:

- Continued infantile behavior.
- Decreased learning ability.
- Failure to meet intellectual developmental markers.
- Inability to meet educational demands at school, lack of curiosity.

DSM-IV additional features:

1. The onset before the age of 18 years.
2. Deficits / impairments in present adaptive functioning in at least 2 spheres:

- Communication.
- Self-care
- Home living
- Social / interpersonal skills
- Use of community resources
- Self-direction
- Functional academic skills
- Work
- Leisure
- Health
- Safety

1Q range for categories	ICD-10	DSM-IV
Mild	50–69	50 to 70
Moderate	35–49	35–40 to 50–55
Severe	20–34	20–25 to 35–40
Profound	Below 20	Below 20–25

DSM-IV, Axis 11 / / ICD-10, F7x

Note: Changes to normal behaviors depend on the severity of the condition. Mild retardation may be associated with a lack of curiosity and quiet behavior. Severe mental retardation is associated with infantile behavior throughout life.

Exams and Tests.

- Abnormal Denver developmental screening test.
- Adaptive behavior score below average.
- Development way below that of peers.
- Intelligence quotient (IQ) scores below 70 on a standardized IQ test.

Outlook (prognosis).

The outcome depends on:

- Opportunities.
- Other conditions.
- Personal motivation.
- Treatment.

Many people lead productive lives and function on their own; others need a structured environment to be most successful.

CHAPTER 4. History Taking

Psychosis – History Taking. Depression – History Taking. Mania – History Taking. Suicidal ideation – History Taking. Cognitive impairment – History T 'aking. Delirium – History Taking. Substance use – History Taking.

4.1. Psychosis – History Taking

History of present illness. Current symptoms, a date of onset, duration, recent stressors, and a degree of functional impairment. Symptoms of psychosis are often elicited by first asking: ''Have you felt like your mind has been playing tricks on you?". Find out about unusual or odd experiences, auditory hallucinations, (including command hallucinations, a number of voices the patient hears, and voices commenting or conversing). Ask the patient to describe where the voices are coming from (e. g., inside or outside his head).

Ask about the presence of visual, tactile, and olfactory hallucinations. Assess delusional content, paranoid thinking, suspiciousness, fear, ideas of reference, ideas of influence, special powers, thought broadcasting, thought insertion, delusions of guilt or sin, grandiose delusions, somatic delusions, and magical thinking.

Ask about the history of violent acting or responding to command hallucinations. Assess disorganized behavior by asking about eating habits, recreational activities, social and sexual activity, and agitated behavior. Allow the patient to speak freely to assess the presence of thought

disorders, such as circumstantiality, tangentiality, derailment, loosening of associations, word salad, or neologisms.

Ask the patient about negative symptoms such as anhedonia, apathy, and social withdrawal. Suicidal ideation, plans, and a history of suicide attempts should also be assessed. Ask about symptoms of clinical depression and mania to exclude schizoaffective disorder, major depression with psychotic features, or bipolar I disorder.

Past psychiatric history. Previous psychiatric diagnoses, symptoms of previous psychotic episodes, date of first psychiatric contact, and reasons for first hospitalization. Assess number of hospitalizations, duration of hospitalization, number per year, and whether hospitalizations tend to occur during a specific time of year. Previous treatments, medication history with duration and dosages, treatment adherence, and side effects from past medications: dystonia, tardive dyskinesia, parkinsonism, akathisia and neuroleptic malignant syndrome. Ask about current psychiatric care, day treatment programs, and management by an intensive case manager or outpatient therapist.

Substance abuse history. Exclude substance induced psychotic symptoms with questions about alcohol, amphetamines, cannabis, hallucinogens, cocaine, and PCP use. Withdrawal from substances, such as barbiturates and alcohol, can also cause psychotic symptoms.

Social history. Prenatal insults, childhood trauma or illness, social functioning, relationship history, level of education, job history, housing, and source of income. Assess the impact of psychotic symptoms on daily functioning.

Family history. Presence of psychotic disorders or odd and eccentric personality traits in family members, distant relatives, or other household members.

Past medical history. Psychotic symptoms can be caused by delirium, AIDS, systemic lupus erythematosus, Wemicke-Korsakoff syndrome, seizures, Parkinson's disease, dementias, cerebrovascular disease, CNS lesions, herpes encephalitis, neurosyphilis, head trauma, and Wilson's disease.

Medications: Ask about medical and psychiatric medications, dosages, adherence, and who administers the medication. Corticosteroids, anticholinergics, and levodopa can all cause psychotic symptoms.

Mental Status Examination.

General description: Disheveled, poorly related, possible psychomotor agitation or retardation (including catatonia), guarded, suspicious, menacing, uncooperative at times; the patient may appear to be responding to hallucinations.

Speech: Normal rate, rhythm, and volume.

Mood: "Fine," "bad," or "scared."

Affect: Often blunted or flat.

Thought.

Thought process disturbance. Circumstantiality (speech includes irrelevant details but eventually makes a point), tangentiality (speech is not goal-directed, and a point is never made), flight of ideas (rapid thinking with fast changes in topics), loosening of associations (flow of thought with ideas that are coherent but unrelated), thought blocking (flow of thought is interrupted by silence, and the patient does not return to the same topic when speech resumes), word salad (individual ideas and speech are incoherent), clang associations (word association by thyming), neologisms (creating new words).

Thought content. Paranoid delusions about family, friends, neighbors, coworkers, doctors, government agencies or strangers. Ideas of reference, thought insertion or withdrawal and somatic, erotic or grandiose delusions.

Thought content disturbance. Delusions (fixed, false beliefs without a cultural basis), ideas of reference (belief that the television or radio speaks directly to patient), ideas of influence (belief that other forces control the patient's behavior), paranoid ideation (thoughts of being harmed, followed, or persecuted), obsession (a recurrent thought experienced as intrusive), compulsion (a repetitious act designed to alleviate), poverty of content (thought that is vague, repetitious, or obscure), phobia (an unfounded fear that triggers panic).

Perceptual: Hallucinations may be auditory, visual, olfactory, tactile, or gustatory, although auditory hallucinations are most common.

Suicidality: Suicide attempts occur more frequently in patients with psychotic disorders, and 10 percent of people with schizophrenia will eventually commit suicide.

Homicidality: Homicidal ideation directed towards objects of paranoia.

Sensorium / cognition: Alert and oriented; possible impairment in the ability to immediately repeat or recall words depending on the presence of distracting hallucinations or formal thought disorder. Poor concentration, no apparent language deficits, fair fund of knowledge and vocabulary. Thinking is usually concrete. The mini-mental state exam is not reliable in acutely psychotic patients.

Impulse control: Possibly poor impulse control (e. g., attacks a person about whom patient has become paranoid).

Judgment: Impaired. The patient has a markedly altered sense of reality.

Insight: Limited. The patient does not understand why he has been brought to the hospital.

Reliability: Maybe significantly impaired. Corroborative data is usually helpful.

Laboratory data: Complete blood count, chemistry, liver function tests, thyroid function tests, vitamin B12 and folate levels; urinalysis with toxicology screen, blood alcohol level, HIV testing, RPR, and serum ceruloplasmin.

Diagnostic testing: Electroencephalography, computed tomography, or magnetic resonance imaging for new onset psychosis, Scale for the Assessment of Negative Symptoms (SANS), and the Scale for the Assessment of Positive Symptoms (SAPS).

Diagnosis: Axis I, **DSM-IV** / / F2, **ICD-10** (for schizophrenia).

Differential diagnosis for psychosis:

- Psychiatric: major depression with psychotic features, bipolar I disorder, autistic disorder, obsessive-compulsive disorder (OCD), delirium, dementia, schizotypal, schizoid, borderline, and paranoid personality disorders, factitious disorder, substance-induced psychotic disorder, and malingering.
- Medical: AIDS, B12 deficiency, Wernicke-Korsakoff syndrome, carbon monoxide or heavy metal poisoning, systemic lupus erythematosus, and Wilson's disease.
- Neurological: epilepsy, cerebral neoplasm, cerebrovascular disease, head trauma, herpes encephalitis, neurosyphilis, Creutzfeldt-Jakob disease, and normal pressure hydrocephalus.

4.2. Depression – History Taking

History of present illness. Current symptoms, duration, date of onset, diurnal variation in severity of symptoms, seasonal variation, and psychosocial stressors. Ask about irritable or depressed mood, loss of interest in previously pleasurable activities, decreased libido, changes in appetite, weight loss or weight gain, decreased energy, too much or too little sleep, psychomotor agitation or retardation, problems with concentration, guilt or regret about the past, hopelessness, and suicidal ideation. If the patient is suicidal, ask about the presence of a plan. Assess type of insomnia (sleep onset, early moming wakening, difficulty staying asleep, or hypersomnia). Assess severity of depressive symptoms by noting impact on their home, school, or work life.

Exclude a bipolar disorder with questions about periods of persistently elated mood, increased self-esteem, racing thoughts, pressured speech, distractibility, increased goal-directed activity, and hedonism. Exclude psychotic features or schizoaffective disorder by asking about hallucinations and delusions.

Past psychiatric history. Previous psychiatric diagnoses, previous depressive or manic episodes, history of panic attacks or other anxiety symptoms, history of psychiatric hospitalizations, including dates and locations, outpatient therapy, past medications, side effects, and adherence to treatment. History of suicide attempts and specific methods employed; assess potential lethality of previous attempts. Panic disorder, posttraumatic stress disorder, and substance abuse are the most common comorbid conditions with major depressive disorder.

Substance abuse history. Assess temporal relationship between any substance use and depressive symptoms. For example, persistent alcohol use or cocaine withdrawal may present with depressive symptoms.

Past medical history. Hypothyroidism, anemia, seizure disorders, migraine headaches, HIV, systemic lupus erythematosus, Parkinson's disease, diabetes, and Cushing's disease may present with symptoms of depression.

Medications. Antihypertensives, oral contraceptives, corticosteroids, analgesics, sedatives, hypnotics, anxiolytics, stimulants, antipsychotics, –_ antibiotics, anticonvulsants, and chemotherapy may cause depressive symptoms.

Mental Status Examination

General description: Stooped or downcast posture, poor eye contact, psychomotor retardation, or sometimes restlessness.

Speech: Decreased volume, slow rate, and normal rhythm; speech may not be spontaneous.

Mood: Often described as "depressed," "sad," or "irritable."

Affect: Constricted in dysphoric range, but congruent with the patient's reported mood.

Thought process: Linear and goal-directed in the majority of patients, but often impoverished.

Thought content: Ruminations of guilt about the past, hopeless about the future, poverty of content, or paranoid ideation; content disturbance may reach delusional proportions in depression with psychotic features.

Perceptual: Auditory, command or visual hallucinations may occur with psychotic features.

Suicidality: Suicidal ideation is present in more than half of depressed patients. A plan needs to be specified if present. Assess how the patient manages or resists suicidal impulses.

Homicidality: May occur with psychotic features.

Sensorium / cognition: Oriented, some problems with immediate recall (registration), but not delayed recall; concentration is often poor, and language deficits are rare. The patient may have a good fund of knowledge and vocabulary, without disturbance in abstract thinking.

Impulse control: Generally intact except when patients have psychomotor agitation or severe anxiety.

Judgment: Often impaired by the intensity of depressive symptoms.

Insight: Distorted with exaggerated emphasis on depressive symptoms.

Reliability: Patients may overemphasize symptoms in the midst of a depressive episode, or minimize symptoms for fear of appearing "crazy."

Laboratory data. Complete blood count, chemistry, thyroid function tests, liver function tests, urinalysis with toxicology screen, blood alcohol level, urine pregnancy test, vitamin B12 and folate levels, and HIV in high-risk patients.

Diagnostic testing. The Hamilton Rating Scale for Depression (HAM-D) and the Beck Depression Inventory.

Diagnosis: Axis I: Major depression, bipolar I disorder, **DSM-IV** / / F3, **ICD-10**.

Differential diagnosis:

 Psychiatric: dysthymia, cyclothymia, bipolar II disorder, substance-induced 'mood disorder, schizoaffective disorder, bereavement, and adjustment disorder with depressed mood.

 Medical: hypothyroidism, infection, chronic disease, cancer, medications, and vitamin deficiency,

 Neurological: Parkinson's disease, dementia, Huntington's disease, temporal lobe epilepsy, cerebral tumors, multiple sclerosis, and head trauma.

4.3. Mania – History Taking

History of present illness. Current symptoms, duration, and date of onset. Irritability, elevated mood, euphoria, inflated self-esteem, and grandiosity. Ask the patient how much he or she has been sleeping; ask about energy during the day. Racing thoughts, talkativeness, distractibility and psychomotor agitation. Increased goal-directed activity, excessive _ involvement in pleasurable _ activities, hypersexuality, disrobing in public, money spending, tisk-taking behavior and pathological gambling. Ask about religious preoccupation and political preoccupation. Assess psychotic features, such as grandiose delusions, paranoid delusions, mind reading, ideas of reference, ideas of influence, thought broadcasting, or other special powers. Assess for concurrent or alternating depressive symptoms.

Past psychiatric history. Past hospitalizations, diagnoses, treatments, and outpatient follow-up. Past depressive symptoms, depression during adolescence, manic episodes, psychotic symptoms, suicide attempts, comorbid alcohol and other substance abuse.

Substance abuse history. Alcohol, cocaine, heroin, marijuana, hallucinogens, benzodiazepines, barbiturates, and analgesics.

Social history. Living situation, psychosocial support, marital status, employment, and level of education. Note extent of recent stressors, including impact of manic symptoms on relationships and occupational functioning.

Family history. History of depression, bipolar disorder, psychotic disorders, suicide, and substance abuse in family members,

Past medical history. Ask about all medical and neurological problems because many diseases can cause symptoms consistent with mania (see differential diagnosis).

Medications. Antidepressants, amantadine, bromocriptine, corticosteroids, disulfiram, isoniazid, levodopa, procarbazine, levothyroxine, and CNS stimulants (eg, methylphenidate) can cause manic symptoms.

Mental Status Examination.

General appearance: The patient appears excited, restless, hyperactive, and dressed in colorful or dramatic clothing. They may be engaging and entertaining, but may also be hostile and uncooperative.

Speech: Rapid rate, increased volume, increased quantity, and difficult to interrupt.

Mood: "Great."

Affect: Expansive, euphoric, labile at times with rapid shifts to irritability; sometimes alternating with intense dysphoria.

Thought process: Pressured, with flight of ideas.

Thought content: Grandiose delusions of great wealth and intelligence, feelings of having special powers, such as clairvoyance, or ideas of reference.

Perceptual: Auditory, visual, or command hallucinations may occur with psychotic features.

Suicidality: May be present, especially in mixed manic states with depressive symptoms.

Homicidality: Typically denies.

Sensorium / cognition: Alert and oriented, with variable immediate and delayed recall, depending on the patient's ability to focus or cooperate. The patient may be easily distracted, with poor attention and concentration. Thinking is not concrete or abstract, but may be bizarre and incoherent at times.

Impulse control: Impaired. The patient may be hypersexual and repeatedly attempt to touch the examiner.

Judgment: Impaired. Manic patients often do not understand how their symptoms affect behavior or other people.

Insight: Impaired. Patients may like the symptoms of mania and do not recognize the need for treatment.

Reliability: Limited. Patients experiencing manic episodes may not be able to give accurate information about past medical, psychiatric, personal, or substance-abuse histories.

Laboratory data. Complete blood count, chemistry, liver function tests, lipase, amylase, ceruloplasmin, vitamin B12, vitamin B3, RPR, thyroid function tests, and toxicology screen.

Diagnostic testing. Electroencephalography, computed tomography, magnetic resonance imaging.

Diagnosis. Axis I: Bipolar I disorder, manic episode, **DSM-IV** / / F3, **ICD-10.**

Differential Diagnosis:

 Psychiatric: Bipolar II Disorder, cyclothymia, borderline personality disorder, substance-induced manic symptoms (e. g. amphetamines, PCP), schizoaffective disorder, and delirium.

 Medical: hyperthyroidism, renal failure, vitamin B3 deficiency (pellagra), vitamin B12 deficiency, carcinoid syndrome, and medication-induced mania (e. g., antidepressants, amantadine, bromocriptine, corticosteroids, disulfiram, isoniazid, levodopa, procarbazine, levothyroxine, CNS stimulants).

 Neurological: Huntington's disease, Wilson's disease, CNS infection, neoplastic disease, cerebrovascular accidents, head trauma, temporal lobe epilepsy, multiple sclerosis, and Pick's disease,

4.4. Suicidal ideation – History Taking

History of present illness. The interview should begin with questions about current symptoms, duration, and date of onset. Ask about recent life changes, interpersonal stress, marital conflict, illness in the family, or legal problems. Assess suicide potential by addressing intent, plans, means, and perceived consequences, Distinguish between passive and active suicidal ideation in assessing intent by asking about specific plans, the ability to resist suicidal impulses, and what factors influence the degree of determination, such as, children, spouse, or work.

Assess the lethality of the plan, and ask about any preparations made, such as writing a will or giving away personal belongings. Always ask about the availability of weapons or medication to assess means. Ask about the perceived consequences of suicide and evaluate the patient's beliefs about a desirable outcome, such as financial benefit to the family, or reunion with a deceased loved one. Negative consequences of suicide such as emotional pain to the family should be discussed. Ask about anything the patient may feel they have to live for, and assess evidence of plans for the future, such as a trip to see children, or concern that hospitalization may interfere with an important event. Evaluate concurrent depressive symptoms, feelings of hopelessness, substance abuse, anxiety, and psychosis. Ask about command auditory hallucinations. Consider features of personality disorders in the assessment of suicidal ideation, such as poor impulse control, mood lability, unstable self-esteem, unstable relationships, and other cluster B personality traits.

Past psychiatric history. Ask about all past psychiatric symptoms, diagnoses, treatments, and previous suicide attempts. Suicide is more likely to occur in patients just recovering from suicidal depression or in the few weeks to months following discharge from the hospital. Patients with a history of suicide attempts are at greater risk. Suicide is most commonly associated with major depression, but also occurs with significantly increased rates in bipolar disorder, schizophrenia, substance abuse disorders, borderline personality disorder, antisocial personality disorder, cognitive disorders, organic mental disorders, anxiety disorders, and adjustment disorders.

Substance abuse history. Ask about all substances used. Alcohol abuse and dependence is most commonly associated with suicide, especially in the presence of comorbid psychiatric disorders. Heroin dependence is also associated with increased rates of suicide. Ask about availability of lethal amounts of the substance abused and method of use. Substance abuse can sometimes be perceived as a form of suicidal behavior, and accidental overdose is a frequent cause of death in substance abusers.

Social history. Ask about marital status, living situation, social support, family conflict, employment, legal trouble, financial trouble, illness in the family, recent loss of a loved one, and feelings of social isolation, Divorce, unemployment, living alone, poor social support, and loss of a loved one are significant risk factors for suicide,

Family history. A history of suicide in the family increases the risk for suicide. Also ask about family history of psychiatric illness and treatment.

Past medical history. Comorbid medical illness increases the risk of suicide. Epilepsy, multiple sclerosis, cardiovascular disease, Huntington's disease, dementia and AIDS are all associated with depression and increase the risk of suicide. Other medical problems that occur with mood disorders also increase suicidal risk and include: Cushing's disease, anorexia nervosa, porphyria, cerebrovascular disease, and cirrhosis.

Medications. Ask about all medications, especially ones potentially lethal in overdose, such as barbiturates, anticonvulsants and tricyclic antidepressants.

Mental Status Examination.

General appearance: Withdrawn, uncooperative, with poor eye-contact.

Speech: Not spontaneous, soft, slow, with paucity of speech.

*Mood***:** "Depressed," "sad," "angry," "hopeless," "worthless".

Affect: Constricted, dysphoric, congruent.

Thought process: Linear, but may have increased response latency.

Thought content: Possible ruminations of guilt or obsessive thoughts about suicide methods.

Perceptual: Possible auditory hallucinations with commands to "just do it".

Suicidality: Positive ideation with plans to jump in front of traffic, history of attempts via overdose; the patient may be unable to commit to contacting someone if feeling suicidal, or he may be unable to agree not to hurt himself (i. c., commit to safety).

Homicidality: Denies.

Sensorium / cognition: Memory and concentration may be impaired. Perform the mini-mental state exam in patients with suspected dementia or cognitive impairment related to depression. Impulse control: Variable. A history of poor impulse control increases the risk of suicide.

Judgment: Impaired. The patient may not understand how their behavior will affect family and friends.

Insight: Fair. The patient wishes to die but may not understand the significance of the underlying illness.

Reliability: Fair; reliability is crucial in assessing commitment to safety.

Laboratory data. Complete blood count, chemistry, urinalysis with toxicology screen and blood alcohol level, and urine pregnancy test.

Diagnostic testing. Testing should be done according to the differential diagnosis and depending on symptom presentation.

Differential diagnosis:

 Axis I: Major depression, bipolar I disorder, schizophrenia and other psychotic disorders, alcohol and other substance abuse disorders, dementia, adjustment disorder, panic and other anxiety disorders, and anorexia nervosa.

 Axis II: Borderline and antisocial personality disorders.

 Axis III; Neoplastic disease, epilepsy, multiple sclerosis, Huntington's disease, AIDS, Cushing's disease, cirrhosis, and porphyria.

4.5. Cognitive impairment – History Taking

History of present illness. Begin with questions about current symptoms and duration. Determine acute or gradual onset of symptoms. If cognitive impairment is worsening, assess gradual or stepwise decline. Ask questions about memory loss, memory for time, place, person, recent memory, and remote memory. Language disturbance (aphasia), motor activity (apraxia), recognition (agnosia), and executive functioning should be assessed in addition to memory loss (amnesia).

Ask about word finding difficulties, activities of daily living (eg, dressing, tying shoes, domestic chores), naming objects, recognizing faces, planning, organizing, and concentrating.

Ask about diurnal variation of symptoms, wandering, impulsivity, anger, irritability, agitation, apathy, depressed mood, delusional thinking, and perceptual disturbance. Rule out delirium by assessing causative precipitants, symptom acuity, level of consciousness, and attention.

Past psychiatric history. Clarify a history of depressive symptoms to consider pseudodementia. Ask about previous amnestic episodes, psychotic symptoms in the past, and a history of transient cognitive impairments associated with medical illness or surgery.

Substance abuse history. Alcohol intoxication and withdrawal may cause cognitive impairment, amnesia, and psychotic symptoms. Long-term, continuous alcohol abuse can cause dementia.

Ask about extent of use, withdrawal symptoms, shakes, seizures, delirium tremens, and blackouts (anterograde amnesia). Benzodiazepines can mimic or exacerbate symptoms of dementia by causing confusion, disinhibition, and amnesia.

Social history. Ask about housing, nursing home care, supervised living, and the assistance of a home-health aide. Assess extent of family support, marital status, children, income, and safety in the home.

Family history. Alzheimer's disease, Huntington's disease, and Parkinson's. disease have a pattern of familial inheritance and may be associated with symptoms of dementia.

Past medical history. Assess history of cerebrovascular disease, cardiovascular disease, demyelinating disorders, head trauma, systemic lupus erythematosus, CNS infection, liver disease (hepatic encephalopathy), and renal disease (uremia). Ask about risk factors associated with multi-infarct dementia: hypertension, hyperlipidemia, diabetes, smoking, obesity, atrial fibrillation, and hypercoagulable states.

Medications. Obtain details of medications with dosages and duration of treatment.

Ask about over-the-counter medications, alternative treatments, and dietary supplements. Medications that can cause symptoms of dementia include anticholinergics, antihypertensives, and anticonvulsants. Toxic levels of medications can cause delirium (e. g., anticholinergics, anticonvulsants, antipsychotics, antihypertensives, steroids, sedatives, hypnotics).

Mental Status Examination.

General appearance: Disheveled, angry and uncooperative, poorly related, inattentive, limited eye contact, and confused.

Speech: Normal rate, rhythm, and volume in general, but possibly dysarthric if associated with cerebrovascular disease.

Mood: "Fine," "depressed."

Affect: Dysphoric, irritable, and labile with intermittent hostility.

Thought process: Mlogical, tangential, difficulty following train of thought, perseverative at times.

Thought content: Paranoid delusions, such as people stealing from the patient or impersonating family members, and confabulation.

Perceptual: Auditory, visual, and command hallucinations are possible.

Suicidality: Varies with level of self-awareness and presence of psychosis or affective symptoms.

Homicidality: May occur in association with paranoia.

Sensorium / cognition: Non-delirious, demented patients should be alert, but may not be oriented to place or time. Registration and recall may be impaired, concentration is impaired, word finding difficulties are common, an¢ apraxia affects ability to follow commands. On the clock-drawing task, patients may bunch numbers together, skip numbers, or indicate the time incorrectly. The mini-mental state score will be less.

than 24 in demented patients.

Impulse control: Limited. Patients have aggressive outbursts with difficulty controlling anger.

Judgment: Impaired. Patients are socially inappropriate and potentially disinhibited.

Insight: Insight is characteristically absent, and patients tend to minimize symptoms.

Reliability: Impaired. Family members and caregivers should be interviewed for information.

Table 4.5.1. MINI-MENTAL STATUS EXAM (MMSE) (FOLSTEIN)

Orientation.

orientation to time [5 points]:

- what year is this?
- what season of the year is it?
- what is the month?
- what day of the month is it?
- what day of the week is it?

orientation to place [5 points]:

- what country are we in?
- what province are we in?
- what city are we in?
- what street are we on / what hospital are we in?
- what is the number of this house / what floor or ward are we on?

Memory.

immediate recall [3 points]:

- ask the patient to immediately repeat the following 3 words: “honesty, tulip, black”.

delayed recall [3 points]:

- ask the patient to recall 3 words previously given, approximately 5 minutes after telling them to the patient.

Attention and concentration.

attention [5 points]: do either one of:

- serial 7s.
- spell “WORLD” backwards.

Language tests.

comprehension (three stage command) [3 points]:

- “take this piece of paper in your right hand, fold it in half, and place it on the floor” – reading [1 point].

- ask the patient to read the words “close your eyes” on a piece of paper, and then to do what it says – writing [1 point].
- ask the patient to write any complete sentence repetition [1 point].
- repeat “no ifs, ands, or buts” – naming [2 points].
- point to a watch and pen and ask the patient to name them.

Testing spatial ability.

copying [1 point]:

- ask the patient to copy the design in Figure 1 exactly.

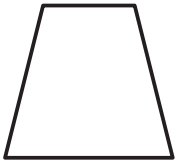

Figure 1

- all ten angles must be present and two must intersect to score | point.

Total score out of 30; abnormal if < 26.

Note: although not officially part of the Folstein, many examiners ask the patient to draw a clock with the time showing “10 after 11”.

Laboratory data. Complete blood count, chemistry, toxicology screen, urinalysis, thyroid function tests, vitamin B12 and folate levels, RPR, thiamine level, homocysteine level, and HIV testing.

Diagnostic testing. Chest x-ray, computed tomography, magnetic resonance imaging, Boston Naming Test (language), Weschler memory scale, Weschler Adult Intelligence Scale, Wisconsin Card Sorting Test (executive function), Trail Making A and B (cognitive processing speed), Halstead Battery Category Test (abstraction), Hachinski ischemia score.

Diagnosis: Axis I: Delirium, dementia, depression (pseudodementia), amnesia,

DSM-IV / / FO, **ICD-10.**

Differential diagnosis of dementia

A. Delirium.

1. Delirium is the most common disorder that may mimic dementia.

Differentiation of delirium from dementia can be difficult because demented individuals are prone to developing a superimposed delirium.

2. Demented patients are alert, whereas, delirious patients have an altered level of consciousness. Delirious patients demonstrate an acutely fluctuating clinical course, whereas demented patients display a stable, slowly progressive, downhill course.

B. Amnestic disorder is characterized by isolated memory disturbance, without the cognitive deficits seen in dementia.

C. Major depressive disorder.

1. Both dementia and depression may present with apathy, poor concentration, and impaired memory. Cognitive deficits due to a mood disorder may appear to be dementia, and this is referred to as "'pseudodementia."

2. Differentiation of dementia from depression can be difficult, especially in the elderly. Demented patients are often also depressed. In depression, the mood symptoms should precede the development of cognitive deficits and in dementia, and the cognitive symptoms should precede the depression.

3. A medical evaluation to rule out treatable causes of dementia or medical causes of depression should be completed.

4. If the distinction between dementia and depression remains unclear, a trial of antidepressants is warranted. If the depression is superimposed on the dementia, treatment of the depression will improve the functional level of the patient.

VI. Clinical evaluation of dementia

A. All patients presenting with cognitive deficits should be evaluated to determine the etiology of the dementia. Some causes of dementia are treatable and reversible.

B. A medical and psychiatric history and a physical examination and psychiatric assessment, with special attention to the neurological exam, should be completed.

VII. Laboratory evaluation of dementia.

A. Complete blood chemistry. I. Serological studies (VDRL or.

B. CBC with differential. MHA-TP).

C. Thyroid function tests. J. BERG.

D. Urinalysis. K. Chest X-ray.

E. Drug screen. L.EEG.

F. Serum levels of all measurable M. Brain Imaging (CT, MRI) is medications. indicated if there is a suspicion of.

G. Vitamin B12 level. CNS pathology, such as a mass.

H. Heavy metal screen. lesion or vascular event.

4.6. Delirium – History Taking

History of present illness. Assess impaired consciousness; fluctuating levels of consciousness, arousability, ability to sustain attention, ability to focus, and reduced clarity of awareness of the environment. Ask about current symptoms, nature of onset, causative precipitants, and duration; delirium develops over a short period of time and symptoms fluctuate over the course of the day. Assess cognitive changes, such as, memory impairment, disorientation, and language disturbance.

Ask about abnormalities of mood (e. g., anger), perception (e. g., visual hallucinations), and behavior (e. g., agitation). Assess psychomotor disturbance, such as hyperactivity with increased startle response, flushing, sweating, tachycardia, nausea, vomiting, and hyperthermia. Hypoactivity may manifest with slowed reaction time, catatonia, and depression. Language disturbance may include rambling, changes in the flow of speech, or incoherent speech. Ask about sleep disturbance; insomnia, nightmares, hypnopompic and hypnagogic hallucinations, reversal of the sleep-wake cycle, daytime drowsiness, and exacerbation of symptoms at night (i. e., sundowning).

Past psychiatric history. Ask about previous delirious episodes, psychotic symptoms in the past, and a history of transient cognitive impairments associated with medical illness or surgery.

Substance abuse history. Alcohol intoxication and withdrawal may cause cognitive impairment, delirium, amnesia, and psychotic symptoms. Ask about all substances used, extent of use, and history of withdrawal symptoms. Alcohol dependence increases the risk of developing delirium.

Social history. Ask about housing, employment, extent of family support, marital status, and children.

Family history. Ask about family history of psychiatric illness and dementia.

Delirium does not occur more frequently among family members unless the underlying etiology is heritable.

Past medical history. Assess history of seizure disorder, neoplasm, infection, vascular disease, or trauma. Ask about cardiovascular disease, liver disease (hepatic encephalopathy), and renal disease (uremia).

Medications. Obtain details of medications, with dosages and duration of treatment. Ask about over-the-counter medication and alternative treatments. Toxic levels of anticholinergics, anticonvulsants, antipsychotics, antihypertensives, steroids, lithium, and sedatives can cause delirium.

Mental Status Examination

General appearance: Inattentive, limited eye contact, confused.

Speech: Normal rate, rhythm, and volume.

Mood. “Angry,” “afraid.”

Affect: Dysphoric, irritable, and labile.

Thought process: Tangential, incoherent or irrelevant speech.

Thought content: Paranoid delusions without systematized content.

Perceptual: Auditory and visual hallucinations are most common in delirium.

Suicidality: Varies according to the presence of psychosis and affective symptoms.

Homicidality: May occur in association with paranoia.

Sensorium / cognition: Not alert, disoriented, with fluctuating level of consciousness.

Impaired memory and concentration, poor attention and limited problem-solving abilities.

Impulse control: Limited. Patients may be aggressive with difficulty controlling anger.

Judgment: Impaired. Patients may be inappropriate and disinhibited.

Insight: Fair. Patients realize the nature of their symptoms.

Reliability: Limited. Attention and thinking are typically too impaired to give a reliable history.

Laboratory data. Complete blood count, chemistry, thyroid function tests, RPR,
HIV testing, urinalysis, toxicology screen, serum medication levels, blood and urine cultures if indicated, vitamin B12, thiamine, and folate levels, and lumbar puncture with CSF examination if indicated.

Diagnostic testing. Electroencephalography, chest x-ray, computed tomography, and Delirium Rating Scale.

Diagnosis: Axis I: Delirium due to a general medical condition, substance intoxication delirium, substance withdrawal delirium, delirium due to multiple etiologies, and delirium not multiple etiologies, and delirium not otherwise specified **DSM-IV** / / FOx.5, F1x.4, **ICD-10.**

Differential Diagnosis:

- Psychiatric: dementia, substance intoxication or withdrawal, depression, schizophrenia, brief psychotic disorder, mania, and dissociative disorders.
- Medical: epilepsy, head trauma, infection, medication toxicity (e. g., anticholinergics, | anticonvulsants, antipsychotics, antihypertensives, sedatives, lithium, steroids), heavy metal poisoning, endocrine dysfunction, hepatic encephalopathy, uremic encephalopathy, carbon dioxide toxicity, hypoxia, cardiac failure, vitamin deficiencies (c. g., thiamine, B12, folate), and electrolyte imbalance.

4.7. Substance Use – History Taking

History of present illness. The date of first and last use of the substance should be defined. Determine the frequency and patterns of use, amount of substance used; daily, weekly, monthly. Longest period of sobriety, route of administration, circumstances of use, triggers, and psychosocial stressors. Failure to fulfill obligations at home, work, or school; substance-related legal problems, and substance use in situations that are dangerous (e. g., driving). Screening for alcohol abuse should be accomplished by asking about feeling the need to cut down, becoming annoyed by people who criticize the alcohol use, guilt about drinking, and eye openers to steady nerves in the morning (CAGE questionnaire).

If substance dependence is suspected, ask about the need for increasing amounts of the substance to produce intoxication (tolerance) and withdrawal symptoms. For alcohol with-

drawal, ask about shakes, seizures, psychotic symptoms, and orientation. For opioid withdrawal, ask about dysphoria, nausea, vomiting, muscle aches, lacrimation, rhinorrhea, diarrhea, yawning, and insomnia.

For cocaine withdrawal, ask about anxiety, irritability, dysphoria, and insomnia. Sedative, hypnotic, and anxiolytic withdrawal may include tremors, insomnia, nausea, vomiting, anxiety, agitation, hallucinations, and seizures. Barbiturate abuse should be carefully assessed because withdrawal is potentially fatal. Question the patient and family members about behavioral changes, such as mood lability, aggressiveness, impulsivity, anxiety, irritability, sexual dysfunction, and impaired judgment. Substance abuse may also induce delirium, dementia, mood disorders, anxiety disorders, psychosis, amnesia, and sleep disorders.

Past psychiatric history. Past history of substance abuse, substance abuse treatment programs, medications, hospitalizations, past psychiatric diagnoses and treatment. Mood disorders, anxiety disorders, antisocial personality disorder, and borderline personality disorder occur with increased frequency in people with substance abuse disorders. Suicide is more frequent in people with substance abuse disorders.

Substance abuse history. Ask about all substances used: alcohol, cocaine, amphetamines, heroin, marijuana, hallucinogens, benzodiazepines, and analgesics.

DSM-IV Diagnostic criteria substance-related disorders

I. Substance intoxication.

A. Intoxication is defined as a reversible syndrome that develops following ingestion of a substance.

B. Significant maladaptive, behavioral or psychological changes occur, such as mood lability, impaired judgment, and impaired social or occupational functioning due to ingestion of the substance.

II. Substance abuse.

A. Substance use has not met criteria for dependence, but has lead to impairment or distress as indicated by at least one of the following during a 12-month period:

1. Failure to meet work, school, or home obligations.
2. Substance use during hazardous activities.
3. Recurrent substance-related legal problems.
4. Continued use of the substance despite continued social problems.

III. Substance dependence.

A. The diagnosis of substance dependence requires substance use, accompanied by impairment, and the presence of three of the following in a 12-month period:

1. Tolerance: An increased amount of substance is required to achieve the same effect, or a decreased effect results when the same amount is used.

2. Withdrawal: A characteristic withdrawal syndrome occurs, or the substance is used in an effort to avoid withdrawal symptoms.

3. The substance is used in increasingly larger amounts or over a longer period of time than desired.

4. The patient attempts or desires to decrease use.

5. A significant amount of time is spent obtaining, using, or recovering from the substance.

6. Substance use results in a decreased amount of time spent in social, occupational, or recreational activities.

7. The patient has knowledge that the substance use is detrimental to his health, but that knowledge does not deter continued use.

IV. Substance withdrawal.

A. A substance-specific syndrome develops after cessation or reduction in the amount of substance used.

B. The syndrome causes clinically significant distress or impairment.

C. Symptoms are not due to a medical condition or other mental disorder.

V. Substance-induced disorders.

A. Substance-induced disorders include delirium, dementia, persisting amnestic disorder, psychotic disorder, mood disorder, anxiety disorder, sexual dysfunction, and sleep disorder.

B. Diagnosis requires meeting criteria for specific disorder with evidence that substance intoxication and not another condition (medical disorder) has caused the symptoms.

VI. Clinical evaluation of substance abuse.

A. The physician should determine the amount and frequency of alcohol or other drug use in the past month, week, and day. For alcohol use, the number of days per week alcohol is consumed, and the quantity consumed should be determined.

B. Effects of substance use on the patient's life.

1. Family manifestations. Family dysfunction, marital problems, divorce physical abuse and violence.

2. Social manifestations. Alienation and loss of friends, gravitation toward others with similar lifestyle.

3. Work or school _manifestations. Decline in work school performance, frequent job changes, frequent absences, requests for work excuses.

4. Legal manifestations. Arrests for disturbing the peace or driving while intoxicated, stealing, drug dealing, prostitution, motor vehicle accidents.

5. Financial manifestations. Irresponsible borrowing or owing money, selling of possessions

Social history. Living situation, employment, level of education, history of violence or criminal activity, physical or sexual abuse history.

Family history. Alcohol and substance-related disorders in first-degree relatives, family history of suicide and psychiatric illness.

Past medical history. Ask about medical complications from alcohol abuse, such as liver disease, gastritis, peptic ulcer disease, pancreatitis, cardiomyopathy, hypertension, nutritional deficiencies, and neuropathy. Assess physical signs of alcoholism, such as varices, hepatosplenomegaly, ascites, gynecomastia, and spider nevi. Complications from cocaine use, such as ulceration of the nasal septum, cardiac arrhythmias, and seizures. Complications from intravenous drug use, such as HIV, hepatitis, cellulitis, or osteomyelitis.

Mental Status Examination of the intoxicated patient.

General appearance: Disheveled, poorly groomed, malodorous; may appear older than stated age, restless with mild shaking of the hands, gait is ataxic, and breath may smell of alcohol.

Speech: Slurred rhythm, increased volume, normal rate.

Mood: "Depressed."

Affect: Constricted to the dysphoric range, anxious, but appropriate.

Thought process: Circumstantial, gives irrelevant answers to questions, and words are sometimes incomprehensible.

Thought content: Paranoid ideation and ideas of reference occur. Patients may be dismissive of concerns about their drug use.

Perceptual: Depending on the level of intoxication or extent of withdrawal, patients may have auditory, visual, or tactile / olfactory hallucinations.

Suicidality: Substance abuse increases suicidal risk, so ideation and plans need to be assessed.

Homicidality: Possible homicidal ideation with plans that vary in specificity.

Sensorium / cognition: Inconstant alertness with variable degrees of orientation to place and time, poor concentration, poor registration and recall. The patient may refuse to cooperate with a mini-mental state exam, and cases of alcoholic dementia may show scores less than 24.

Impulse control: When intoxicated, behavior may be aggressive and unpredictable.

Judgment: Impaired. There is often a lack of regard for how substance abuse affects family members and friends.

Insight: Limited. The patient does not recognize the substance abuse as a problem and relates difficulties to environmental stressors or "depression."

Reliability: Poor. There are frequent inconsistencies in the patient's story and symptom reporting.

Laboratory data. Complete blood count, chemistry, liver function tests, coagulability panel, amylase, lipase, cholesterol, triglycerides, B12 and folate level, blood alcohol level, and urinalysis with toxicology screen.

Diagnostic testing. CAGE Screening Questionnaire, Michigan Alcoholism Screening Test (MAST), Alcohol Use Disorders Identification Test (AUDIT), chest x-ray, and electrocardiogram.
Diagnosis: Axis I: Substance-related dependence, abuse, intoxication, withdrawal, delirium, dementia, amnestic disorder, psychotic disorder, **DSM-IV** / / Flx, **ICD-10.**
Differential Diagnosis: Alcohol-related disorders, amphetamine- related disorders, caffeine-related disorders, cannabis-related disorders, cocainerelated disorders, hallucinogen-related disorders, inhalant-related disorders, _nicotine-related disorders, opioid-related disorders, phencyclidinerelated disorders, sedative-, hypnotic-, or anxiolytic-related disorders, and polysubstance dependence.

GLOSSARY

Acute confusional state – delirium.

Affect – the emotional state prevailing in a patient at a particular moment and in response to a particular event or situation. Contrasted with mood which is the prevailing emotional state over a longer period of time.

Agoraphobia – a generalized phobia in which there is fear of open spaces, social situations, crowds, etc. Associated with avoidance of these stimuli.

Akathisia – a subjective sense of uncomfortable desire to move, relieved by repeated movement of the affected part (usually the legs). A side-effect of treatment with neuroleptic drugs.

Alexithymia – the inability to describe one's subjective emotional experiences verbally. May be a personality characteristic but is also associated with somatisation.

Alogia – the poverty of thoughts as observed by absence of spontaneous speech. A negative symptom of schizophrenia and a symptom of depressive illness.

Ambitendency – a motor symptom of schizophrenia in which there is an alternating mixture of automatic obedience and negativism.

Amnesia – the loss of the ability to recall memories for a period of time. May be global (complete memory loss for the time period), or partial.

Anhedonia – the feeling of absent or significantly diminished enjoyment of previously pleasurable activities. A core symptom of depressive illness also a negative symptom of schizophrenia.

Anorexia – the loss of appetite for food. Seen in depressive illness and many general medical conditions. Interestingly, patients with anorexia nervosa often do not have anorexia as so defined. They commonly describe themselves as very hungry controlling their desire for food by supreme effort in order to control their weight.

Anterograde amnesia – the period of amnesia between an event (e. g. head injury) and the resumption of continuous memory. The length of anterograde amnesia is correlated with the extent of brain injury.

Anxiety – a normal and adaptive response to stress and danger which is pathological if prolonged, severe or out of keeping with the real threat of the external situation. Anxiety has two components: psychic anxiety, which is an affect, characterised by increased arousal, apprehension, sense of vulnerability, and dysphoria; and somatic anxiety, in which there are bodily sensations of palpitations, sweating, dyspnoea, pallor, and abdominal discomfort.

Ataxia – the loss of coordination of voluntary movement. Seen in drug and alcohol intoxication and organic disorders, particularly cerebellar.

Athetosis – sinuous, writhing involuntary movements.

Aura – episode of disturbed sensation occurring before an epileptic event. Wide range of manifestations although usually stereotyped for each individual.

Automatism – a type of behavior which is apparently conscious by nature which occurs in the absence of full consciousness (e. g. during a temporal lobe seizure).

Biological features of depression – symptoms of a moderate to severe depressive illness which teflect the disturbance of core vegetative function. They are depressive sleep disturbance, anorexia, loss of libido, anergia, and subjective impression of deterioration in memory and concentration.

Blunting of affect – the loss of the normal degree of emotional sensitivity and sense of the appropriate emotional response to events. A negative symptom of schizophrenia.

Bulimia – the increased appetite and desire for food and / or excessive, impulsive eating of large quantities of usually high-calorie food. Core symptom of bulimia nervosa and may also be seen in mania and in some types of learning disability.

Capgras syndrome – a patient has a feeling that a person familiar to him, usually a family member has been replaced by a double i.e. an identical looking imposter.

Catalepsy – a rare motor symptom of schizophrenia. Describes a situation in which the patient's limbs can be passively moved to any posture which will then be held for a prolonged period of time. Also known as waxy flexibility.

Cataplexy – a symptom of narcolepsy in which there is a sudden loss of muscle tone leading to collapse. Usually occurs following emotional stress.

Catatonia – the increased resting muscle tone which is not present on active or passive movement (in contrast to the rigidity associated with Parkinson's disease and extra-pyramidal side-effects). A motor symptom of schizophrenia.

Chorea – a sudden and involuntary movement of several muscle groups with the resultant action appearing like a part of voluntary movement.

Circumstantial thinking – a disorder of the form of thought where irrelevant details and digressions overwhelm the direction of the thought process. This abnormality may be reflected in the resultant speech. It is seen in mania and in anankastic personality disorder.

Clang association – speech abnormality when the connection between words is their sound rather than their meaning. May occur during manic flight of ideas.

Command hallucination – an auditory hallucination of a commanding voice, instructing the patient towards a particular action. Also known as teleological hallucination.

Compulsion – a kind of behavior or action which is recognized by the patient as unnecessary and purposeless but which he cannot resist performing repeatedly (e. g. hands washing). The drive to perform the action is recognized by the patient as his own but it is associated with a subjective

sense of need to perform the act, often in order to avoid the occurrence of an adverse event. The patient may resist carrying out the action for a time at the expense of mounting anxiety.

Concrete thinking – the loss of the ability to understand abstract concepts and metaphorical ideas leading to a strictly literal form of speech and inability to comprehend allusive language. Seen in schizophrenia and in dementing illnesses.

Confabulation – the process of describing plausibly false memories for a period during which the patient has amnesia.

Confusion – the core symptom of delirium or acute confusional state. There is disorientation, clouding of consciousness and deterioration in the ability to think rationally, accumulate new memories, and to understand the sensory input.

Conversion – the development of features suggestive of physical illness but which are attributed to a psychiatric illness or emotional disturbance rather than to organic pathology.

Coprolalia – the vocalization of obscene words or phrases. The symptom Is largely involuntary but can be resisted for a time, at the expense of mounting anxiety.

Cotard syndrome – a presentation of psychotic depressive illness seen particularly in elderly people. There is a combination of severely depressed mood with nihilistic delusions and / or hypochondriacal delusions. The patient may state that he is already dead and should be buried, that his viscera have stopped working and are rotting away, or that he has stopped existing.

Cyclothymia – a personality characteristic in which there is cyclical mood variation to a lesser degree than in bipolar disorder.

Delirium tremens – the clinical picture of acute confusional state secondary to alcohol withdrawal. Comprises confusion, withdrawals, visual hallucinations, and, occasionally, persecutory delusions and Lilliputian hallucinations.

Delusion – an abnormal belief which is held with absolute subjective certainty, which requires no external proof, which may be held in the face of contradictory evidence, and which has personal significance and importance to the individual concemed. The beliefs which can be understood as a part of the subject's cultural or religious background are excluded. While the content is usually demonstrably false and bizarre by nature, it is variable.

Primary delusions – the direct result of psychopathology, while secondary delusions can be understood as delusions arised in response to other primary psychiatric conditions (e. g. a patient with severely depressed mood developing delusions of poverty or a patient with progressive memory impairment developing a delusion that people are entering his house and stealing or moving items).

Delusional misidentification – a delusional belief that certain individuals are not who they appear to be externally. The delusion may be that familiar people have been replaced with outwardly

identical strangers (Capgras syndrome) or that strangers are familiar people (Fregoli syndrome). It is a rare symptom of schizophrenia or other psychotic illnesses.

Delusional mood – a primary delusion which is recalled following the period of abnormal mood state characterized by anticipatory anxiety, the increased sense of significance of minor events.

Delusional perception – a primary delusion which occurs as a result of abnormal perception (e. g. a patient watching that two white cars have stopped in front of his house became convinced that he would be wrongly accused of paedophilia). The percept is a real external object, not a hallucinatory experience.

Delusions of control – a group of delusions which are also known as passivity phenomena or delusions of bodily passivity. They are considered as first-rank symptoms of schizophrenia. The core feature is the delusional belief that one is no longer in control of one's own body. The individual delusions are that one is being forced by an external agent to feel emotions, to desire to do things, to perform actions, or to experience bodily sensations. Respectively these delusions are called: the passivity of affect, passivity of impulse, passivity of volition, and somatic passivity.

Delusions of guilt – a delusional belief that one has committed a crime or other reprehensible act. A feature of psychotic depressive illness (e. g., an elderly woman with severe depressive illness who became convinced that her child, who had died from sudden infant death syndrome many years before, was in fact murdered by her).

Delusions of infestation – a delusional belief that one's skin is infested with multiple, tiny animals.

Delusions of love – a delusion when the patient believes that another individual is in love with him and that they are destined to be together. A rare symptom of schizophrenia.

Delusions of reference – a delusional belief that external events or situations have been arranged in such way as to have a particular significance or to convey a message to the affected individual. The patient may believe that television news is referring to him or that some chapters of the Bible are about him directly.

Delusions of thought interference – a group of delusions which are considered as first-rank symptoms of schizophrenia: thought insertion, thought withdrawal, and thought broadcasting.

Dementia – chronic brain failure. In dementia, there is a progressive and global loss of brain function. It is usually irreversible. Different dementia illnesses will show different patterns and rates of functional loss but, in general, there is the impairment of memory, loss of higher cognitive function, perceptual abnormalities, dyspraxia, and disintegration of personality.

Dependence – the inability to control the intake of a substance to which one is addicted. Dependence includes two components: psychological dependence, which is the subjective feeling of the loss of control, cravings, and preoccupation with obtaining the substance; and physiological dependence, which is the physical consequences of withdrawal and is specific to every type of drug.

Depersonalisation – unpleasant subjective experience when the patient feels as if everything has become unreal.

*Derailmen*t – a symptom of schizophrenic thought disorder in which there is a total break in the chain of associations between the meaning of thoughts. The connection between two sequential ideas is apparent neither to the patient nor to the examiner.

Derealisation – unpleasant subjective experience when the patient feels as if the world has become unreal. Like depersonalisation it is a non-specific symptom of a number of disorders.

Diogenes syndrome – hiding objects, usually of no practical use, and neglecting one's home or environment. May be a behavioural manifestation of organic disorder, schizophrenia, depressive disorder, or obsessive-compulsive disorder.

Disinhibition – the loss of awareness about what type of behavior is appropriate in the current social setting. It is the symptom of manic illnesses and occurs in the later stages of dementia illnesses and during drugs or alcohol intoxication.

Disorientation – the loss of the ability to recall and accurately update information regarding current time, place, and personal identity.

Dissociation – the separation of unpleasant emotions and memories from consciousness with subsequent disruption to the normal integrated function of consciousness and memory. Conversion and dissociation are related concepts. In conversion the emotional abnormality produces physical symptoms; while in dissociation there is the impairment of mental functioning (e. g. in dissociative fugue and dissociative amnesia).

Dysarthria – the impairment in the ability to articulate speech properly. Caused by lesions in the brain stem, cranial nerves, or pharynx. Distinguished from dysphasia because there is no impairment of comprehension, writing, or higher language function.

Dyskinesia – the impairment of voluntary motor activity by superimposed involuntary motor activity.

Dysmorphophobia – the type of over-valued idea when the patient believes that one part of his body is abnormal or conspicuously deformed.

Dysphasia – the impairment in producing or understanding speech (expressive dysphasia and receptive dysphasia respectively) related to cortical abnormality, in contrast to dysarthria, when abnormality in the organs of speech production is present.

Dysphoria – an emotional state experienced as unpleasant. Secondary to a number of symptoms (e. g. depressed mood, withdrawals).

Dyspraxia – the inability to carry out complex motor tasks (e. g. dressing, eating) although several components of motor movements are preserved.

Dysthymia – chronic, mildly depressed mood and diminished enjoyment, not severe enough to be considered as a depressive illness.

Echo de la pense – a synonym of thought echo.

Echolalia – the repetition of phrases or sentences spoken by the examiner. Occurs in schizophrenia and mental retardation cases.

Echopraxia – a motor symptom of schizophrenia, when the patient mirrors the doctor's body movements. This continues after the patient was asked to stop.

Elemental hallucination – a type of hallucination when false perceptions are of a very simple character (e. g. light flashes or clicks and bangs). Associated with organic illnesses.

Elevation of mood – the core feature of manic illnesses. The mood is preternaturally cheerful, and the subjectively increased speed and ease of thinking are observed.

Entgleiten – a synonym for thought blocking or switching-off.

Erotomania – a synonym for delusion of love.

Euphoria – sustained and unwarranted cheerfulness. Associated with manic states and organic impairment.

Extracampine hallucination – a hallucination that something happens in the area which is beyond the visual field of a patient.

Extra-pyramidal side-effects (EPSE) – side-effects of rigidity, tremor, and dyskinesia caused by anti-dopaminergic effects of psychotropic drugs, particularly neuroleptics. In comparison to idiopathic Parkinson's disease, bradykinesia is not prominent.

False perceptions – internal perceptions which do not have a corresponding object in the external world. Includes hallucinations and pseudo-hallucinations.

Flashbacks – exceptionally vivid and affect-laden re-experiencing of remembered experiences. Flashbacks of the initial traumatic event occur in PTSD and flashbacks to abnormal perceptual experiences initially experienced during LSD intoxication can occur many years after the event.

Flattening of affect – the diminution of the normal range of emotional experience. A negative symptom of schizophrenia.

Flight of ideas – subjective experience of one's thinking which is more rapid than normal one, with each thought having a greater range of consequent thinking than a normal one has. Meaningful connections between thoughts are maintained.

Fregoli syndrome – a type of delusional misidentification in which the patient believes that strangers have been replaced with familiar people.

Functional hallucination – a hallucination that occurs only when experiencing a normal percept in that modality (e. g. hearing voices when the noise of an air conditioner is heard).

Fugue – a dissociative reaction to unbearable stress. Following a severe external stressor (e. g. marital break-up) the affected individual develops global amnesia and may wander to a distant location. Consciousness is not impaired. Following resolution there is amnesia for the events which occurred during the fugue.

Grandiose delusion – a delusional belief that one has special power, is unusually rich or powerful, or that one has an exceptional destiny (e. g. a man who requested admission to hospital because he had become convinced that God had granted him and that coming into contact with him would cure others of mental illnesses).

Grandiosity – the exaggerated sense of one's own importance or abilities.

Hallucination – an internal percept without a corresponding external object. The subjective experience of hallucination is that of experiencing a normal percept in that modality of sensation.

Hypnagogic hallucination – a transient false perception experienced while on the verge of falling asleep (e. g. hearing a voice calling one's name which then startles you back to wakefulness to find no one there). The same phenomenon is experienced while waking up and called hypnopompic hallucination. Frequently experienced by healthy people and is not a symptom of mental illness.

Hypochondriacal delusions – a delusional belief that one has a serious physical illness (e. g. cancer, AIDS). Most common in psychotic depressive illnesses.

Hypomania – describes a mild degree of mania when mood is elevated but no significant impairment of the patient's day-to-day functioning is observed.

Illusion – a type of false perception in which the perception of a teal world object is combined with internal imagery to produce a false internal percept. Three types are recognized: affect, completion, and pareidolic illusions. In affect illusion there is a combination of heightened emotion and misperception (e. g. whilst walking across a lonely park at night, briefly seeing a tree moving by wind as an attacker). Completion illusions rely on our brain's tendency to presume missing parts of an object to produce a meaningful percept and are the basis for many types of optical illusion.

Imperative hallucination – the form of command hallucinations in which a hallucinatory instruction is experienced as irresistible, the passivity of action is present.

Impotence – the loss of the ability to consummate sexual relationships. It refers to the inability to achieve penile erection in men and the lack of genital preparedness in women. It may have a primary medical cause and related to psychological factors, or can be a side-effect of many psychotropic medications.

Incongruity of affect – refers to the objective impression that the displayed affect is not consistent with current thoughts or actions, (e. g. laughing while discussing traumatic experiences). Occurs in schizophrenia.

Insightlessness – see the lack of insight.

Irritability – the diminution in the stressor that provokes anger and verbal or physical violence. Seen in manic illnesses, organic cognitive impairment, psychotic illnesses, drug and alcohol intoxication. Can also be a feature of normal personality types and personality disorder.

Lack of insight – the loss of the ability to recognize that one's abnormal experiences are symptoms of a psychiatric illness and that they require treatment.

Lilliputian hallucination – a type of visual hallucination in which the subject sees people or animals in miniature size. Associated with organic states, particularly delirium tremens.

Loosening of associations – the symptom of formal thought disorder in which there is a lack of meaningful connection between sequential ideas.

Magical thinking – a belief that certain actions and outcomes are connected although there is no rational basis for establishing a connection. Magical thinking is common in normal children and is the basis for most superstitions.

Mania – the form of mood disorder initially characterized by elevated mood, insomnia, loss of appetite, increased libido, and grandiosity.

Mental retardation – the level of intelligence is diminished below the second standard deviation (IQ<70). The increasing severity of retardation is associated with the decreased ability to learn, to solve problems, and to understand abstract concepts. Motor symptoms of schizophrenia – a schizophrenic illness associated with a variety of soft neurological signs and motor abnormalities. Recognized motor symptoms in schizophrenia include: catatonia, catalepsy, automatic obedience, negativism, ambitendency, mannerism, stereotypy, echopraxia, and psychological pillow.

Multiple personality – the finding of two or more personalities in one individual. These personalities may answer to different names, exhibit markedly different behaviours, and describe amnesia in the periods when other personalities were active.

Mutism – the absence of speech without the impairment of consciousness.

Negative symptoms (of schizophrenia) – the symptoms of schizophrenia which reflect the impairment of normal function: lack of volition, lack of drive, apathy, anhedonia, flattening of affect, blunting of affect and alogia. They are believed to be related to the cortical cell loss.

Negativism – a motor symptom of schizophrenia when the patient resists carrying out examiner's instructions and attempts to move or direct the limbs.

Neologism – a made-up word or normal word used in an idiosyncratic way.

Nihilistic delusions – a delusional belief that the patient has died or no longer exists or that the world has ended or is no longer real, so nothing matters any longer and continued effort is pointless. A feature of psychotic depressive illness.

Obsession – an idea, image, or impulse which is recognized by the patient as his own, but which is experienced as repetitive, intrusive, and distressing. The return of the obsession can be resisted

during certain time at the expense of mounting anxiety. In some situations the anxiety accompanying the obsessional thoughts can be relieved by associated compulsions, (e. g. a patient with an obsession that his wife may be in danger and hi has to phone her constantly during the day to check if she is still alive).

Othello syndrome – a delusional disorder when the core delusion has the content of delusional jealousy.

Overvalued ideas – the form of an abnormal belief. These ideas are reasonable and understandable by a patient, but they take an unreasonably dominating part in the patient's life.

Palimpsest – the episode of discrete amnesia related to alcohol or drug intoxication. The individual is not able to recall the period when, although intoxicated, he appeared to function normally.

Panic attack – a paroxysmal, severe anxiety which may occur in response to a particular stimulus or without apparent stimulus.

Paranoid delusion – self-referential delusions, i.e. grandiose delusions and persecutory delusions. It is however more commonly used as a synonym of persecutory delusion.

Paraphasia – the substitution of words by non-verbal sounds which may occur in organic lesions affecting speech.

Persecutory delusion – a delusional belief that someone tries to harm patient's life. Perseveration – replying with the same phrase or action to different questions.

Phobia – a particular stimulus, event, or situation which arouses anxiety in an individual and therefore it is associated with avoidance.

Positive symptoms (of schizophrenia) – the symptoms of schizophrenia which are qualitatively different from normal experience (i.e. delusions, hallucinations, schizophrenic thought disorder). Pressure of speech – the speech pattern is determined by the pressure of thought. The speech is rapid, difficult to interrupt, and, with the increasing severity of illness, the connection between sequential ideas may become very hard to follow.

Pressure of thought – the subjective experience of one's thoughts occurring rapidly when each thought is associated with a wider range of consequent ideas in contrast to normal thinking and with the inability to concentrate on one idea during certain period of time.

Pseudohallucination – a false perception occurring as a part of one's internal experience, not as a part of the external world.

Psychomotor agitation – a combination of psychic anxiety and excess and purposeless motor activity.

Psychomotor retardation – the decreased spontaneous movement and slowness in instigating and completing voluntary movements.

Retrograde amnesia – the period of amnesia between the moment of the happened event (e. g. head injury) and the last continuous memories before the event.

Rumination – the obsession to engage in repetitive and pointless consideration of phrases or ideas, usually of a pseudo-philosophical nature. May be resisted for a period with consequent mounting anxiety.

Running commentary – a type of "third-person" auditory hallucination which is the first-rank symptom of schizophrenia. The patient hears one or more voices providing a narrative of their current actions.

Schizophasia – a synonym of "word salad".

Schizophrenic speech disorder – abnormalities of the form of speech caused by schizophrenic thought disorders, and language use abnormalities characteristic for schizophrenia, such as the use of neologisms and stock words / phrases.

Schizophrenic thought disorder – abnormalities in the subjective description of the form of thinking which occur in case of schizophrenia. They include: loosening of associations, derailment, thought blocking, fusion, and muddling.

Stereotypy – a repetitive and bizarre movement which is not purposeful (in contrast to mannerism). The action may have a delusional significance to the patient. Seen in schizophrenia – stock phrases / stock words.

Stupor – the absence of movement and mutism when there is no impairment of consciousness. Functional stupor occurs in a variety of psychiatric illnesses. Organic stupor is caused by lesions in the midbrain.

Synaesthesia – a stimulus in one sensory modality is perceived in a fashion characteristic of the experience in another sensory modality. Occurs in hallucinogenic drug intoxication and in epileptic states.

Tangentiality – replying with answers which are very indirectly related to a question asked by the examiner.

Thought blocking – a symptom of schizophrenic thought disorder. The patient experiences a sudden break in the chain of thinking process. It may be explained by thought withdrawal. In the absence of such delusional elaboration this symptom is not first-rank.

Thought broadcasting – the delusional belief that one's thoughts are accessible directly to others. A first-rank symptom of schizophrenia.

Thought echo – the experience of an auditory hallucination in which the content is presented by current thoughts of the individual. A first-rank symptom of schizophrenia.

Thought insertion – a delusional belief that thoughts have been placed into the patient's head from outside. A first-rank symptom of schizophrenia.

Tic – sudden twitches of a single muscle or muscle group.

Trichotillomania – the inclination for pulling own hait.

Verbigeration – the repetition of words or phrase while unable to articulate the next word of the sentence. Seen in expressive dysphasia.

Word salad – the most severe degree of schizophrenic thought disorder in which no connection of any kind is understandable between sequential words and phrases that the patient uses. It is also called schizophasia.

International Classification of Disease (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)

ICD-10	DSM-IV	Disorder
F00	**290**	**Dementia in Alzheimer's disease**
F00.0	290.10	Early onset
F00.1	290.0	Late onset
F00.2	294.1	Atypical or mixed type
F00.9	294.1	Unspecified
F01	**290.40**	**Vascular dementia**
F01.0	290.40	Acute onset
F01.1	290.40	Multi-infarct
F01.2	290.40	Subcortical
F01.3	290.40	Mixed cortical and subcortical
F02.0	**290.10**	**Dementia in Pick's disease**
F02.1	**290.0**	**Dementia in Creutzfeldt-Jakob disease**
F02.2	**294.1**	**Dementia in Huntington's disease**
F02.3	**294.1**	**Dementia in Parkinson's disease**
F02.4	**294.9**	**Dementia in HIV disease**
F02.8	294.1	Dementia in other specified diseases
F03	294.8	Unspecified dementia
F04	**294.0**	**Organic amnesic syndrome, not induced by alcohol and other psychoactive substances**
F05	**293.0**	**Delirium**
F05.0	293.0	Delirium not superimposed on dementia
F05.1	293.0	Delirium superimposed on dementia
F06	**293.8**	**Mental disorders due to brain damage, dysfunction, and physical disease**
F06.0	293.82	Hallucinosis
F06.1	293.89	Catatonic disorder
F06.2	293.81	Delusional (schizophrenia-like) disorder
F06.3	293.83	Mood (affective) disorders
F06.4	293.84	Anxiety disorder
F06.5	293.9	Dissociative disorder
F06.6	293.9	Emotionally labile (asthenic) disorder
F06.7	294.9	Mild cognitive disorder

F07	**310.1**	**Personality and behavioural disorders due to brain disease, damage, or dysfunction**
F07.0	310.1	Organic personality disorder
FO7.1	310.1	Postencephalitic syndrome
FO7.2	310.1	Post-concussional syndrome
F09	**293.9**	**Unspecified organic or symptomatic mental disorder**
ICD-10	**DSM-IV**	**Disorder**
F20	**295**	**Schizophrenia**
F20.0	295.30	Paranoid
F20.1	295.10	Hebephrenic
F20.2	295.2	Catatonic
F20.3	295.90	Undifferentiated
F20.4	311	Post-schizophrenic depression
F20.5	295.60	Residual
F20.6	295.90	Simple
F21	**301.22**	**Schizotypal disorder**
F22	**297**	**Persistent delusional disorder**
F22.0	297.1	Delusional disorder
F22.8	297.1.	Other persistent delusional disorders
F23		**Acute and transient psychotic disorders**
F23.0	298.9	Acute polymorphic psychotic disorder without symptoms of schizophrenia
F23.1	295.40	Acute polymorphic psychotic disorder with symptoms of schizophrenia
F23.2	295.40	Acute schizophrenia-like psychotic disorder
F233	297.1	Other acute predominantly delusional psychotic disorders
F24	**297.3**	**Induced delusional disorder**
F25	**295.7**	**Schizoaffective disorder**
F25.0	295.70	Manic type
F25.1	295.70	Depressive type
F25 2	295.70	Mixed type
F28	**298.9**	**Other non-organic psychotic disorders**
F29	**298.9**	**Unspecified non-organic psychosis**
ICD-10	**DSM-IV**	**Disorder**
F30		**Manic episode**
F30.0	296.00	Hypomania
F30.1	296.03	Mania without psychotic symptoms

F30.2	296.04	Mania with psychotic symptoms
F31		**Bipolar affective disorder**
F31.0	296.40	Current episode hypomanic
F31.1	296.43	Current episode manic without psychotic symptoms
F31.2	296.44	Current episode manic with psychotic symptoms
F31.3	296.52	Current episode mild or moderate depression
F31.4	296.53	Current episode severe depression without psychotic symptoms
F31.5	296.54	Current episode severe depression with psychotic symptoms
F31.6	296.60	Current episode mixed
F31.7	296.66	Currently in remission
F32		**Depressive episode**
F32.00	296.21	Mild without somatic symptoms
F32.01	296.21	Mild with somatic symptoms
F32.10	296.22	Moderate without somatic symptoms
F32.11	296.22	Moderate with somatic symptoms
B32.2	296.23	Severe without psychotic symptoms
1323	296.24	Severe with psychotic symptoms
F32.8	311	Other
F33		**Recurrent depressive disorder**
F33.00	296.31	Current episode mild without somatic symptoms
F33.01	296.31	Current episode mild with somatic symptoms
F33.10	296.32	Current episode moderate without somatic symptoms
F33.11	296.32	Current episode moderate with somatic symptoms
F33.2	296.33	Current episode severe without psychotic > symptoms
F33.3	296.34	Current episode severe with psychotic symptoms
F33.4	296.36	Currently in remission
F34		**Persistent mood (affective) disorders**
F34.0	301.13	Cyclothymia
F34.1	300.4	Dysthymia
F38		**Other mood (affective) disorders**
F38.0	296.90	Other single mood (affective) disorders
F38.1	296.90	Other recurrent mood (affective) disorders
F38.8	296.90	Other specified mood (affective) disorders
F39	**296.90**	**Unspecified mood (affective)disorders**
ICD-10	**DSM-IV**	**Disorder**
F40		**Phobic anxiety disorders**

F40.00	300.22	Agoraphobia without panic disorder
F40.01	300.21	Agoraphobia with panic disorder
F40.1	300.23	Social phobias
F40.2	300.29	Specific (isolated) phobias
F41		**Other anxiety disorders**
F41.0	300.01	Panic disorder (episodic paroxysmal anxiety)
F41.1	300.02	Generalised anxiety disorder
F41.2	300.00	Mixed anxiety and depressive disorder
F413	300.00	Other mixed anxiety disorders
F42		**Obsessive-compulsive disorder**
F42.0	300.3	Predominantly obsessional thoughts or ruminations
F421	300.3	Predominantly compulsive acts (obsessional rituals)
F42.2	300.3	Mixed obsessional thoughts and acts
F43		**Reaction to severe stress and adjustment disorders**
F43.0	308.3	Acute stress reaction
F43.1	309.81	Post-traumatic stress disorder
F43.2	309.9	Adjustment disorders
F44		**Dissociative (conversion) disorders**
F44.0	300.12	Dissociative amnesia
F44.1	300.13	Dissociative fugue
F44.2	300.15	Dissociative stupor
F44.3	300.15	Trance and possession disorders
F44.4	300.15	Dissociative motor disorders
F44.5	300.15	Dissociative convulsions
F44.6	300.15	Dissociative anaesthesia and sensory loss
F44.7	300.15	Mixed dissociative (conversion) disorders
F44.80	300.11	Ganser syndrome
F44.81	300.14	Multiple personality disorder
F44.82	300.11	Transient dissociate (conversion) disorders occurring in childhood and adolescence
F45		**Somatoform disorders**
F45.0	300.81	Somatisation disorder
F45.1	300.82	Undifferentiated somatoform disorder
F45.2	300.7	Hypochondriacal disorder
F45.3	300.82	Somatoform autonomic dysfunction
F45.4	307.80	Persistent somatoform pain disorder
F48		**Other neurotic disorders**

F48.0	300.82	Neurasthenia
F48.1	300.6	Depersonalisation-derealisation syndrome
ICD-10	**DSM-IV**	**Disorder**
F50		**Eating disorders**
F50.0	307.1	Anorexia nervosa
F50.1	307.1	Atypical anorexia nervosa
F50.2	307.51	Bulimia nervosa
F50.3	307.51	Atypical bulimia nervosa
F50.4	307.50	Overeating associated with other psychological disturbances
F50.5	307.50	Vomiting associated with other psychological disturbances
F51		**Non-organic sleep disorders**
F51.0	307.42	Insomnia
F51.1	307.44	Hypersomnia
F51.2	307.45	Disorder of the sleep-wake schedule
F51.3	307.46	Sleepwalking (somnambulism)
F51.4	307.46	Sleep terrors (night terrors)
F51.5	307.47	Nightmares
F52		**Sexual dysfunction, not caused by organic disorder or disease**
F52.0	302.71	Lack or loss of sexual desire
F52.1	302.79	Sexual aversion and lack of sexual enjoyment
F52.2	302.72	Failure of genital response
F52;3	302.73 / 4	Orgasmic dysfunction
F52.4	302.75	Premature ejaculation
F52.5	306.51	Non-organic vaginismus
F52.6	302.76	Non-organic dyspareunia
F527	302.9	Excessive sexual drive
F53		**Mental and behavioural disorders associated with the puerperium, not elsewhere classified**
F53.0	293.9	Mild
F531	293.9	Severe
F54	**316**	**Psychological and behavioural factors associated with disorders or diseases classified elsewhere**
F55	**305**	**Abuse of hon-dependence-producing substances**
F55.0	305.90	Harmful use of antidepressants
F55.1	305.90	Harmful use of laxatives
F55.2	305.90	Harmful use of analgesics

B55.3	305.90	Harmful use of antacids
F55.4	305.90	Harmful use of vitamins
F55.5	305.90	Harmful use of steroids or hormones
F55.6	305.90	Harmful use of specific herbal or folk remedies
F55.8	305.90	Harmful use of other substances that do not produce
		dependence
F59	**300.9**	**Unspecified behavioural syndromes associated with physiological disturbances and physical factors**
ICD-10	**DM-IV**	**Disorder**
F60		**Specific personality disorders**
F60.10	301.0	Paranoid
F60.1	301.20	Schizoid
F60.2	301.7	Dissocial
F60.30	301.9	Emotionally unstablesh"impulsive type
F60,31	301.83	Emotionally unstables h" borderline type
F60.4	301.50	Histrionic
F60.5	301.4	Anankastic
F60.6	301.82	Anxious (avoidant)
F60.7	301.6	Dependent
F61	**301.9**	**Mixed and other personality disorders**
F62		**Enduring personality changes, not attributable to brain damage and disease**
F62.0	301.9	After catastrophic experience
F62.1	301.9	After psychiatric illness
F63	**312**	**Habit and impulse disorders**
F63.0	312.31	Pathological gambling
F63.1	312.33	Pathological fire-setting (pyromania)
F63.2	312.32	Pathological stealing (kleptomania)
F63.3	312.39	Trichotillomania
F64		**Gender identity disorders**
F64.0	302.85	Transsexualism
F64.1	302.85	Dual-role transvestism
F64.2	302.6	Gender identity disorder of childhood
F65		**Disorders of sexual preference**
F65.0	302.81	Fetishism
F65.1	302.3	Fetishistic transvestism
F65.2	302.4	Exhibitionism

F65.3	302.82	Voyeurism
F65.4	302.2	Paedophilia
F65.5	302.83 / 4	Sadomasochism
F65.6	302.9	Multiple disorders of sexual preference
F66		**Psychological and behavioural disorders associated with sexual development and orientation**
F66.0	302.6	Sexual maturation disorder
F66.1	302.6	Egodystonic sexual orientation
F66.2	302.6	Sexual relationship disorder
F68		**Other**
F68.0	300.9	Elaboration of physical symptoms for psychological reasons
F68.1	300.19	Intentional production or feigning of symptoms or disabilities, either physical or psychological
ICD-10	**DSM-IV**	**Disorder**
F70	317	Mild mental retardation
F71	318.0	Moderate mental retardation
E72	318.1	Severe mental retardation
F73	318.2	Profound mental retardation
F78	319	Other mental retardation
F79	319	Unspecified mental retardation
ICD-10	**DSM-IV**	**Disorder**
F80		**Specific developmental disorders of speech and language**
F80.0	315.39	Specific speech articulation disorder
F80.1	315.31	Expressive language disorder
F80.2	315.32	Receptive language disorder
F80.3	307.9	Acquired aphasia with epilepsy (Landau-Kleffner)
F80.8	307.9	Other developmental disorders of speech and language
F81		**Specific developmental disorders of scholastic skills**
F81.0	315.00	Specific reading disorder
F81.1	315.2	Specific spelling disorder
F81.2	315.1	Specific disorder of arithmetical skills
F81.3:	315.9	Mixed disorder of scholastic skills
F81.8	315.9	Other developmental disorders of scholastic skills
F81.9	315.9	Developmental disorder of scholastic skills, unspecified
F82	**315.4**	**Specific developmental disorder of motor function**
F83	**315.4**	**Mixed specific developmental disorders**
F84		**Pervasive developmental disorders**

F84.0	299.00	Childhood autism
F84.1	299.80	Atypical autism
F84.2	299.80	Rett's syndrome
F84.3	299.10	Other childhood disintegrative disorder
F84.4	299.80	Overactive disorder associated with mental retardation and stereotyped movements
F84.5	299.80	Asperger's syndrome
F84.8	299.80	Other pervasive developmental disorders
F88	**299.80**	**Other disorders of psychological development**
F89	**299.80**	**Unspecified disorder of psychological development**
ICD-10	**DSM-IV**	**Disorder**
F90		**Hyperkinetic disorders**
F90.0	314.9	Disturbance of activity and attention
F90.1	312.81	Hyperkinetic conduct disorder
F90.8	314.9	Other hyperkinetic disorders
F91	**312.8**	**Conduct disorders**
F91.0	312.89	Confined to the family context
F91.1	312.89	Undersocialised conduct disorder
E91.2	312.89	Socialised conduct disorder
F91.3	313.81	Oppositional defiant disorder
F91.8	312.89	Other conduct disorders
F92		**Mixed disorders of conduct and emotions**
F92.0	312.89	Depressive conduct disorder
F92.8	312.89	Other mixed disorders of conduct and emotions
F93		**Emotional disorders with onset specific to childhood**
F93.0	309.21	Separation anxiety disorder of childhood
E93.1	300.29	Phobic anxiety disorder of childhood
F93.2	300.23	Social anxiety disorder of childhood
F93.3	V61.8	Sibling rivalry disorder
F94		**Disorders of social functioning with onset specific to childhood and adolescence**
F94.0	313.23	Elective mutism
F94.1	313.89	Reactive attachment disorder of childhood
F94.2	313.89	Disinhibited attachment disorder of childhood
F94.8	313.9	Other childhood disorders of social functioning
F95		**Tic disorders**
F95.0	307.21	Transient tic disorder

F95.1	307.22	Chronic motor or vocal tic disorder
F95.2	307.23	Combined vocal and multiple motor tic disorder
F95.8	307.20	Other tic disorders
F98		**Other**
F98.0	307.6	Non-organic enuresis
F98.1	307.7	Non-organic encopresis
F98.2	307.59	Feeding disorder of infancy and childhood
F98.3	307.52	Pica of infancy and childhood
F98.4	307.3	Stereotyped movement disorders
F98.5	307.0	Stuttering (stammering)
F98.6	307.9	Cluttering
F98.8	313.9	Other specified behavioural and emotional disorders with onset usually occurring in infancy or childhood

QUESTIONS FOR THE EXAMINATION IN PSYCHIATRY

1. Psychiatry as a branch of medicine. Branches of psychiatry.
2. Psychiatric help and guarantees of the rights of citizens at its rendering. Abstracts from the Law of the Republic of Belarus "About the psychiatric help and guarantees of the rights of citizens at its rendering".
3. The grounds for involuntary hospitalization to the psychiatric hospital.
4. The concept of the International Classification of Disease (ICD-10).
5. The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM- IV).
6. Global assessment of functioning (Axis V, DSM-IV).
7. Psychiatric history.
8. Psychosis – history taking.
9. Depression – history taking.
10. Mania – history taking.
11. Suicidal ideation – history taking.
12. Cognitive impairment – history taking.
13. Delirium – history taking.
14. Substance use – history taking.
15. Organic brain disorders and functional mental illnesses.
16. Characteristics of psychosis and neurosis.
17. General psychopathology. Hallucinations: classification, clinical picture, nosological nature.
18. General psychopathology. Illusions.
19. General psychopathology. The forms of thinking disturbances.
20. General psychopathology. The classification of consciousness disturbances. The criteria of the changed consciousness (by K. Jaspers). Nosological nature.
21. General psychopathology. The classification of mood disturbances.
22. General psychopathology. Ammesia. Clinical picture of qualitative memory impairment. A nosological appliance.
23. Organic brain syndromes: delirium. Causes. Clinical picture.
24. Organic brain syndromes: dementia. The classification of dementia (cortical and subcortical).
25. Senile dementia of Alzheimer type. AIDS dementia complex. Medical tactics of a doctor.
26. Vascular dementia. The methods of prevention.
27.Clinical picture of mental disturbances in the remote period of craniocerebral trauma. Medical tactics.
28. Fatal deliberate self-harm (suicide, completed suicide).

29. Non-fatal deliberate self-harm (DSH, parasuicide, attempted suicide).

30. The classification of mood disorders according to ICD-10 and DSM-IV.

31. Clinical features of depressive illnesses. Types. Diagnosis.

32. Clinical features of mania. Diagnosis. Bipolar disorders (DSM-IV). Clinical features. Medical tactics.

33. The official criteria for acute stress disorder (DSM-IV). Types of trauma. Post-traumatic stress disorder (PTSD).

34. Schizophrenia. Modern representations about the etiology of schizophrenia. The classification of schizophrenia according to ICD-10.

35. Schizophrenia. Positive and negative symptoms.

36. The diagnostic criteria of schizophrenia (Schneider (1959). Differential diagnosis.

37. Mental retardation. Causes of mental retardation. The classifications of mental retardation (ICD-10).

38. Personality disorders. Definition. Diagnostic criteria (Gannushkin P. B.).

39. Cluster A personality disorders (DSM-IV).

40. Cluster B personality disorders (DSM-IV).

41. Cluster C personality disorders (DSM-IV).

42. Food intake disorders: anorexia nervosa, bulimia nervosa. Clinical features. Treatment.

43. Epilepsy. Epidemiology, questions of etiology and pathogeny. The classification of the forms of epilepsy.

44. Epileptic paroxysms. The classification. Clinical picture.

NARCOLOGY

45. The classification of mental and behavioural disorders due to the use of psychoactive substances, according to ICD-10.

46. Specific substance-related disorders according to DSM-IV.

47. Acute intoxication caused by the use of psychoactive substances. Diagnostic criteria (ICD-10).

48. The harmful use of psychoactive substances. Diagnostic criteria (ICD-10).

49. Dependence syndrome due to the use of psychoactive substance. Diagnostic criteria (ICD-10).

50. Clinical evaluation of substance abuse.

51. Withdrawal state caused by the use of psychoactive substances. Diagnostic criteria (ICD-10).

52. Withdrawal state with delirium caused by the use of psychoactive substances. Diagnostic criteria (ICD-10).

53. Psychotic disorders due to the use of psychoactive substance. Diagnostic criteria (ICD-10).

54. Acute intoxication caused by the use of alcohol.

55. Acute intoxication caused by the use of opioids.

56. Mental and behavioural disorders due to the use of alcohol.
57. Mental and behavioural disorders due to the use of opioids.
58. Mental and behavioural disorders due to the use of cannabinoids.
59. Mental and behaviourai disorders due to the use of sedative hypnotics.
60. Mental and behavioural disorders due to the use of cocaine.
61. Mental and behavioural disorders due to the use of other stimulants, including caffeine.
62. Mental and behavioural disorders due to the use of hallucinogens.
63. Mental and behavioural disorders due to the use of tobacco.
64. Mental and behavioural disorders due to the use of volatile solvents.
65. The grades of withdrawal state due to the use of opioids.
66. Korsakoff's syndrom. Wernicke's encephalopathy. Clinical picture. Nosological nature.

TREATMENT

67. The general principles of using psychotropic drugs.
68. The classification of neuroleptic agents.
69. Typical neuroleptics and their use in psychiatric practice.
70. Atypical neuroleptic agents. Indications.
71. The classification of tranquilizers.
72. Tranquilizers. The use of tranquilizers in psychiatric and therapeutic practice.
73. The classification of antidepressants.
74. Antidepressants and their use in psychiatric and therapeutic practice.
75. Treatment of dementia syndrome. Cholinesterase inhibitors.
76. Nootropics. The use of nootropics in psychiatric practice.
77. Treatment of delirium.
78. Treatment of acute intoxication caused by the use of opioids.
79. Mood stabilizers.
80. Psychotherapy. The value of psychotherapy in various diseases. The types of psychotherapy.
81. Side effects and complications caused by the use of antidepressants.
82. Side effects of tranquilizers. Treatment.
83. Side effects of typical neuroleptic agents. Medical approaches to elimination.
84. Side effects of atypical neuroleptic agents. Medical approaches to elimination.
85. Neuroleptic malignant syndrome. Medical tactics.
86. Treatment of epilepsy. Anticonvulsants. Surgical treatment.
87. Electroconvulsive therapy (ECT). Indications. The mode of action.
88. Electroconvulsive therapy (ECT). Contraindications.

READING REFERENCES

1. Lishman W. A. Organic Psychiatry: Psychological Consequences of Cerebral Disorder, 3rd ed. Oxford: Blackwell Scientific Publications, 1998.

2. World Health Organization. Schedules for Clinical Assessment in Neuropsychiatry (SCAN). Geneva: Division of Mental Health, World Health Organization, 1992.

3. Folstein M. F., Folstein S. E., McHugh P. R. Mini-Mental State. J Psych Res 1975; 12: 189–198.

4. American Psychiatrie Association. Diagnostic and Statistical Manual, 4th ed. text revision (DSM-IV-TR). Washington, D.C.: American Psychiatric Press, Inc., 2000.

5. Goodwin DW, Guze SB. Psychiatric Diagnosis. New York: Oxford University Press, 5th ed., 1996.

6. Ekman P., Davidson R. J., eds. The Nature of Emotion. New York: Oxford University Press, 1994.

7. Lipowski Z. J. Delirium: Acute Confusional States. New York: Oxford Universities Press, 1990.

8. McHugh P. R., Slavney P. R. The Perspectives of Psychiatry, 2nd ed. Baltimore: Johns Hopkins University Press, 1998.

9. Taylor M. A. The Fundamentals of Clinical Neuropsychiatry. New York: Oxford University Press, 1994.

10. Berrios G. E. The History of Mental Symptoms: Descriptive Psychopathology since the Eighteenth Century. Cambridge: Cambridge University Press, 1996.

11. Morrison J. DSM-IV Made Easy: The Clinician's Guide to Diagnosis. New York: The Guilford Press, 2001.

12. Shea S. C. Psychiatric interviewing: the art of understanding. A practical guide for psychiatrists, psychologists, counselors, social workers, nurses, and other mental health professions, 2nd ed. Sydney: Harcourt Brace, 1998.

13. MacKinnon R. A., Michels R., Buckley P. J. The Psychiatric Interview in Clinical Practice, 2nd ed. Washington DC: American Psychiatric Press, 2006.

14. Sajatovic M., Ramirez L. F. Rating scales in mental health, 2nd ed. Hudson OH: Mental Health Series, 2006.

15. Cummings J. L., Mega M. S. Neuropsychiatry and Behavioral Neuroscience. New York: Oxford University Press, 2003.

16. Moore D. P., Jefferson J. W. Handbook of Medical Psychiatry, 2" ed. Philadelphia: Elsevier-Mosby, 2004.

17. Burns J., Job D., Bastin M. E., Whalley H., Macgillivray T., Johnstone E. C., Lawrie S. M. Structural disconnectivity in schizophrenia: a diffusion tensor magnetic resonance imaging study. Br J Psychiatry 2003; 182: 439–443.
18. Lewis D. A. Retroviruses and the pathogenesis of schizophrenia. Proc Nat Acad Sci USA 2001; 94: 4293–4294.
19. Holmes C., Cairns N., Lantos P., Mann A. (1999) Validity of current clinical criteria for Alzheimer's disease, vascular dementia and dementia with Lewy bodies. Br J Psych 174, 45$_{в}$ “50.
20. Freedman R., Schizophrenia. N., Engl J. Med. 2003 Oct 30; 349(18): 1738–49. [PMID: 14585943]
21. Dystonia fact sheet: National Institute of Neurological Disorders and Stroke Theodore I. Benzer, MD, PhD (2005). "Neuroleptic Malignant Syndrome". Emedicine.
22. Mihara K., Kondo T., Suzuki A., et al (2003). "Relationship between functional dopamine D2 and D3 receptors gene polymorphisms and neuroleptic malignant syndrome". Am, J. Med. Genet. B. Neuropsychiatr. Genet. 117(1): 57–60.
23. Gray F., Adle-Biassette H., Chrétien F., Lorin de la Grandmaison G., Force G., Keohane C. (2001). "Neuropathology and neurodegeneration in human immunodeficiency virus infection. Pathogenesis of HIV-induced lesions of the brain, correlations with HIV-associated disorders and modifications according to treatments". Clin. Neuropathol. 20(4): 146–155. PMID 11495003.
24. Grant I., Sacktor H., and McArthur J. (2005). "HIV neurocognitive disorders", in H. E. Gendelman, I. Grant, I. Everall, S. A. Lipton, and S. Swindells. (ed.): The Neurology of AIDS, 2nd, London, UK: Oxford University Press, 357–373.
25. Caroff, Stanley N, MD (Editor); Mann, Stephen C (Editor); Francis, Andrew (Editor); Fricchioni, Gregory L, MD (Editor); Catatonia: From Psychopathology to Neurobiology; American Psychiatric Publishing, Inc. 2004.
26. Schatzberg, A. F. (2000). "New indications for antidepressants.". Journal of Clinical Psychiatry 61(11): 9–17. PMID 10926050. Retrieved on 2007-11-20.
27. Stephen M. Stahl, M.D., Ph.D; et al (2004). "A Review of the Neuropharmacology of Bupropion, a Dual Norepinephrine and Dopamine Reuptake Inhibitor" (pdf). Journal of Clinical Psychiatry; 6(04) 159-166 2004.
28. Mant A.; Whicker S. D., McManus P., Birkett D. J., Edmonds D., Dumbrell D. (Dec 1993). "Benzodiazepine utilisation in Australia: report from a new pharmacoepidemiological database". Aust J Public Health. 17(4): 345-9.
29. Olive G; Dreux C. (Jan 1977). "Pharmacologic bases of use of benzodiazepines in peréinatal medicine". Arch Fr Pediatr. 34(1): 74–89.

30. "WHO Model List of Essential Medicines" (PDF). World Health Organization (March 2005). Retrieved on 2006-03-12.
31. B. Granger, S. Albu, The Haloperidol Story, Annals of Clinical Psychiatry (after Jan 1, 2004), Volume 17, Number 3, Number 3 / July-September 2005, pp. 137–140(4).
32. Joy C. B., Adams C. E., Lawrie SM (2006). "Haloperidol versus placebo for schizophrenia". Cochrane Database Syst Rev (4): CD003082.

Internet materials:

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