Zaporozhye State Medical University
Department of Psychiatry, psychotherapy, general and medical psychology, addiction and sexology

Approved on the methodical conference of department psychiatry, psychotherapy, general and medical psychology, addiction and sexology
Head of the Chair MD, professor V.V.Chuhunov
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“_____”_____2015 year

METHODOLOGICAL DEVELOPMENTS

to practical lessons on the topic "Neurotic, stress related and somatoform disorders" for students of 4th year medical faculty
(specialty "medicine")

Zaporozhye - 2015

SUBJECT: Neurotic, stress-related and somatoform disorders.

Number of training hours - 4 academic hours.

I. The urgency of the topic.

Neurosis is a common pathology, while lately the number of patients on them is growing rapidly, which is associated with social transformations resulting from pervasive advent of scientific and technological progress. Along with the obvious benefits it has the need to mobilize resources adaptive personality to which not all are ready. On the prevalence of neurosis in the population demonstrates their significant share in other mental illnesses, which, according to various authors, is 15-30%. Timeliness of examination, diagnosis and differential therapy significantly increases the effectiveness of treatment.

II. Whole lessons:

Students must:

1. To know the definition of "reactive psychosis," "neurotic" "neurotic disorders" (and II).

2. To know the etiological factors of neurotic disorders and reactive psychosis (a-II).

3. Know the pathogenetic mechanisms that underlie neurotic disorders and reactive psychosis (a-II).

4. Know brief description of neurotic reactions (a-II).

5. Know the classification of neurotic disorders and reactive psychosis (a-II).

6. Know the clinical picture of neurasthenia, dissociative, conversion disorder, obsessive-compulsive disorder and reactive psychosis (a-II).

7. Know the indications for hospitalization of patients with psychogenic disorder (a-II).

8. Know the principles of treatment of patients with neurotic disorders and reactive psychoses (a-II).

Students must:

1. To be able to assess the clinical features of neurotic states and reactive psychoses (A-III).

2. To be able to diagnose reactive stupor, reactive depression, reactive paranoyid (A-III).

3. Be able to carry out differential diagnosis of hysterical and epileptic seizures (a third).

4. To be able to carry out labor, military and forensic psychiatric examination in patients with neurotic disorders and reactive psychoses (A-III).

Develop creative abilities of students that the search for innovative approaches to the treatment of psychogenic disorders in the laboratory and clinical studies of patients (according to their age and sex) (a-IV).

III. Educational goals.

Develop a sense of responsibility for the timeliness and accuracy of clinical diagnosis formulation, to assess the general condition, presence of complications and emergency care to patients with psychogenic disorder. Develop ethical attitude and keenness to develop on the future of professional features to patient with psychogenic disorder.

IV. Interdisciplinary integration:

Discipline	Know	Be able
I. Previous disciplines 1. Normal anatomy	To know the structure of the cortex, subcortical centers and the vascular system of the brain.	To be able to determine the possible location of abnormal cells in the CNS. To be able to

2. Normal physiology	To learn the functionality of different parts of the brain.	determine the parameters of the normal functioning of the various parts of the brain according to EEG EPO.
3. Patanatomy	Know postmortem possible changes in the vascular system and cerebrospinal fluid, brain tissue with organic forms of personality disorders.	To be able to interpret typical pathological changes in the vascular system and cerebrospinal fluid, brain tissue with organic forms of personality disorders.
4. Pathophysiology	To learn the features of brain activity in disorders of personality.	To be able to determine the clinical and laboratory signs of brain activity in disorders of personality according to EEG KTHM.
II. The following subjects		
1. Neurosurgery	Find the initial symptoms and clinical peculiarities of tumors, hematomas, birth defects of the brain.	To be able to put a diagnosis on clinical signs of organic forms of personality disorders. To be able to assist with surgical intervention

		on exhaustion hematoma (or tumor removal).
2. Neurology (pediatric neurology)	Know residual neurological mikrosymptomatyku: asymmetry of facial innervation, minor okoruhovi disorders, uneven skin and tendon reflexes, diencephalic disorders.	To be able to put the previous diagnosis and treatment.
III. Interdiscipline integration 1. Adulthood personality disorders, anxiety-phobic and affective disorders 2. Diagnostic and therapeutic measures for various disorders of children and adolescents.	Know etio pathogenesis and clinical peculiarities of personality disorders adulthood, anxious-phobic and affective disorders. To master the basic diagnostic criteria and therapeutic interventions in various forms of disorders of children and adolescents.	To be able to assign inspection plan, identify the main clinical symptoms. To be able to be differentiated treatment of various disorders of children and adolescents.

V. Content of the topic of employment.

Psychogenic disorder (Psychological causes of diseases) caused by interpersonal conflicts resulting experiences psyhotravmivnoyi situation. Psychologically caused traumatic circumstances act in this case as exogenously-stress agent that violates the homeostasis of the organism.

CLASSIFICATION

BY ICD-10 psychogenic disorders (psychogenic) is given in categories P-40 - P-48, P 40 anxiety-phobic disorders P 41 Other anxiety disorders P 42 Obsessive-Compulsive Disorder R 43 Reaction to severe stress and abuse adaptation P 44 dissociative (conversion) disorders P 48 Other options neurotic disorders (48.0 Neurasthenia R)

For OM8-IV coding Psychological causes of diseases in these categories:

300. Anxiety disorders

306. dissociative disorders

307. Eating Disorders

309. Adjustment disorder

For traditional domestic classification Psychological causes of diseases are divided into neurosis and reactive psychoses.

16.2. **NEUROSIS**

Neurosis - a group of functional, psychogenic caused by mental illness with the tendency to transient protracted course, which is clinically characterized by asthenic syndrome, obsessive-compulsive disorder and hysterical disorders in the absence of violations reflection of reality and awareness of their own condition.

By neuroses are not case sensitive neurotic mental disorders - neurotic reactions that often accompany physical and nervous disease. Neurotic reaction, neurosis and psychopathy is the subject of study so-called boundary or small, psychiatry. Neuroses must be distinguished as from neurosis disorders that usually clinically presented as symptoms of fatigue, obsessive-phobic or hysterical disorders have psychogenic origin constitute the clinical picture of other lingering mental (eg schizophrenia) or somatic (hypertensive disease, peptic ulcer) disease .

16.2.1. Historical data

The concept of "neurosis" was first introduced in the literature Scottish doctor \ U. Syiiep in 1776, meaning by this term nervous disorder that is not accompanied by fever not associated with one of the local lesions of the internal organs and is caused by "common disease, which determines movements and thought." The basis of the regulation of life processes he saw in tension and relaxing the nervous system and its violation of origin linked abnormalities in mental activity, which called neurosis.

In the early nineteenth century. neuroses attributed to various diseases, conditions and symptoms. However, in the mid-nineteenth century. thanks largely do¬syahnennyam in the field patomorfolohy meaning of "neurosis" has undergone significant changes and clarifications.

With improvement pathological nature of research and the establishment of morphological changes in organs and systems of many conditions and diseases from the group of neuroses began to attribute to other forms of lymphoma. In the second half of the nineteenth century. definition of neurosis implies compulsory absence of the disease by organic changes. However, while this opinion was shared not all researchers. Thus, R. Kautopo! in 1907 suggested that if no neurosis only anatomical changes that can be detected at the time modern research methods.

At the same time carried clarify the etiology of neurosis, there was the idea of them as psychogenic disorder. A significant contribution to the study of neuroses made problems Veahsi O. (1868), b. Zyishtreyi (1878)]. Spahsoyi (1888) iapeyi R. (1903).

Decisive in this direction have been studies Oyoiz R. (1912), which is considered the main feature of neuroses intervention MIND "mental representations" in all their symptoms. Based on this, he suggested that instead of the term "neurosis" using the name "psychoneurosis".

Complex Development had received the study clinic neuroses and differentiation of their forms. In particular, hysteria as a disease was known BC

(Egyptian papyrus Kayp mention it as a painful condition, which is based on the movement in the body of the uterus).

Almost 100 years after the introduction of the concept of "neurosis" IZeahd American physician S. (1869) described in detail the state of irritating weakness of industrial workers in America. At first he called this condition "American neurosis" and later neurasthenia. In 1880 S. \ Uezhra1 formulated definition compulsive (obsessive) states, which made it possible to differentiate them from neurasthenia.

Thus, the beginning of XX century. described the main forms of neurosis, but their continued differentiation. This process is influenced by such research areas as psychoanalysis 3. Freud, behaviorism, existentialism and others. Great importance was also teaching IP Pavlov on higher nervous activity.

An important role in the study of neuroses played SM research Davidenkov (1963), OV Kerbikova (1962), AM Svyadoscha (1974), BD Karvasarskoho (1980) and others.

16.2.3. Etiology

Today there is no doubt that the emergence of neuroses caused by informational influence factors (trauma). For the first time it has proven IP Pavlov experiments on animals. Psychogenic factors may include:

• external conflicts;

• vnutrishnopsyhichni conflicts;

• durable (psyhotravmivna situation) or too spicy strong emotional or intellectual mental strain.

Psyhotravmivnoho degree of influence is determined not primarily physical intensity signal, not the volume of information it carries, and its significance for a particular individual. Therefore neurosis can not be viewed through the prism of a simple ratio of "stimulus - reaction". Educating people, their experiences, attitudes, ideology and form another value, and hence for its pathogenicity of any information.

An important role in causing congenital diseases can play a typological features of the nervous system and its condition at some point. Most in this respect are those

with asthenic, and psychasthenic hysterical traits, especially if they reach psychopathic level. Thus, PB Gannushkina noted that between the phase dynamics as a form of neurosis and psychopathy are no fundamental differences. It is generally accepted notion that the likelihood of some form of neurosis determined by the characteristics of human nature in accentuation premorbid condition. In particular, personality, accented by asthenic type, prone to develop neurasthenia, anxious for type - to obsessional neurosis, for hysteroid type - to hysterical neurosis.

To promote the emergence of neuroses can also lasted existing idea affectively colored, reflecting deep traumatic experiences. E. Vieyieh proposed to call their *complexes*.

16.2.4. Pathogenesis

For IP Pavlov, pathogenetic basis neurosis is a violation (failure) higher nervous activity (VID) of the surge of nerve processes or their mobility under the influence of excessive superstrong stimuli.

In particular, neurasthenia characteristic pathological predominance of excitation over the inner conditional inhibition due to violation of the latter under the influence of pathogenic factors. It occurs in people who are different choleric premorbid state, and in severe cases sanhvinistychnym temperament. For further psyhotravmivnyh factors influence the process of moving towards sustainable development dominance pozamezhnoohoronnoho inhibition and excitation surrender. In people with weak inhibition of type TYPE excitement begins to dominate once, due to the initial weakness of the cortical cells.

Hysterical neurosis for IP Pavlov, occurs in patients with low artistic type GNI. The main factor is the predominance of subcortical processes of cortical function due to the weakness of the cerebral cortex, domination it first signaling system on the second and pathologically negative pronounced induction. Near strong affective impulses from subcortical ("instinctive") structures and verbal (external or own) stimuli in the cortex forms a strong focus of excitation. It covers the area once powerful negative induction, isolating from other areas of the cortex.

This explains the origin of emergency naviyuvanosti hysterical, because the pathological process is isolated from the past experience. For localization in the motor areas of the cortex of excitation having various tics and hyperkinesis and otherwise - paresis, paralysis, astasis-abasia.

Underlying pathophysiological mechanisms for IP-compulsive disorder Pavlov (1933) is a violation (failure) GNI to form stable (unlike hysteria) pathological zones (points) cortex in people with weak analytical type GNI. Along with unconditional recognition Pavlovska school to study this issue, noted that in 1913 a prominent psychiatrist M. Asatiani published a study on phobia like reflexes. He saw them as "pathologically inert excitation stagnant in patients paragraphs."

OG Ivanov-Smolensky (1952, 1974) concluded that an important role in the mechanism of obsessional phenomena belongs pathologically pathologically positive and negative induction in violation of inhibitory processes, which are formed in ontogenesis.

It is necessary to take into account the importance of phase states. Thus, the mechanism ultraparadoksalnoyi phase causes the appearance of contrasting opinions and trains. Most compulsive disorder is associated with the second system. The temporary calm that feels

patient after the compulsive ritual, most likely can be explained by the emergence of new foci of excitation in the motor analyzer with the development of negative induction and pryhniche¬nnyam main focus inert excitement.

According to other views on the pathogenesis of neurosis, its main link is dysfunction of brain systems that control the process of adaptation. The larger the discrepancy between the existing situation and projected, the more likely the pathological consequences for the organism. There tension with a sense of frustration - frustration and stress with relevant endocrine and autonomic manifestations.

Forecasting processes affect of emotions in response to the information. According electroencephalography, prediction is made as a result of netted

material, limbic system and cingulate gyrus. Especially important role belongs to the limbic system ("visceral brain"), regulating of emotions.

Deviations from the predicted course of events triggers the body to mobilize the operation of large power consumption, especially in endocrine levels (increased secretion of adrenaline and other hormones). Emotional stress (and with it the possibility of action psyhotravmivnoyi conflict) can be leveled only develop a clear strategy of conduct to facilitate defuse emotional.

16.2.5. Classification

For domestic traditional classification are three classical forms of neuroses:

• hysterical neurosis;

• neurasthenia;

• obsessive-compulsive disorder.

At one time the term "neurosis organs" (heart, lungs, stomach) and "systemic neurosis" (cardiovascular, respiratory, urogenital systems) signified a form of neurosis with a predominant fixation of the patient to dysfunction of corresponding organ or system, ie clinical variety of common neurosis. These autonomic disorders that have an organic base, formerly known as vegetative neurosis, but correct to speak of vegetative (initial) phase of neurosis.

In ICD-10 instead of the term "neurosis" adopted the term "neurotic disorders"; obsessive-compulsive disorder was named "obsessive compulsive disorder"; hysterical neurosis - "dissociative (conversion) disorders," the term "neurasthenia" saved. Separately allocated *fear neurosis*, and *depressive* and *hypochondriac neuroses.*

Over time, with psyhotravmivnoyi situation continues, neurotic disorders can acquire chronic, causing neurotic personality development with a predominance in the clinical picture asthenic, obsessive-phobic and hysterical disorders that cause social exclusion of the patient.

16.2.6. Neurasthenia

Neurasthenia - psychogenic illness with the group neuroses (neurotic disorders), the main manifestation of which is irritating state of weakness, that increased vysnazhuvanist slow recovery and mental processes. There is mostly aged 20-40 years, more often in men than in women. Neurasthenia first described in 1869 an American psychiatrist O. Veahsi. He linked its emergence from prolonged emotional and physical stress of the nervous system that leads to its depletion.

Clinic. Subacute disease develops gradually. The first phase in the case of physical or emotional stress occurring *autonomic dysfunction* (tachycardia, sweating, cold extremities, dysomniya) that inadequate stimulus intensity and quickly pass. In the next stage there *sensorimotor disorders* (hypersensitivity, meteopatiya) that cause hypochondriacal mood and dramatically reduce performance. Later joined *affective disorders* (excessive emotional lability, urinary affections, inadequate reaction of resentment, irritability with little regard). In the future, become the leading *ideatornoy disorder*s with the severity of focus, decreased memory and a penchant for continuous introspection.

In domestic psychiatry are three clinical forms of neurasthenia under the successive phases of its development.

1. *Hypersthenic form*, which debuted illness, mostly manifested by irritability and a tendency to rapid breakdown. Insignificant or indifferent for healthy human stimulus begin to cause increased reaction (hypersensitivity). Patients are inflammatory, irritated even with a small drive can not tolerate loud noise and bright lights, crowded people's assembly. Occurrence of hypersensitivity about intero- proprioceptors and also due to the emergence of numerous complaints of discomfort in various parts of the body (head and toothache, tinnitus, paresthesia etc.).

Reduced efficiency at this stage there is not so much because of fatigue, but mainly as a result of mental confusion and dispersion of patients due to the weakness of the primary active attention. Holding the work, they have not needed to withstand this mental stress and distracted by extraneous stimuli stop it.

Attempts to overcome "difficult start" and restore can be numerous, but due to considerable loss of time such work efficiency is very low.

These disorders are unstable, quickly disappear due treatment and rest.

2. Form irritating weakness is characterized by intermediate and unfolded displays and more resistant state irritating weakness. Along with increased emotional excitability, hypersensitivity, incontinence, low tolerance to frustration, drastically growing sense of mental exhaustion, weakened even more active attention. Irritability is pronounced, but affective reactions and shouting with excitement quickly fade, replaced by the impotence of mental images flair, full of emotional surrender and tears. Characteristically, these polar manifestations occur with small drives, demonstrating the inherent suffering from neurasthenia cowardice.

Holding the work, the patient quickly gets tired, starts to feel a headache, lose the ability to focus and complete depletion stops. The constant increase intervals between working "paroxysms" does not work, because there is no recuperation.

Often there are decreased muscle tone, tremor of the fingers, tongue, which increases during the unrest. There are sleep disorder severity as sleep, anxiety waiting insomnia, hallucinations sometimes possible hipnahohichni. Sleep shallow, with anxious dreams, after which patients feel nevyspanymy, broken. Insomnia may be associated with increased sleepiness during the day.

Compulsory component of neurasthenia is polymorphic somatic-vegetative disorders caused by dysfunction of the hypothalamic-vegetative. The most typical are functional cardiovascular disorders (transient arterial hypo- and hypertension, feeling the ripple vessels), headaches, often with a sense of tightening head ("neurasthenic helmet"), a general or a local hyperhidrosis and functional disorders of the digestive system (anorexia, with a sense hiposalivatsiya dry mouth, nausea, flatulence, constipation, sometimes alternating with diarrhea). It could be sexual disorders: decreased sex drive, weakening of erection, premature ejaculation.

These disorders are usually observed on the background of unstable, mostly subdepresyvnoho mood.

3. Hipostenic form or neurasthenia occurs primarily in asthenic and anxious and worrisome figures, or as a stage (third stage) of the disease in people with severe type look.

The leading manifestation of this form is the constant fatigue against the lowered mood. Emotional background slightly disturbing with a touch of grief and apathy. There are excessive tearfulness and emotional lability. Often available hypochondriacal complaints fixation on internal sensations.

16.2.7. Hysterical neurosis (conversion, dissociative disorders)

This kind psyhoheniy psyhotravmivnoyi resulting from the impact of climate on people with hysterical temperament.

In the pathogenesis of the disease mechanism plays an important role "in escaping the disease", "conditional pleasure, desire" morbid symptom. IP Pavlov proved that temporary disruption of the body, giving the person a particular standard of benefits, such as the way out of a threatening situation or escape from the hard reality may be due to its "conditional pleasure" to consolidate the mechanism of the conditioned reflex. This phenomenon underlies hysterical fixation painful symptom.

Hysterical neurosis occurs mostly in young women, although men are sick. In its various manifestations reminiscent zahvoryuvannya.Vnaslidok what he titled the "chameleon that changes its color continuously." The features of patients with hysterical neurosis is a show off, the desire in any way to attract attention, suggestibility and samonaviyuvanist and infantile (children's) psychological defense mechanisms in conflict situations.

Clinic. Given the very diverse symptoms of hysterical neurosis inherent disorder conventionally divided into motor, sensory, autonomic-visceral and mental.

Motor disorders can be detected hysterical paroxysms, functional paralysis, paresis, aphonia, muscle contractures, hyperkinesias, gait disorders (astasis) and inability to stand (abasia), stuttering and more.

Hysterical paroxysm (an attack) usually occurs in the presence of spectators fall turns usually safe in a slow descent, then, by E. KheI8ssheh statement, "fire erupted various expressive reflex movements." Patients with shaking, go for a drive on the floor, bent arc, leaning their backs on the floor and heels ("hysterical arc"), scream, cry, shout some phrases, quotes, sing or something whispered, biting his hands, scratching his face and body , tearing clothes, pull hair, throw up their hands, take the so-called passionate poses with the corresponding characteristic facial flushing and face (rarely with cyanosis or pallor).

Hysterical attack lasts from several minutes to several hours. Can be interrupted by external influences, such as loud sound, sharp command, pouring cold water on others.

Often the attack goes into mourning, state weakness, fatigue, weakness, less to sleep. About hysterical attack during partial memories are stored.

Hysterical paralysis (as paresis) occurs as monoplehiyi (monoparezu), paraplegia (paraparesis), quadriplegic (tetraparesis). This zone paralysis (paresis) may be limited to the thumb, hands, feet, arms or legs ("bird paw"). Usually he, unlike organic, not accompanied by pathological reflexes, pyramidal signs and topographically not responsible course of the nerve trunks.

At the heart of *hysterical aphonia* is paralysis of the vocal cords.

Hysterical contracture encompasses both individual muscle groups (blepharospasm hysterical, hysterical torticollis), and a complex, through patient suffering from hysteria may freeze for a long time in "stiff posture."

Hysterical Hyperkinesis mainly manifested in the form tykopodibnyh and anxious movements of individual body parts (chin, eyelids, hands, feet, head), and the entire body. It is caused by the patient and affective elements characterized by imitation, which distinguishes it from organic Hyperkinesis.

Astasis-abasia - hysterical disorder as the inability for independent standing and walking in the absence of organic disorders of the musculoskeletal system. Patients being in bed alone move their feet, but fell to the floor while trying to walk.

Sensory disorders can manifest decreased sensitivity up to full anesthesia or hypertension in response to tactile impact, temperature or pain stimuli.

Lots of anesthesia or hyperesthesia thus also may not meet certain zones of innervation, with so-called view jackets, napivkurtok, shorts, napivtrusiv, stockings, socks, gloves. Often there are hysterical blindness, deafness and dumbness (surdomutyzm), loss of smell, taste, absence of pharyngeal reflex. Hysterical pain, different lengths and intensities can be observed in any part of the body (head, back, joints, abdomen). There are cases when patients with hysteria stomach look chess board acquired through deformation scars after numerous laparotomiy. Such patients migrate from one clinic to another for the sole purpose - to get even conservative and surgical treatment. Sometimes the pain in the heart simulate angina or myocardial infarction.

Vegetative-visceral disorders in case of hysterical neurosis is the most widespread and diverse. As a result of spasm of smooth muscle may have a sense of compression of the larynx (§1oii8 $ iehisy8 pu) Lack of air that resembles asthma, obstruction of the esophagus (dysphagia), urinary retention, constipation. There hysterical anorexia (sometimes with disgust to a certain type of food), hiccups, vomiting, impaired salivation, diarrhea, nausea. Vomiting can be a sporadic and very frequent, almost constant, similar to the relentless vomiting in pregnant women. It is not associated with disorders of the digestive system and is caused by psychogenic spasms home. There are disorders that resemble obstruction of the intestines, chronic appendicitis clinic. Often there are a variety of dysfunction of the cardiovascular system (heart rate lability, dystonia). There may be a disorder of thermoregulation in low, irregular rises in temperature.

Sexual disorders occur mostly irregular menstruation, amenorrhea, dysmenorrhea, menorrhagia, vaginismus.

Sometimes there is a woman *hysterical pseudo pregnancy* that simulates complex symptoms (amenorrhea, abdominal enlargement due to bloating, breast augmentation, nausea, vomiting, etc.).

There may be *vicarious bleeding* as a result of local changes in vascular permeability is bleeding from intact skin.

In some cases, this will cause vascular permeability *dermatosis hysterical* when through self-hypnosis patients may cause local disturbances in the form of lots of skin hyperemia, hemorrhagic rash, blisters and others. The varieties hysterical dermatosis rank and various skin lesions that artificially cause patients to draw attention. Later in such cases is often possible amnesia their actions.

Mental rohiady are especially high afektyvnistyu, patients frustrated with the slightest reason to cry, stamp their feet, beat the dishes, capricious as children. Labile mood, with frequent sharp differences of simulated hijacked-to-dissatisfied grouchy. Hysteria can mimic some symptoms of any mental illness, which patients have at least some idea.

Often there is *psychogenic amnesia* (total or partial).

Fixed hysterical fears and depression usually shallow and accompanied by bright external design in a theatrical poses, moan, so pathetic statements.

Hysterical hallucination shaped, brightly colored, usually psychogenic reflect the situation in the desired form for patients, have short-term episodic nature may be stsenopodibnimy. There are also delusional fantasy.

Hysterical loss of consciousness (syncope) is different from the present less deep confusion, easing breathing and circulation, vidsutnisttyu usually sharp pale face.

Hysterical twilight state of consciousness lasts from a few minutes to several days. Consciousness thus narrowed, surrounding reality not fully perceived, patients fully covered by their own painful experiences. In the minds dominate this time brightly colored mayachnopodibni hallucinations and fantasies that reflect the real or (more often) a more favorable light for the patient suffered psyhotravmivnu situation.

Hysterical twilight state of consciousness can occur in the form of somnambulism, dissociative fugues, trance Dr o m o m a n and her.

With the situation unresolved psychogenic patients can detect *puerylizmu syndrome, pseudodementia syndrome Hanzera.*

You may experience *psychogenic (hysterical) stupor* (usually with expressive posture), combined with mutyzmu manifestations (failure of communication with others). *Hysterical mutism* can also occur in isolation, as a separate disorder.

16.2.8. Невроз нав'язливих станів (обсесивно-компульсивні розлади)

Для цієї форми невротичних розладів характерні психогенно зумовлені нав'язливі стани (образи, думки, чуття чи дії), які мимовільно виникають у свідомості, необґрунтованість яких хворі розуміють, борються з ними, але здолати їх не можуть. Клінічні складові неврозу такі:

- *фобії*— нав'язливі страхи;
- *обсесії* — різноманітні нав'язливі думки, ідеї та уявлення;
- *компульсії* — нав'язливі прагнення і дії.

Раніше цю форму невротичних розладів розглядали як психастенію, проте вже у 20-ті роки XX ст. Е. Кгаереііп запропонував розцінювати її як самостійну нозологічну форму — "нав'язливий невроз". Неврозом нав'язливих станів називають форму неврозів, яка може виникати як на основі психастенічної конституції, так і в здорових суб'єктів.

Іноді до цих розладів призводять психотравмівні ситуації, які зумовлюють співіснування конфліктних внутрішньоособистісних тенденцій. Наприклад, жити разом з матір'ю чи окремо; статевий потяг і уявлення про неприпустимість його задоволення; чуття ненависті до близької людини, бажання їй смерті та розуміння неприпустимості цих бажань.

Невроз нав'язливих станів може виникати в осіб з різноманітними типологічними особливостями характеру. Особливо легко нав'язливі стани виникають у людей тривожних, боязливих, занадто совісних.

На першому етапі, зазвичай після формування невротичного тла (дратівливості, емоційної лабільності, безсоння), виникають фобії, потім нав'язливі компульсивні розлади (за типом контрастних потягів) і пізніше — обсесивні явища.

16.2.8. Obsessional neurosis (obsessive compulsive disorder)

For this form of neurotic disorder characterized by obsessive-compulsive disorder caused by psychogenic (images, thoughts, senses or actions) that spontaneously arise in the minds of grounds which patients understand fighting with them, but they can not overcome. Clinical neurosis following components:

• *fobiyi*- obsessive fears;

• *obsesiyi* - a variety of intrusive thoughts, ideas and concepts;

• *compulsive behavior* - compulsive desire and action.

Previously, this form of neurotic disorders seen as psychasthenia, but already in the 20-ies of XX century. E. Khaereiip proposed to regard it as an independent nosological form - "compulsive neurosis." Obsessional neurosis called a form of neurosis that may arise as psychasthenic based on the constitution and in healthy subjects.

Sometimes these disorders lead psyhotravmivni situations that cause conflict intrapersonal coexistence trends. For example, to live with his mother or separately; sexual desire and understanding of the inadmissibility of his pleasure; flair loved to hate, desire and understanding of her death inadmissibility these desires.

Obsessional neurosis can occur in individuals with a variety of typological features of nature. Especially easy obsessive-compulsive disorder occur in people anxious, fearful, too conscientious.

In the first stage, usually after the formation of neurotic background (irritability, emotional lability, insomnia), there are phobias, obsessive compulsive disorders then (like contrast trains) and later - obsessive phenomenon.

Clinic. Phobias or obsessive fears, there are very often in various forms. The most common ones are:

agoraphobia - fear of open spaces;

claustrophobia - fear of closed, closed premises;

acrophobia (hipsofobiya) - fear of heights;

pantofobiya - general fear;

erytrofobiya - fear blush in public;

dysmorfofobiya - fear of physical disability;

filth-dread - fear of pollution;

tanatofobiya - fear of death;

tafefobiya - fear of being buried alive;

nozofobiya - fear of contracting serious illness.

There may also bakterio-, helminto- and Cancer phobia, lisofobiya (fear of rabies) syfilofobiya, SNIDofobiya and others.

Special cases - obsessive concern because of inability to perform any normal or professional life act: the teacher - lecture, the singer - performance and more.

All these forms of phobias tend to "fouling" vegetative hypochondriac layers that impede treatment.

By obsessive fears are usually joined by a variety of protective action - *rituals*. They are mostly direct nature protection, concrete and not symbolic, but over time can expand and become more complex.

Obsessive thoughts - and painful unnecessary sophistication that XV. Shie8ip§eh called "psychic or mental, chewing gum." For example, why table stands on four legs? Why chalk white?

Obsessive memories - vivid memories of some unpleasant event. Contrasting views and opinions of the expletive - in its meaning opposite view of the world of the patient, its ethical installations.

Obsessive doubt lie in uncertainty as to the correctness and completeness of their own actions (such as locked or not locked the door, turned off the iron or does not like. Obsessive trains - a clear desire to commit a useless, dangerous or indecent act (eg hidromaniya - throw in water; homitsydomaniya - kill someone,

pyromania - set fire to something.) However, unlike the violent and impulsive actions, obsessive desires are not realized.

Obsessive action. Primitive neurotic obsessive actions are tykamy - a kind of stereotyped movements when the patient without the need for hand held hair (straightening hair style), head back, eyes flashing and others. There are primarily in childhood and adolescence and have a favorable prognosis. In contrast, complex intrusive actions (ritual) related to obsessive doubts and phobias.

In patients with obsessive-compulsive disorder may be present disorders peculiar neuroses in general (irritability, hypersensitivity, sleep disorders, autonomic dysfunction).

The course is characterized by compulsive disorder varying from almost complete disappearance of a significant gain, even over considerable intervals.

16.2.9. Neurotic disorders in dental practice

In patients with congenital and acquired defects of the face often have different neurotic disorders. As a person with disabilities often turn to dentists to perform corrective operations, awareness of the clinical features of these disorders is needed for effective treatment. However, neurotic disorders in people with congenital disabilities face have certain features neurotic reactions compared to individuals who received cosmetic defect in adulthood. This is because in the first there Psychological causes of diseases in childhood and depending on the duration and frequency of psychogenic dekompensatsiy changing nature of mental reactions. In the second group of patients is the face of trauma distorting unexpected tragedy that causes pronounced neurotic reactions peculiar character. Such reactions should be considered as primary psychogenic. If continued existing defects that can not be corrective cosmetic surgery, possible deep qualitative change of mentality.

In the case of congenital defects neurotic reactions usually occur early in school (7-11 years) or puberty (12- 14 years) age. Aggravating ridicule such reactions, comments and offensive remarks about external defect. They usually unstable and arise directly in response to travmivnu situation.

The clinic neurosis caused by a congenital and acquired defects of the face, is central to the syndrome dysmorfofobiyi. Unlike schizophrenia, in which case it has an objective basis and mechanism of psychogenic.

Clinical manifestations of the syndrome dysmorfofobiyi depend on the duration and severity of the defect, and micro-conditions. There are three variants of neurotic syndromes: asthenic, asthenic-depressive and asthenic-phobic.

In the early school years asthenic and affective reactions often combined with passive-aggressive or defensive behaviors. For older adulthood and is characterized by asthenic-depressive and sensitive-phobic reaction.

In the case of acquired cosmetic defects that change the appearance of the face, neurotic reactions occur after the acute period of trauma, when patients first realize that the appearance of their face irrevocably changed. This reaction should be considered as distress resulting from socio-personal decompensation.

Clinically it is manifested depressive or asthenic-depressive symptoms. Patients occur heightened emotional vulnerability, fear of dealing with people. This often develop autonomic reactions such as heart rate, blood pressure fluctuations, hyperhidrosis. Patients become tearful, they are often disturbed sleep. In the event of these reactions are important in nature and severity of previous trauma, mental health and premorbid personality traits.

Neurotic reactions are fragile, their occurrence is associated with additional psychogenic factors (a reminder of the ugliness, meeting with relatives and friends).

In many cases painful phenomena disappear 1,5- 2 months after the effective complex treatment or corrective plastic surgery. With the emergence of additional factors psyhotravmivnyh acute neurotic reactions may become neurotic stable condition with frequent decompensation, complexity of emotional disorders. Patients are most of the time in a depressed mood, depression feel hopeless, they have obsessive thoughts about the loss of "own person". This condition may be accompanied by suicidal tendencies. There symptom mirror - constant scrutiny own face in the mirror. Patients seeking solitude, losing social contacts, friends. At

this stage of the disease have the following major syndromes, depressive, asthenic-depressive and depressive-phobic. Against the background of depression or having to do with the idea of self-incrimination (associates deliberately considering their face hint at the ugliness). Mounting manifestations asthenia (increased fatigue, low productivity), there are fears: *dysmorfofobiya*- own ugliness; Speech - *lalofobiya*; bullying - *skoptofobiya*; People - *anthropophobia* and others.

16.2.10. Treatment

Treatment along with pharmacotherapy necessarily involves psychotherapeutic effect. It is advisable to use physiotherapy and exercise therapy. In case of severe neurotic disorder patients need to be isolated from the environment psyho traumatic (preferably by hospitalization), to divert his attention from the conflict.

If neurasthenia patient needs a rest and destination restorative treatment (multivitamins, magnesium, B6, enerion, adaptogens, glucose, small doses of insulin), effective treatment prolonged sleep. In cases vyrazheno¬ho mental agitation, incontinence along with tranquilizers (phenazepam 1.2 mg three times a day, tranksen 20-60 mg per day, meprobamate 0.2-0.4 mg daily) appropriate destination nevroleptykiv small doses - phenothiazines (chlorpromazine, tyzertsyn). To combat insomnia (giperstenicheskogo neurasthenia) used radedorm (5-20 mg per dose), ivadal (10 mg dose), meleryl (10-75 mg dose), phenazepam (2-3 mg per day with the main dose at night). An effective complex homeopathic medicine is homvionervin.

In the case of hysterical neurosis nevroleptychni such effective means as ehnonil (100-200 mg daily) sonapaks meleryl (40 to 60 mg per day).

In the case of asthenic state of sleepiness and drowsiness advisable to begin therapy with sedatives, drugs bromine, small doses of hypnotic drugs during the month. Only then can assign tonizuvalni and stimulating agents. Preferred biological stimulants (ginseng tincture, lemongrass), but in the future a transition to synthetic stimulants (tsentedryn, sidnokarb etc.), And nootropic agents (piracetam, Aminalon). If asthenic-depressive condition prescribed antidepressants

in moderate doses (coaxil, anafrynil, ludiamil, sertraline, CIPRAMIL APPLICATION, tsyproleks, velbutryn, lamiktal).

In the case of obsessional neurosis with severe phobias and anxiety are the most effective use of tranquilizers (fenazepama, tranksenu, lorazepam, eleniumu - libriumu) and intravenous drip nevroleptykiv (three ftazynu, leponeksu, azaleptynu) in moderate doses.

When dysomniyi prescribed zopiclone (apo-zopiclone), zolpidem (ivadal) - 5.10 mg per night.

In patients with neurotic disorders using all types of psychotherapy, but it is mandatory to use rational psychotherapy. At the initial stage it should be mostly sedative aimed at eliminating internal stress in the patient. If this goal is achieved, you can go to efforts to review and adjust the system of personal and social relations of the patient, and then there comes a stage person-directed reconstructive therapy. Rounding out this process usually so-called activating therapy that prepares the patient for restoration work and complete return to society. Direct evidence is for psychoanalytic (psychodynamic), and other behavioral psychotherapy.

16.2.11. Examination

Medical-labor examination. The vast majority of patients with neurotic disorders recover and return to full work. Indication for disability cases may be prolonged and unfavorable obsessional neurosis with cardio and photophobia, obsessive fear of mental illness and the presence of severe Easten paresis, paralysis, astasis-abasia formation ipohodrychnoho and other options neurotic personality disorder .

Military medical examination. Patients with obsessive remain in the military, receiving treatment in general terms.

Forensic psychiatric examination. Offense in neurotic states no cause for excluding criminal responsibility, as patients are aware of their actions and are able to manage them.

16.3. REACTIVE PSYCHOSIS

Reactive psychoses (reactive state, psychogenic psychoses) - a temporary disturbances of mental activity matched resulting from trauma. From neurotic disorders (neuroses), they differ in severity and severity of trauma that spry¬chynyuyut occurrence of deep mental disorders psychotic level. In addition, in patients with reactive psychosis is no critical attitude to the presence of productive symptoms. The term "reactive psychosis" is used mainly in domestic psychiatric literature. In foreign - common name "abnormal reaction", "psychogenic reactions" and others.

16.3.1. Historical data

For the first time psychogenic dizziness sensitivity of hysterical disorders described 8. Oapzeh in 1897, which defined it as hysterical twilight disorder of consciousness. Then came this mental disorder in psychiatric classification as hanzerivski dusk. Before that, in 1888, the phenomenon of "mymomovlennya" prisoners watched S. Moeii, but he regarded it as diving. According to some researchers (N1881, 1902), hanzerivskyy syndrome "mymomovlennya" may be interpreted as hysterical only when its origin as a manifestation of congenital hysteria. In all other cases, it is a symptom of catatonic negativism that is caused by trauma, usually prisoners. Final clarity on this issue made IN Vvedensky (1905), noting that "mymomovlennya" psychogenic origin not beyond question, while for answers catatonic syndrome have even an approximate relation to the content of a given issue.

In 1898, NM Popov as described puerylizm reactive state. Labour Vihppashp K. (1908) contained information on a display of trauma symptoms.

Complex evolution undergone clinical understanding of psychogenic delusional formations. In cases of acute paranoia reactive nature first noticed PB Gannushkina (1904) and in 1910 E. Kheyizspteh and K .. Oayrr described more May reactive states. Determination of reactive depression diagnostic framework and its distinction from endogenous held K.ei $$ E. (1911), M. Keispahsi (1922), and. Ap £ e (1925).

On the basis of summarizing the results of previous studies K. reg $ ia $ (1923) formulated the basic principles of diagnosis of reactive psychosis (triad Jaspers):

1. Reactive conditions resulting from trauma.

2. Contents of trauma symptoms of the disease appear.

3. After Dis trauma reactive state are reduced.

Subsequent studies have demonstrated the relativity of the second principle of conditionality and a clear third.

A significant contribution to the study of reactive states did OM Bunyeyev, NI Felinska, FI Ivanov.

16.3.2. Epidemiology

Precise information on the prevalence of reactive psychosis in a population there. Certain statistical problems associated with the fact that some authors use the term as a synonym hysterical psychosis jet, although they are samostiy¬nymy lymphoma. There is information only for reactive depression, which is 59% of the reactive psychosis.

It is believed that women reactive condition occurs twice as often than men.

16.3.3. Etiology and pathogenesis

In the occurrence reactive psychosis crucial nature of the combination of trauma (intensity, duration and nature of the action), constitutional personality traits (especially the presence of sensitive or hysteroid radical) and functional state of the central nervous system at the moment.

The factors that determine susceptibility to reactive psychosis, are consequences of brain injury, chronic infections, intoxication, atherosclerosis, age crises psyhotravmivnyh Impact factors can be acute or protrahovanym. Despite the diversity of these factors caused them psychogenic disorder is largely determined by the value system of the individual.

Duration psyhotravmivnoyi situation is of some value, but more important is the attitude of the individual features of this situation is adaptation or sensitization.

Equally important is the orientation of psyhotravmivnyh personal circumstances in the hierarchy of human values.

In the development of acute (affective-shock) reactive psychosis premobidni personality is not decisive, the main importance and significance of the severity of trauma. Subacute (hysterical) psychoses occur by the mechanism of suggestion and self-hypnosis to protect the individual from unbearable for her situation. In subjectively important situations of protracted development of psychosis play a significant role premorbid personality, level of mental maturity.

16.3.4. Classification

The peculiarities of the origin and course of reactive psychoses (jet mills) are divided into three groups.

I. Acute (affective-shock):

• hypokinetic variant (acute reactive stupor);

• hyperkinetic option:

- Acute twilight condition;
- Acute reactive confusion;
- Acute reactive paranoyid.

II. Subacute (hysterical):

• crepuscular hysterical state;

• pseudodementia:

- Agitated option;
- Depressive option;

• regression syndrome ("savagery");

• puerylizm;

• Hanzera syndrome;

• mayachnopodibnyy condition;

hysterical stupor

III. Protracted (subjectively meaningful):

• reactive depression:

- Paranoid;

- Asthenic;

- Hysteroid.

• jet paranoyid:

- Paranoid;

-hypochondriac;

- External circumstances (war, Railway tyu¬remnyy).

According to ICD-10 is mainly reactive psychoses are presented in categories P 40 - P 48 "Neurotic, stress-related and somatic disorders-forming."

16.3.5. Acute reactive psychoses

Affective-shock reaction - a brief psychotic conditions arising primarily in a situation of sudden global threat to the very existence of the individual: earthquake, fire, flood, etc. terorestychnyy act. They are always accompanied by twilight eclipse of consciousness, experiencing despair, motor and autonomic disorders (tachycardia, sudden pallor or flushing of the skin, profuse sweating).

There hypo- and hyperkinetic options affective-shock reactions.

Acute reactive stupor meets hypokinetic variant of acute reactive psychosis. This condition Kheyivspteh E. (1924) described the response as "apparent death". It is characterized by the sudden emergence of travmivniy situation of complete immobility mutism. In this condition, patients do not perceive the environment, facial expression hardens them in horror, eyes wide open, there is a cold sweat, often have involuntary urination and defecation.

Acute twilight condition develops acute, characterized by a complete dezoriyentuvannyam, inability of verbal contact with the patient, psychomotor agitation and chaotic escape attempts (sometimes towards risk).

The disappearance of painful disorders often occur suddenly, as if the patient wakes up after a nightmarish sleep. However, when usually gradual and can pass

through a period stupidnosti - avoiding sharp depletion of intellectual activity, thus resembling mentally retarded patients.

Simple Form twilight dizziness usually lasts a few minutes or hours and is accompanied by the onset of amnesia, sometimes after sleep.

Patients with twilight eclipse of consciousness even in partial amnesia peculiar attitude to what they have committed (such as murder), as an alien committed by someone else.

Acute reactive confusion manifested as dizziness twilight emotion of fear and psychomotor agitation, against which there is a continuous linguistic "products" for the type of language vinaigrette.

Acute jet paranoyid often observed in judicial practice; is characterized by a combination of delirium and persecution relationship with verbal hallucinations and individual manifestations of mental automatism. Content jet hallucinatory-paranoid psychosis closely related to psyhotravmivnoyu situation.

Proper state of confusion with the emotion of fear, anxiety. Delirium emotionally rich, his story reflects the traumatic situation. At the height paranoyidu may be disturbed consciousness - to a narrowing of affective twilight state. You may experience hallucinations (real and pseudo) and other elements of the syndrome Kandinsky-Klerambo.

In the initial period of acute reactive paranoyidu there mentism (influx of thoughts). Flowing memories of long-forgotten episodes. Along with this feeling "pull," "mind reading" sense "internal transparency", combined with hearing pseudohallucinations situational content (often situation investigation). Patients have reported internal voices that interfere with the flow of their thoughts, reflect the process of investigation, are heard in 'their heads. There are some components in the form of automatism senestopatychnoho unpleasant sensations in the body (cold, burning).

At the height of psychosis, amid intense fear of having true passion verbal hallucinations associated with content travmivnoyu situation. Voices who hears patient with multiple character (polivokalnyy hallucinosis) or take the form of

dialogue that full recovery clarity of consciousness is possible in some visual hallucinations, which also reflects the situation.

Watch delirium relationships, values, prosecution and external influence ideas, continuous monitoring matched by using hypnosis, special devices and more.

Change of clinical disease occurs immediately after admission of the patient to the hospital. The first to disappear hallucinations, intense fear changes affect depression, delirium becomes residual nature. Gradually formed krytych¬ne relation to deferred painful disorders. Within a month or more after the release of psychosis observed fatigue, irritable weakness which intensified in the afternoon and evening, affective lability with a predominance of depressed mood, capriciousness, frustration and tearfulness.

16.3.6. Subacute reactive psychosis

When Sharp (hysterical) reactive psychosis with polymorphic clinical picture and the transformation from a combination of various hysterical disorders.

Hysterical twilight state unlike acute reactive psychosis characterized by affective narrowing of consciousness that leads to fragmentary perception of the original. Clinical picture different dynamic and polimorfnistyu. The behavior of the patient demonstrative, short, colored by anxiety and emotion of fear arousal changes to substupor. Mozh¬lyve occurrence maniakalnopodibnyh states, convulsive hysterical paroxysms, illusion-eidetic visual phenomena.

Typical delirium may be associated with false identification (symptoms which, Freholi). Affective disorders by twilight eclipse of consciousness characterized by very intense and tension. In most cases this fear, terror, dull bitterness, anger, ecstasy, etc. Movement disorders are manifested in excitement, often in the form of senseless destructive actions aimed at surrounding objects and people.

Course twilight confusion with disabilities can be productive and continuous alternuvalnym, ie with spontaneous disappearance briefly many, even all their symptoms with subsequent recurrence.

The duration of this form of twilight dizziness varies from several hours up to 1-2 weeks. Amnesia after it can be: partial (if awareness on different dates content is primarily visual hallucinations and passion that accompany them) retardovanoyu (retired) or complete.

Pseudodementia - psychopathological condition mynuchoho regression of mental activity that mimics dementia. More frequently observed in men. It was first described by S. \ ¥ ehpiske (1906).

Clinically pseudodementia to an abrupt decline in mental activity, appears false answers {mymomovlennyam) and actions (mymodiyamy). Patients are not oriented in the environment: do not know where they are, can not correctly identify the current month and year. They incorrect answer basic questions, perform simple tasks with gross errors: on request show showing eyes nose instead of hand - foot shoes put on hands, feet promoting a coat sleeve, trying to strike a match and so the other end. It answers such patients always give the plane a given subject (eg white is called black summer - winter window - door; the question as he fingers or eyes, the patient can respond that his 4 fingers and 5 eyes).

There abuse reading and writing (ahramatyzm omissions letters inequality writing). The distinctive appearance of patients - they lost, vytrischayut eyes, meaningless smile.

There agitated and depressed pseudodementia options.

Pseudodementia develops acutely agitated, amid hysterical narrowing of consciousness arise psychomotor agitation. Patients fussy, not vsydyat in one place, their attention is difficult. They perform many unnecessary movements, without the need to touch surrounding objects, move their clothes, kryvlyayutsya. Mostly euphoria, easily changing the intensity of anxiety and fear. It accelerated to the question patients meet without delay.

Depressive pseudodementia develops against psychomotor retardation. Mood patients anxious and depressed, they sit with a sad look, well opened his eyes silently crying, confused, cowardly examined. Thinking slow in tempo, answered questions after repeated repetition answers are characterized by denial

(do not know, do not remember, forgot) or perseveratsiyi. Symptom wrong actions must erase rudimentary nature. Yes, at the request of a patient to stretch his left arm long examines both hands, then picks up one and then another, and then one of the last stretches hands. Pseudodementia can fully determine the clinical picture of reactive psychosis. Ts deepening disease often agitated pseudodementia changes to puerylizm, depressive - to psychogenic stupor.

Duration pseudodementia is usually from 2 to week From months, sometimes protracted course possible. This clinical picture is monotonous and monotonous, against substuporu. Memories of the painful condition or completely absent (especially azhyto-vanoho option), or fragmentary.

Regression syndrome (savagery) occurs infrequently and turns hysterical confusion with particular psychomotor agitation in which regression of mental activity reaches an extreme degree: patients knees crawling, eating a plate of mouth, growl, bark, bite and more. Sometimes this behavior is accompanied by delirium reincarnation (attempts to move and behave like animals).

Puerylizm - state of regression of mental activity in which the language and behavior of adult children occur traits. The term "puerylizm" (from ryehiyiiz - children) suggested E. Byrhe in 1903

Patients puerylizm speak with children's intonation, shepelyavlyat, syusyukayut, all turning on "you", called "dyadyamy" and "aunt". They betray joy when they see shiny, bright objects, drag them arms, happy to play children's games (build huts, collect pictures, playing with dolls), capricious, dissatisfied with inflated lips hurt cry, but in general their behavior is not identical to the normal infant behavior. It differs dysotsiyovanistyu - along with children's behavior traits are kept separate patient habits and skills of an adult. For example, the correct way to light a match, get a light.

Sometimes jet disease throughout the state retains a coherent form puerylizmu same type, but mostly the latter.

is a form of hysterical or development stages reactive psychosis. This occurs after puerylizm psychogenic depression or pseudodementia and may further

deepen as reactive change state Syndrome savagery. In some cases puerylizm changes to psychogenic stupor.

Hanzera Syndrome - symptoms of deep hysterical twilight disorder of consciousness dominated the clinical picture mymomovlennya.

Polymorphic clinical picture of the syndrome in clearly defined orientation in ambient complicated perception of reality, because of the violation of the environment, puerylizmu manifestations. The patient focuses on a narrow circle isolated concepts within which there is some coherence and consistency. The mood of the patient is lifted, the anxious-shy. Sometimes there are hallucinations, usually visual, stsenopodibni threatening content (situationally-stage trial due to the testimony of witnesses, sentencing, etc.). Mymomovlennya is exaggerated - meaningless answers to everyday questions. The possible accession as mymodiyi phenomenon - the patient takes the wrong actions he proposed. Sometimes there is no reaction to pricking needle, insensitivity to cold and heat.

Hanzerivskyy syndrome lasts from several days to a week after it occurs amnesia.

Mayachnopodibnyy state (mayachnopodibnyh fantasy syndrome) was first described Vihpashp K. (1918), manifested in the changing of fantastic ideas that do not fit into a clear system.

In some cases, developing imagination mayachnopodibni sharply, amid hysterical constricted consciousness. It is dominated by unstable ideas of grandeur, wealth, which in exaggerated form reflect the desire to escape from an unbearable situation. Thus, patients talk about their journey to another planet, the untold riches that belong to them, they made major discoveries that have national significance. The content of these statements contradict the general mood of anxiety background, which varies depending on external circumstances, questions the doctor. The plot usually has thoughts of feedback psyhotravmivnoyu situation, ie their ugly deeds issued by deeds, charity.

In other cases mayachnopodibni fantasies are more complex and more stable character, appears a tendency to systematization. During the reduction of reactive

symptoms to the forefront due situational depression, fantasies pale, ozhyvlyayuchys only briefly concern for patients, because of the additional psyhotravmivnyh experiences.

Hysterical stupor is sometimes sharply immediately after trauma as an independent form reactive psychosis. In most cases it develops slowly, as the last stage speakers hysterical syndromes: hysterical depression and pseudodementia puerylizmu.

Despite the real estate and mutism, facial expressions such patients reflects the dominant affect. The facial expression can be moody, angry, sometimes it reflects the suffering and despair. Amid psychomotor retardation are symptoms characteristic pseudodementia and puerylizmu.

Consciousness is altered in these patients and close to the affective narrowed, their physical condition, despite the continued refusal of food, usually passable. Stuporoznyh disorders disappear suddenly or gradually.

16.3.7. Protracted reactive psychosis

Protracted (subjectively meaningful) reactive psychosis try¬vayut 6 months or more.

Reactive depression is characterized by the gradual development and course duration. The plot displays the contents of depressive feelings psyhotravmivnyh circumstances and living manifestations less pronounced than in the case of endogenous depression. Thus in patients with preserved, although somewhat reduced, critical to their own state, and most of the blame is usually laid on others, not themselves. Basically, there are three clinical forms (syndromes) reactive depression.

1. Asthenic depression (asthenic-depressive syndrome) is a sad mood, psychomotor retardation, kvolosti, vysnazhuvanosti fast and gravity concentration. Typical hypersensitivity (neprenosnist bright light, loud noises and sudden smell). There are headaches, sleep disturbances in the form of increased sleepiness or insomnia, autonomic disorders. Depending on the atmospheric pressure changes in

patients with asthenic syndrome may increase the level of fatigue, increase irritable weakness, hypersensitivity (symptom Pirogov).

2. The steroid depression (isterydepresyvnyy syndrome) is characterized by particular intensity of external manifestations. Affective disorders are combined depression, anxiety, zlobnosti, slozlyvosti have variable and depends on the situation. Ideas no self-blame - blame the sick around the others. At the same time they express exaggerated fears about their health, are convinced that their condition is very serious, and therefore not possible for them to nominate any requirements. Mimicry, motility and expression marked theatricality, the desire to attract attention and sympathy, psychomotor retardation available. Sometimes combined with hnivlyvistyu anguish, depression becomes agitated character. Often these patients are a cause of injury, do demonstrative suicidal attempt. This form is often combined with hysterical symptoms as pseudodementia, puerylizm, mayachnopodibni imagination. The course of hysterical depression favorable. Reduction of painful disorders can occur immediately after the positive changes in the situation or treatment. As observed partial recovery hysterical amnesia due to narrowing of consciousness during psychosis. 3. paranoid depression (paranoid-depressive syndrome) develops gradually. First, there is anguish and motor retardation ideatornoy without inhibition. In patients experienced an influx of ideas, the content of which is associated with psyhotravmivnoyu situation. Consciousness is focused on the dominant emotions (affective narrowed). Ambient environment is perceived as unreal (in "shades of gray" as "through the fog" or "water column"). With the deepening depression arising interpretation of the delusional (in the words and gestures of others ill see hints of future punishment, etc), elements of the syndrome Kandinsky-Klerambo and bradypsyhiya. In the future may develop depression

stupor.

Depressive stupor develops slowly and is the final stage of psychogenic depression, accompanied by psychomotor inhibition. His clinical picture is stored affect depression, manifested facial expressions and motor skills of patients. They

barely climb out of bed, and if this happens, then sat in mournful monotonous posture, bent over, head bent low. The patients do not follow their appearance, often refuse to eat, resulting in dramatically lose weight, stop in touch with others. The facial expression of their suffering, depressed, look motionless, drooping corners of the mouth, lips tremble.

Psychomotor retardation usually reach the level substuporu. Patients hard to understand content set of questions. They either did not respond or give monosyllabic answers after multiple repetition of questions. their language is slow with long pauses, his voice quiet, malomodulovanyy, statements indicating the presence ideas of self-blame and suicidal tendencies.

Leaving the state stuporoznyh going through a period of depression, followed by partial amnesia. Depressive stupor usually lasts 2-3 months, during which patients rapidly lose weight, they observed marked autonomic dysfunction (tachycardia, fluctuating blood pressure, feeling of squeezing, pain and heaviness in the heart).

With the change of situation or due to treatment of depressive stupor disappears first, then the interpretation of the delusional in the least affect normal. Along with the improved sentiment arising critical attitude to suffering a disease state. Within a month after that there asthenia.

Jet paranoyid - reactive psychosis is characterized by imaginative delirium and persecution accompanied by fear and anxiety. Occurs in people who are in an unusual situation (relative isolation). Mostly it helps roz¬ladam insomnia.

In an initial phase inactive paranoyidu occurs in patients with unexplained painful anxiety. Then joined delirium, which reflects the specific psyhotravmivnu situation. Patients are protected from imaginary pursuers, sometimes it takes character and hetero-avtoahresiyi. This state lasts from 2 weeks to 2 months. Gradually, after the step doubt, restored a critical attitude to their own patients disease state, delirium disappears.

There are three versions (forms) paranoyidu jet.

Paranoyid paranoid delirium is in an unstable without hallucinations, reflecting psyhotravmivnu situation.

Paranoyid hypochondria develops as a result of a somatic disease. Characterized confidence in their own untreated patients, ideas, influence, special treatment, dysmorfofobiyeyu.

3. Paranoyid external circumstances has several varieties:

A. Wartime paranoyid - plot delirium correlates with the situation. Patients are frightened to see the surrounding enemies make impulsive attempt to escape.

B. Rail paranoyid develops during try¬valyh complex travel in unfamiliar surroundings against the backdrop of exhaustion. Nonsense story - the idea of persecution and relationships.

B. Prison paranoyid - patient arise mainly verbal hallucinations accusatory, threatening or komentuvalnoho character. Their main theme is the situation involving the arrest and imprisonment.

Post-traumatic stress disorder (43.1 PTSR- R) arises as retired (from 2 weeks to 6 months after trauma) prolonged psychotic reaction to a stressful situation catastrophic. Characterized by compulsive syndromes (reministsensiyamy) the transferred event that immerse the patient in a state of emotional alienation zatsipininnya feelings. Potential acute dramatic flashes of fear, panic or aggression during those memories or when a situation gets, which explicitly or transferred remotely resembling psychogenic travmivni circumstances. Often accompanied by autonomic disorders, depression, alcoholism, drug addiction and other behavioral problems. In case of unfavorable long-term course of PTSD, he can transform into a stable personality change after the accident (R 62.1) in which the coming irreversible pathological changes of personality - the distrust and hostility towards others, social vidhorozhenist, a sense of constant threat, anxiety, being "on the verge" of internal emptiness, hopelessness, leading to social exclusion.

16.3.8. Treatment

Patients with reactive psychosis prescribed antidepressants in combination with antipsychotic (nevroleptychnymy) drugs and tranquilizers based on the characteristics of clinical manifestations and course of phase reactive psychosis.

To address acute psychogenic motor excitation psychogenic twilight state and agitated pseudodementia used intramuscular injections nevroleptychnyh means: chlorpromazine (150 mg) tryftazyn (I0 mg), haloperidol (5 mg S) leponeks (50 mg) three times day-klopiksol akufaz (100 mg once a From the days). From tranquilizers effective in such cases Seduxen (15-45 mg per day intramuscularly). These drugs also orally administered to patients with acute and subacute delirium.

In the presence of depression in the complex treatment of antidepressants administered in a daily dose mg: anafranil -75; coaxil - 37.5; ludiomil - 150; sertalin - 100; Paxil - 60; lamiktal - 150; CIPRAMIL APPLICATION - 60; tsypraleks - 60. In the case of psychogenic stupor recommended single amital-to-feyinovi inhibition or even air-Rausch narcosis, which sometimes is very efficient. A prolonged state of apathetic, lethargic stupor course and fatigue are indications for nootropic drugs and restorative care (especially in the presence of reactive psychosis clinical flabby stupor), piracetam, adaptogens (ginseng, eluterokok etc.), Magne-B6. Effective Homvio-nervin. During the exit of patients with a pathological condition appointment psychopharmacological drugs should be combined with well thought step- by-step rational psychotherapy. If insomnia is prescribed nitrazepam (radedorm), zolpidem (ivadal), zopiclone (apo-zopiclone) - 5.10 mg **per night.**

16.3.9. Expertise

Medical-labor examination. Patients with reactive psychosis receiving hospital treatment, while on sick leave, and in most cases do not require the appointment of their disability. In the case of prolonged reactive psychosis is usually limited to MSEK continuation of sick leave not more than 4 months. Exceptions are suffering from a progressive protracted reactive psychosis, which is prescribed III, and sometimes even disability group II. In the case of psychogenic paranoid delirium due to saving patients intelligence and their labor skills

destination of disability in most cases unnecessary, but the whole question in this disease medical-labor examination should be solved purely individual.

Military medical examination. If subacute and most of the protracted reactive psychosis patients are not exempt from military service. Exceptions are suffering from a progressive tightening reactive psychosis and patients with psychogenic paranoid delirium, which is removed from the military records as unfit for military service.

Forensic psychiatric examination. Persons who committed offenses in a state of reactive psychosis, which happens rarely recognize the insane; they are subject to compulsory treatment. If the defendant contracted reactive psychosis after the crime, but the verdict (during the investigation) only suspends judgment on a criminal case of illness, and pidekspert-tion after recovery appears before the court. Only in the case of prolonged Progressive reactive psychosis deal finally stopped, and the patient sent for compulsory treatment.

VI. План та організаційна структура заняття:

/п	The main stages of employment, their functions and content	Educational objectives in the levels of assimilation	Control methods study	Materials methodological support (control, visibility, instruktyvnosti)	ime min.)
The preparatory phase I.					
. . .	**Organization of classes** **Setting training goals and motivation** **Control output knowledge,**	I	Test control Level	Academic journal "Educational Purposes" "Relevance" Methodological developments	5

	skills, **skills:** 1). Classification psychogenic disorders 2). Definitions neurosis, neurotic disorders, reactive psychosis. 3). Etiological factors, pathogenesis of neurosis and reactive psychoses. 4). Neurasthenia, dissociative and conversion-obsessive-compulsive disorder. 5). Neurotic disorders in dental practice 6). Treating of neuroses, drug-labor, forensic psychiatric examination. 7) Acute and subacute reactive psychosis. 8) Protracted reactive psychosis 9) Treatment of	II II II II II II II	Individual oral examination Front conversation Test control level II The solution of typical problems II	Thematic table posters, slides structural logic Questions for individual oral survey Tests I, II level Typical tasks II level	

	reactive psychosis, drug-employment and forensic psychiatric examination.				
II. The main stage					
	Formation of skills and abilities: 1). Mastering the technique of collection history of life and disease and assessment of data; 2). Develop the ability to conduct somatic, psychoneurological and laboratory instrumental examination status of the patient, interpret their data. 3) master the skills to justify a preliminary diagnosis and a plan of inspection of patient. 4). Be able to conduct a differential diagnosis based on clinical and ancillary	III III III III III	Methods of forming habits: professional training III level test solution, typical problems III level professional training in solving atypical clinical situations, problems III level	Algorithms for formation of practical skills Methodical development. Neurological hammers. Table. Tests typical tasks III level Algorithms formation professional skills. Patients. Stories patient. Case custom problem.	60

	laboratory data and establish a final diagnosis. 5). Thoroughly learn the principles and plan of treatment.	IV		Simulation games. Equipment.	
III final stage					
. . .	Control and correction of professional skills and abilities Summing up classes (theoretical, practical, organizational) Homework (basic and additional literature on the subject)	III	Control methods habits: individual control of practical skills and their results. Analysis and evaluation of clinical work, decision tests, tasks	Equipment clinical results examination. Challenges III level Tests of W Estimated to map independent work with literature	5

VI. Materials methodological support classes.

1.2. Materials for monitoring the preparatory stage and basic classes.

Questions to control the initial level of knowledge (II and III)

1. The definition of "neurosis," "neurotic disorders," "reactive psychosis."

2. etiological factors of neurosis (neurotic disorders).

3. Pathogenetic mechanisms underlying neuroses (neurotic disorders).

4. Characteristics of short-neurotic reactions.

5. Classification of neuroses (neurotic disorders).

6. The clinical picture of neurasthenia.

7. Clinical hysterical neurosis.

8. Clinical obsessional neurosis.

10. Differential diagnosis of hysterical and epileptic seizures.

11. Principles of treatment of patients with neurotic disorders.

12. Labour, military and forensic psychiatric examination in patients with

neurotic disorders.

13. Etiology and pathogenesis of reactive psychosis.

14. Classification reactive psychosis.

15. Clinical manifestations of acute reactive psychosis.

16. Description of reactive twilight state of consciousness.

17. Clinical manifestations of subacute reactive psychosis.

18. Description of reactive stupor and reactive depression.

19. Description of reactive paranoyidu.

20. Characteristics and pseudodementia Hanzera syndrome.

21. Clinical manifestations of long jet psychoses.

22. Description of posttraumatic stress disorder and persistent personality changes after the disaster.

23. Examination and treatment of patients with reactive psychosis.

Tests II level

1. Emotional stress plays an important role in causing:

A. Korsakov syndrome

B. Manias

C. Pseudodementia

D. Delirium

2. The typical result is reactive psychosis:

A. Recovery

B. Formation remission

C. Mental - intellectual defect

D. Apatiko-defect abulicheskimi

E. Prolonged remissions without neprohradiyentnyy course.

3. A characteristic feature of affective reactions-shock responses:

A. The presence of hallucinations

B. Sumy and no result

C. Durashlyvist and affectation

D. The phenomenon of mental automatism

E. Dizziness.

4. A characteristic feature of PTSD consider:

A. The presence of delusional ideas of persecution

B. Denial of medical care

C. Flip or excitement

D. Autism and negativism

E. Dizziness.

5. The emergence of children's behavior on a background of severe traumatic events is typical for:

A. Neurosis

B. affective-shock reaction

C. Jet paranoid

D. hysterical psychosis

E. somatoform disorders.

6. Situations related to the sudden emergence of a threat to life, often vyzyvayut:

A. affective-shock reaction

B. reactive depression

C. Reactive paranoia

D. Iisterychnyy psychosis.

7. Vynnyknennyu jet paranoyida helps:

A. A low level of intelligence and education

B. Education in single-parent families

C. Stay in chuzhomovnomu environment

D. Working with technical devices

E. Long-term abstinence from sexual intercourse.

8. The appearance of the patient's negative symptoms:

A. Reiterates diagnosed neurosis

B. confirm the diagnosis of reactive psychosis

C. confirms the diagnosis MD

D. exclude the diagnosis of schizophrenia

E. excludes any diagnosis of psychogenic illness.

9. Most effective in reactive depression is:

A. behavioral

B. Cognitive

C. suggestive

D. relaxing therapy.

10. somatovegetativnyh disorders are characteristic manifestation:

A. neurasthenia

B. Obsessive-phobic neurosis

C. Hysteria

D. Any neurosis.

11. The most favorable option neurosis consider:

A. neurasthenia

B. Obsessive-phobic neurosis

C. Hysteria

12. Neurosis expectations consider option:

A. neurasthenia

B. Obsessive-phobic neurosis

C. Hysteria

13. In the treatment of panic attacks lasting effect observed in the appointment:

A. Antidepressants

B. antipsychotics

C. Barbiturates

D. Benzadiazepinovyh tranquilizers

E. nootropics

14. Violation of swallowing characterized by:

A. For neurasthenia

B. For obsessive-phobic neurosis

C. Hysteria

D. If nervousness is observed.

15. Globus hystericus- this:

A. The feeling hoop on the head

B. Feeling whom throat

C. Narrowing of visual fields

D. Munchausen syndrome Synonym

E.Synonim Hanzera syndrome.

16. The most common cause of neurosis is:

A. The death of a loved one

B. The final break with partner

C. Long-term mental stress

D. Moving to a new residence

E. Internally personal conflict.

17. Hereditary factors in the etiology and pathogenesis of neurosis:

A. We consider as the main reason

B. are essential

C. Determine prognosis of the disease

D. Do not play any role.

18. The mechanisms of repression and dissociation associated with conversion

A. reactive depression

B. hysteria

C. neurasthenia

D. Obsessive-phobic neurosis

E. psychosomatic diseases.

19. Protection from psychological experience, which is reflected in the appearance of functional, neurological and somatic disorders called

A. Regression

B. Dissociation

C. Iintelektualizatsiyeyu

D. Fixing alarm

E. Conversion.

20. psychosomatic diseases include:

A. Progressive paralysis

B. ulcer disease

C. steatosis

D. AIDS

E. Limfohranulomatoz.

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