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ZAPORIZHZHIA STATE MEDICAL UNIVERSITY

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

PSYCHIATRY AND NARCOLOGY. SCHIZOPHRENIA, SCHIZOTYPAL, DELUSIONAL AND AFFECTIVE DISORDERS, CLINIC AND TREATMENT

Tutorial

for 4th year students of international faculty №2

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С 22 Psychiatry and narcology. Schizophrenia, schizotypal, delusional and affective disorders, clinic and treatment: tutorial for 4th year students of International Faculty №2. – Zaporizhzhia, 2022. – 101 p.

The tutorial provides materials on modern ideas about methods of diagnosis and treatment of schizophrenia, schizotypal, delusional and affective disorders and covers 21.9% of the curriculum program «Psychiatry and narcology» for the 4th year students of International Faculty №2. The authors used modern requirements for teaching, control of theoretical knowledge, skills and practical abilities in the system of credit transfer of educational evaluation. The materials of tutorial should help students to improve their knowledge and skills in the basic methods of diagnosing of mental pathology, expand their understanding of this kind psychopathology. The tutorial is a guide for conducting practical classes in psychiatry and were developed for the first time. Due to the progressive development of psychiatry, changes in the requirements for specialists, this tutorial will not meet the pedagogical and professional needs over time, so it will be improved and supplemented.

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FOREWORD

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

CONTENT

INTRODUCTION

Relevance, goals, organizational structure of the lesson

1.1. Relevance of the topic.

Schizophrenia affects about 1% of the population, which is more than 60 million people in the world, mostly youth, young and mature age. The prevalence rate of bipolar affective disorder (formerly manic-depressive psychosis) and schizoaffective disorder is also about 1% of the population. The incidence of the above-mentioned endogenous psychoses is not only a medical, but also a general socio-economic problem in all countries of the world. In the majority of cases, the disease is caused by hereditary burden, leads to disability, social maladjustment of patients and requires long-term psychopharmacological treatment. Timely comprehensive examination of the patient after the onset of the disease is important for diagnosis, clarifying the features of the clinical picture, carrying out differential diagnosis in the middle groups of endogenous psychoses and with psychoses of other etiology and timely appointment of treatment. It is known that in the case of early adequate therapy, psychopathological symptoms disappear permanently or for a long time in about a quarter of patients with schizophrenia. Prognostic characteristics of schizotypal, delusional and affective disorders are better than in schizophrenia.

1.2. Learning objectives of the lesson:

Students must know the definition and characteristics of:

1. Determining the diagnostic limits of schizophrenia and the history of its study.

2. Etiological theories of schizophrenia, theories of the pathogenesis of schizophrenia. Classification of schizophrenia.

3. Clinical manifestations of the paranoid form of schizophrenia.

4. Clinical manifestations of a simple form of schizophrenia.

5. Clinical manifestations of the catatonic form of schizophrenia.

6. Clinical manifestations of hebephrenic form of schizophrenia.

7. Types of schizophrenia. Types of remissions in schizophrenia. The concept of schizophrenic defect.

8. Pharmacotherapy of schizophrenia. Non-drug treatment of schizophrenia.

9. Etiology, theories of pathogenesis of bipolar affective disorder, schizoaffective psychosis and delusional disorders.

10. Classification, clinical manifestations of various forms and types of manic-depressive psychosis, schizoaffective psychosis and delusional disorders.

11. Basic principles of treatment of patients with manic-depressive psychosis, schizoaffective psychosis and delusional disorders.

12. Varieties of acute psychotic states.

Students must be able to:

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

2. Qualify their nature and possible dynamics.

3. Correctly describe the mental state of the patient in the medical records.

4. Carry out differential diagnosis of symptoms and syndromes.

5. Provide medical care in emergencies.

1.3. Objectives of personality development:

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

1.4. Lesson plan and organizational structure:

№	The main stages of the lesson, their functions and content	Learning objectives in the levels of mastery	Methods of learning control	Materials of methodical maintenance (control, clarity, instructiveness)	Time (min.)
	I. Preparatory stage				
1.	Organization of classes			Academic Journal	40
2.	Setting learning goals and motivation			"Learning Objectives"	
3.	**Control of the initial level of knowledge, skills, abilities:**			"Actuality"	
	1. Etiological structure and pathogenesis of mental disorders.	I	Level I test control Individual examination	Methodical developments	
	2. Features of diagnosis of patients with mental disorders.	II		Thematic tables, posters, slides, structural and logical schemes	
	3. Differential diagnosis in psychiatry.	II	Level II test control	Questions for individual examination	
	4. Indications for involuntary hospitalization in a psychiatric hospital.	II		Test tasks of I, II level	
	5. Supervision, examination and treatment of patients in the clinic.	II			

II. The main stage					
4.	**Formation of professional skills and abilities:** 1. Mastering the anamnesis taking and evaluation of these data; 2. To form the ability to conduct somatic, psychoneurological and laboratory-instrumental examination of the patient's status, to interpret these data. 3. Master the ability to justify the syndromic diagnosis and make a plan for examination of the patient. 4. Be able to make a differential diagnosis based on clinical and ancillary laboratory data.	III III III IV	Methods of skill formation: professional training, solution of level II tests, typical level III cases professional training in solving atypical clinical cases, level III tasks	Algorithms for the formation of practical skills: methodical developments. Neurological hammers. Tables. Tests, typical cases of the III level Algorithms for the formation of professional skills. Situational atypical tasks. Simulation games. Equipment.	100
III Final stage					
5. 6. 7.	Control and correction of the level of skills and abilities Summarizing the lesson (theoretical, practical, organizational) Homework (basic and additional literature on the topic)	III	Methods of skill control: individual control of practical skills and their results. Analysis and evaluation of clinical results, solutions of tests, cases	The results of the clinical examination. Level III tasks Level II tests Approximate map for independent work with literature	40

Schizophrenia, clinical forms and treatment

Schizophrenia is a chronic mental disease with unclear etiology, which develops on the basis of hereditary predisposition and is characterized by changes of the personality in the form of autism, emotional flattening, reduced activity, loss of the integrity of mental processes with various productive psychopathological symptoms.

The term **"schizophrenia"** comes from Greek words "schizo", which means "to split, crack", and "phren", which means "soul". Thus, the term emphasizes the main sign of the illness: a disturbance of the integrity, unity of the mind and an inadequacy of mental responses to external stimuli.

The spread of schizophrenia among the population is from 7-8 cases in 1,000 people to 1-2%.

According to modern concepts, schizophrenia belongs to a group of genetic predisposed diseases, which origin is multifactorial. The acquired genetic predisposition each individual patient can be realized only in the interaction of internal and environmental factors.

Clinical manifestations

The most important for clinical practice is division of the schizophrenia symptoms into basic, permanent (negative), typical for all the forms of the illness, and additional (secondary, "productive"), typical for some or another form.

The Four A`s

(primary symptoms of schizophrenia described by E. Bleuler):

1. **A**ssociational disturbances (thought disorder)
2. **A**ffective disturbances (flattering of affect)
3. **A**utism
4. **A**mbivalence

Productive symptoms are called new morbid phenomenon, some new feature, which appeared as a result of the disease, which are absent of healthy people. Examples of positive symptoms are *delusions and hallucinations, epileptiform paroxysms, psychomotor agitation, obsessions, strong sense of melancholy depression*. Productive symptoms are quite dynamic. It can dramatically increases in exacerbation of the disease, and then disappears by itself or influenced by appropriate treatment. Most psychotropic drugs used in psychiatry are intended for the treatment of productive symptoms. Productive symptoms tend to be less specific, so it may be similar in a few different diseases.

Negative symptoms (defect, minus-sign) are called defect that occurs due to illness in healthy natural functions of the body, loss of any ability. Examples of negative symptoms is inability to experience vivid emotional feelings (*apathy*). Negative symptoms are usually irreversible. These symptoms indicate the duration of the disease and the depth of destruction of the mentality. Character of negative symptoms is specific and plays an important role in the diagnosis of schizophrenia.

Autism is disconnection of the personality from the environment, loss of contacts with other people, shutting oneself off, self-reservation, absorption into one's own world of the person's mannered autistic feelings. The patient becomes silent, avoids any contacts with other people, because he feels better alone. Even with the relatives, the verbal contact becomes formal, poor.

Emotional disorders are expressed in a gradual impoverishment of emotional responses. At first, higher emotions (compassion, altruism, emotional sympathy) are affected. Later the patients become cooler and more egoistic. They lose any interest in events at their job and their family. Severe cases develop emotional bluntness with an absolute indifference to the environment and one's own fate. Against a background of a significant impoverishment of the emotional life, some inadequacy and paradoxicalness

of emotional responses is notable. The patient would laugh in an improper situation, quietly state the events which are sad for him and other people, but inadequately and often violently respond to quite insignificant causes. As a result of the splitting process in the emotional sphere, the schizophrenic can simultaneously combine two contradictory feelings: he loves and does not love, he is angry and happy, cheerful and depressed (ambivalent). The patients' mimics do not correspond to their feelings (paramimia), but demonstrates a splitting of their integral emotional mimic reactions. Emotional modulations of the voice and nuances of the intonation are lost; the patients would say about stirring and indifferent things in the same tone (a "wooden voice"). The style of dressing often changes too. Some patients become untidy, careless, while others begin wearing extremely extravagant and flashy clothes, losing even elementary tact and taste.

A splitting of thinking also manifests itself by contradictory judgements and double orientation. In a long course of the illness in the defect state there may be absolute destruction of the thinking and speech. As a result, not only laws of meaning are violated, but syntactical and grammar ones are affected too (a "verbal crumb").

Typical for schizophrenic thinking are symbolization, formation of new concepts, and compression of concepts. A disposition to futile judgments, empty fruitless philosophizing without any logic sense, abstract thinking, its estrangement from the reality, very abstract or strictly concrete generalization is observed.

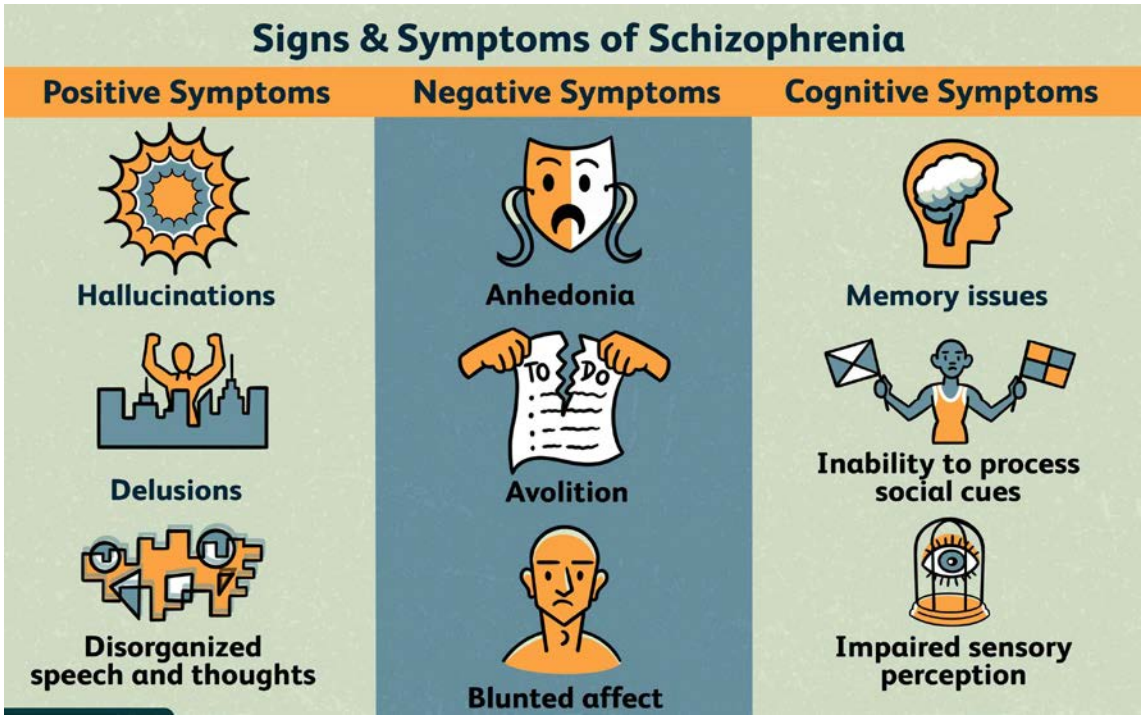
Schizophrenics write in a very peculiar way too. Sometimes from left to right. Their writing abounds in mannered, ornate letters, underlining, exclamation marks, small vertical lines, symbolic designations and drawings.

The rate and course of thoughts are affected. Some patients reveal a flow of thoughts with a feeling of their artificial character – *mentism*, or disappearance of thoughts with a feeling of emptiness in the head – *sperrung*.

Rather often are *perseverations* (repetition of the same words), *verbigerations* (repetition of the same phrases), and ornate expressions. The symptoms of "*open thoughts*" and "*sounding thoughts*" are observed; the patients state that their thoughts are read by people nearby, known for everybody.

Disorders in **the effector-volitional sphere** manifest themselves by a reduction in the purposeful activity (*hypobulia* and *abulia*), it being attributed to a "*lower power potential*". The patients feel it more and more difficult to study and work. Any activity, mental in particular, requires much effort. Concentration of attention is very difficult. Communication with other people is tiresome. As a result, there are increasing problems in studies, professional degradation, or absolute incompetence in severe cases, the formal functions of the intellect being preserved.

Splitting of the mind is reflected by the patients' behavior. In patients with schizophrenia, the struggle of motives in a volitional act is prolonged or does not end at all, so it makes taking of a decision impossible. It is shown by *ambitendency*, when the patient is unable to make any action because two opposite tendencies occur in him. In order to enter the doctor's room, the patient would open the door, but immediately afterwards close it; he would make a step forward, and then back. He would like to shake somebody's hand, but then take his hand off. The patient's instinct life changes, the food, sexual and self-preservation instincts are reduced. Male patients at the age of 30 and older usually do not life a sexual life; as a rule, they masturbate and later regard it as the cause of their illness. Sometimes the sexual instinct is increased and insufficiently differentiated, with resultant homosexuality and disordered sexual life. A higher sexual instinct in women causes their moral degradation earlier, than their morbid state becomes evident. The food instinct is reduced or distorted. In cases of a long course of the process the perversion may reach to coprophagia. The instinct for self-preservation may be increased, as it is demonstrated by aggressiveness, suicidal acts, self-injuries (Pic. 1).



Pic. 1. Main symptoms of schizophrenia [1]

A purposeful activity is always affected to some or another degree. Typical for the patients is their strange behavior, absence of usual logic motives. Such patients often astonish with their absurd actions, though their formal intellectual functions are sufficiently preserved. A sensation of estrangement of their own thoughts, feelings and actions is a peculiar kind of the activity disorder. Some part of the mental activity is felt by the patient as not belonging to him, taking place independently of his will, automatically, against his intention (*Kandinsky-Clérambault syndrome*). Thus, a female patient, who sometimes shouts, dances, swears, states that all these things are done not by her, but the doctor who seized her will and directed her. She knows that she says and does "unnecessary things", but this is because there is some foreign object in her larynx, "my larynx obeys somebody's will". Other

[1] source: https://www.verywellhealth.com/schizophrenia-sign-symptoms-5095511)

patients say that “somebody decides in advance “what I must do”, they “are forced to think, remember, act”. Depersonalization symptom develops: a feeling of splitting of one’s own “ego”. The patient feels two “egos” inside him, says about himself in the third person, “he wants to eat, he went”, uses various family and first names for himself, states that together with his “ego” another one lives in him.

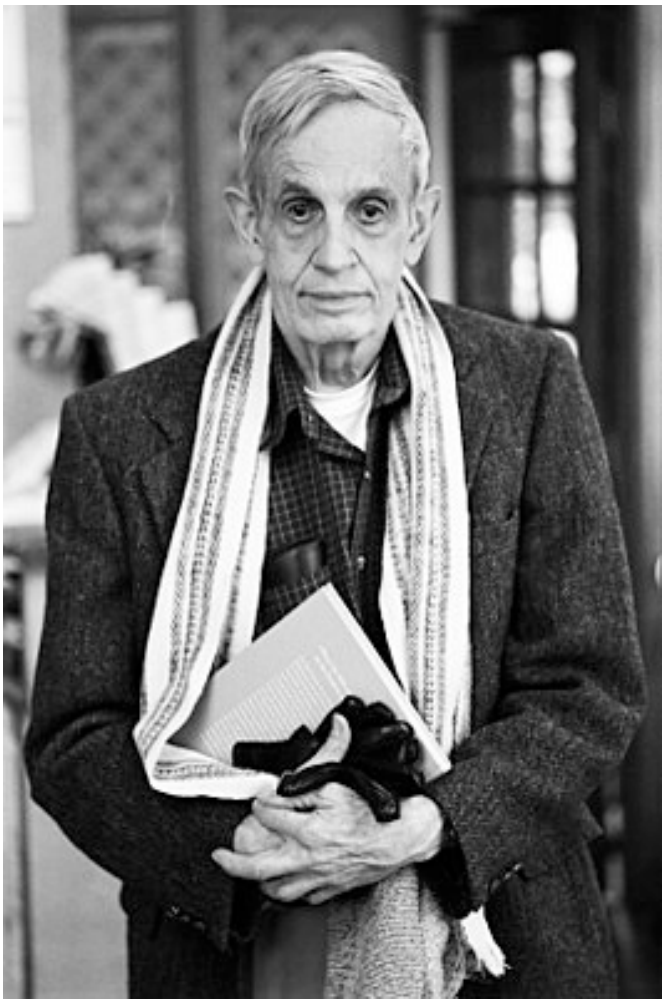
Besides the changes typical for schizophrenia, various productive (delirious, catatonic, hebephrenic and affective) symptom complexes appear and regularly change into one another in the course of the illness; they are responsible for the form of schizophrenia.

Clinical forms of schizophrenia

Paranoid (F20.0) is the commonest form. Hallucinatory-paranoid symptoms develop against a background of mental splitting. The symptoms typical for this form are revealed at the age of 20-40. The appearance of the productive symptom is preceded by suspiciousness, over-anxiousness about one’s health, captiousness, and hypochondria. Exacerbation begins with the appearance of insomnia, anxiety, nervousness, shortness of temper. Against a background of a change in the general condition, there is development of the feeling of an environmental change, appearance of some barrier between the patient and the world. Delusions of reference, persecution, affection and poisoning develop. The patient states that his relatives and friends have changed their attitude to him; everybody in the street pays attention to him, watches him, points at him, and talks about him. The delusions manifest themselves by the patient saying that his organism or mind is subjected to the influence of hypnosis, electrical current, some invisible energy. Sometimes these delusions astonish with their absurdity. The patient may state that having touched door handles he caught syphilis or AIDS, that some animal started living inside his body, that his internal organs have rotten, the food is not

digested, “there are piles of pills in my stomach”. In the onset of the illness the delusions are of an unsystematized and fragmentary character, with time they take a form of some system, often queer-symbolic, with ideas of power, grandeur, reforming; i.e. they get paraphrenic features. The delusions are accompanied by verbal hallucinations and illusions: “they talk about me”, the patients hear somebody calling their names, some words and phrases, “voices”. The latter directly concern the patient, condemn, frighten, threaten him, often are imperative. They, particularly the frightening and imperative ones, create some anxious mood, arouse fear. Often paranoid schizophrenia develops Kandinsky-Clérambault syndrome: a combination of psychic automatisms, pseudohallucinations and delusions of affection, estrangement of one’s own thoughts, actions and “ego”, the patients say about themselves like about an externally controlled automaton. Pseudohallucinations differ from real ones by the fact that the “voices” are heard inside the head and body parts, with their “inner sight” the patients see some figures and parts of their internal organs. Rather common are tactile hallucinations and cenesthopathies. The patient feels that his head, throat and genitals “are pierced with electrical current”, the internal organs are twisted, burst, etc. Olfactory and gustatory hallucinations are not common, but they are particularly unpleasant. The patient feels even smells exhaled by himself rather than by the outside world only (smells of a corpse, intestinal gases, blood, decomposed sperm, etc.). These hallucinations are particularly typical for an unfavorable course of the illness. Visual hallucinations are rare. Usually they are fragmentary, colorless, non-scenic; more frequently the patients see faces or their parts, figures. The patient says that he saw through the wall, a flap of the overall and the hand, and knew that it was the doctor’s hand which “drew a white line of my temperature curve on a white wall with chalk”. Another patient “saw” some bent figure and knew that it was his dead brother, etc. Illusions are rather commonly observed. The patient would take a knock at a door for a shot,

explosion; the patient with delusions of persecution would perceive clattering of kitchen utensils as clanking of weapons.



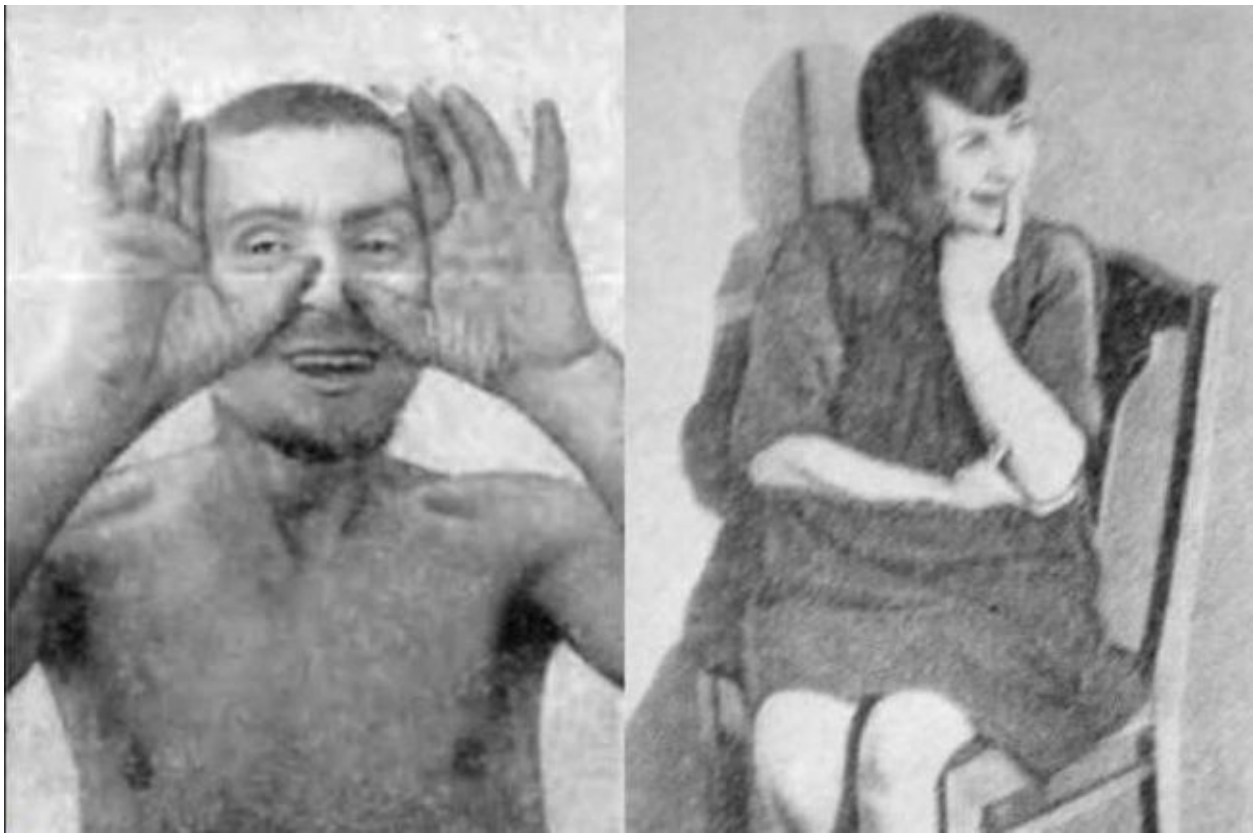
Pic. 2. John Nash, American mathematician and Nobel laureate (1994), one of the most famous people who suffered from paranoid schizophrenia; "A Beautiful Mind" is a biopic about John Nash. [2]

In compliance with the contents of the delusions and hallucinations, the patient's behavior changes. He can be dangerous for both himself and other people. Under the influence of imperative hallucinations the patient would refuse taking food, inflict selfinjuries, and commit suicide. Delusional motives may make the patient be aggressive, kill somebody. It is not in rare cases that the patients would dissimulate their feelings for years; as a result, they may be prematurely discharged with severe consequences.

Many famous people suffered from this type of schizophrenia (Pic. 2).

[2] sourse: https://en.wikipedia.org/wiki/John_Forbes_Nash_Jr.

Hebephrenic (F20.1) is the most malignant form of schizophrenia, which begins at the juvenile or young age. This form is characterized by senseless foolish behavior, emotional disorders in the form of rough inadequate emotions, foolishness, absurd grotesque hilarity, which does not involve other people but astonishes and frightens them. Typical for hebephrenic excitement are purposeless grimacing, clowning, somersaulting. The patients would jump on their beds, roll on the floor, try to hit, laugh at once, shamelessly bare themselves, and masturbate. They are untidy, slovenly and voracious, may purposely urinate and defecate in the beds (Pic. 3).



Pic. 3. Patients with hebephrenic schizophrenia [3]

Turns of their speech, intonation in particular, are pretentious, they would speak in an unnatural voice, lisp like children, torture words and use obscene ones. Their thinking is poor, paralogic and stereotyped. Thus, a patient may jump on one leg, beat himself on the face, laugh and

[3] sourse: https://ppt-online.org/105236

stereotypically repeat “twice two is a rabbit”. Sometimes the patients’ speech resembles a senseless set of words or phrases. This form of schizophrenia starts in puberty (13-15 years), course of the disease without remission, patients state invalidity wary quickly.

Hallucinatory-delirious manifestations are fragmentary and astonish with their absurdity. A sudden transition from foolishness and euphoria to hypochondria is often observed. This form is characterized by an extremely unfavorable prognosis and usually rapidly (during 1-2 years) results in disintegration of the personality and dementia.

Catatonic form (F20.2) begins at a young age and manifests itself by an alternation of catatonic excitement and catatonic stupor. In recent years the typical kind of this form has been seldom observed (Pic. 4).

Pic. 4. Main facts and symptoms of catatonia[4]

[4] sourse: https://barendspsychology.com/mental-disorders-catatonic-depression-symptoms/

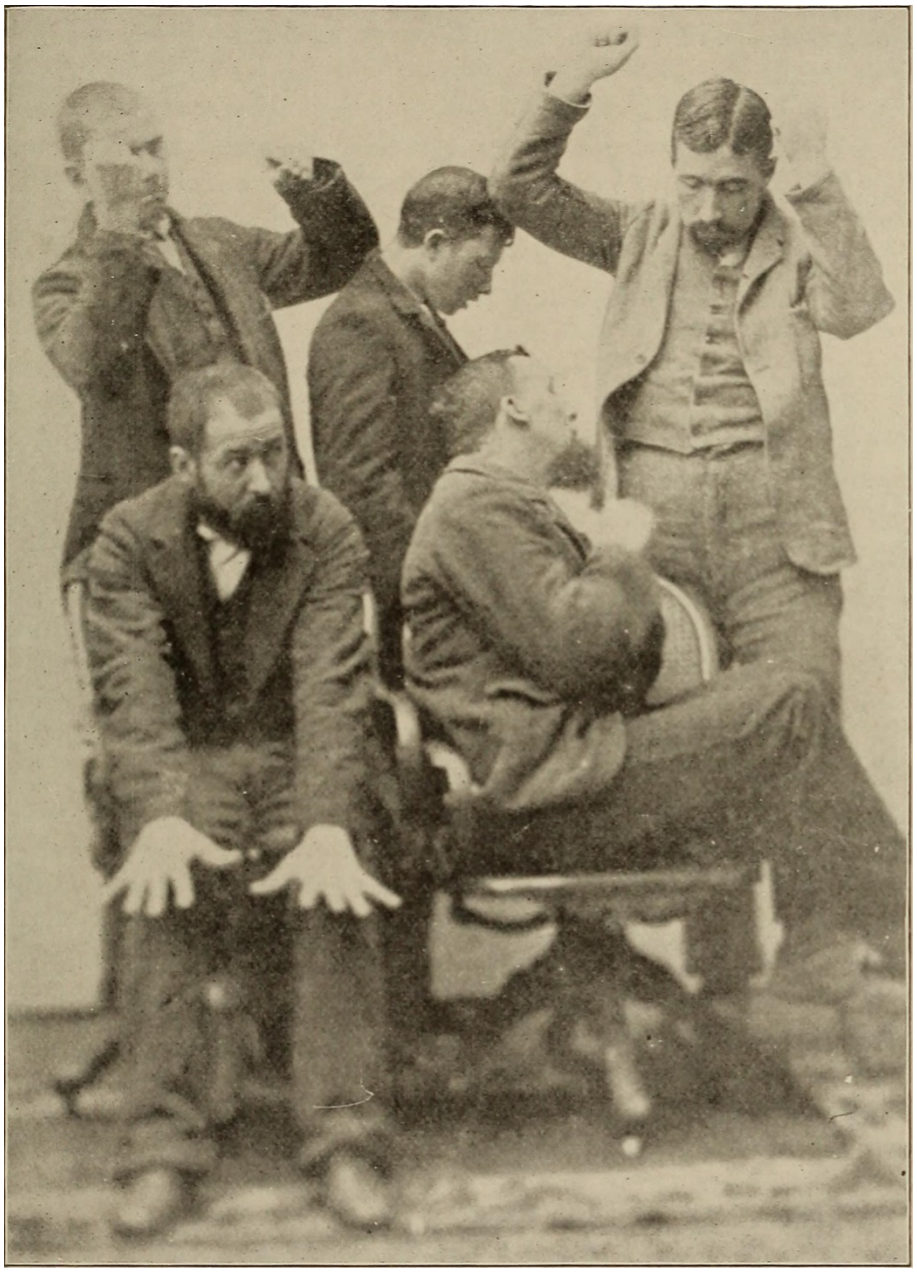
Catatonic excitement is absurd, stereotyped, and purposeless. The patients are impulsive and unreasonably aggressive; they would shout and make faces. Their movements and gestures are monotonous, stereotyped and awkward (Pic. 5). Particularly mannered and pretentious is the patients' gait: with jumps, stops and swift impulsiveness. The thinking is noncontiguous and paralogic, the speech is stereotyped, has verbigerations (repetitions of the same phrases, words and gestures) and neologisms. The patients would repeat words (echolalia) and gestures of the other people (echopraxia). They would stubbornly resist everything, make the opposite to what they are asked about (active negativism), often tear off their clothes, and make self-injuries.

Pic. 5. The most common catatonic behaviors[5]

Catatonic stupor is absolute immobility with muscular tension, mutism, negativism, refusal to eat. The patient would often lie in the embryonal position, resist any attempts to change it (active negativism), on examination

[5] sourse: https://www.verywellmind.com/what-is-catatonic-schizophrenia-2794979

actively resist taking his pulse and temperature and feeding him, would not follow instructions (passive negativism). Feeding in such cases is performed through a tube. Phenomena of catalepsy (wax flexibility) are observed: preservation of the position, given to the body, extremities or head, for an indefinite period of time ("air pillow"). Consciousness during the stupor may be absolutely preserved, and after the stupor passes away the patients describe in detail everything that took place (Pic. 6).



Pic. 6. Vintage photo of patients with catatonic schizophrenia [6]

[6] sourse: https://www.psycom.net/schizophrenia/catatonic-schizophrenia

Catatonic-oneiroid states are characterized by immobility and somnolent cloudiness of consciousness. Various fantastic, often catastrophic situations are experienced (war, earthquake, shipwreck), where the patient does not participate and only observes them, but at the same time “feels particular responsibility for everything that takes place”. The expression of horror on the face changes into some interest and ecstasy depending upon the contents of hallucinations. The patients can describe their feelings later, they perceive real events in a fragmentary way, and the environment is perceived in compliance with the dream-like fantasies (other patients were taken for extraterrestrials, the hospital itself for some camp, etc.).

Simple form (F20.6) is the brightest manifestation of the basic symptoms of schizophrenia: a reduction of volitional activity, affective bluntness and disturbances of thinking, whose totality is designated as the apathoabulic syndrome. The illness begins gradually, more frequently in children and youths. Listlessness, apathy and indifference augment. The patients begin studying bad and missing classes, they develop a disposition to prolonged idleness, spend a larger part of the day in bed, become still more reserved, silent, lose social relations and friends. Emotions grow dull; indifference and even some hostile attitude towards the relatives appear. The lose any interest in their clothes and outward appearance, become slovenly, do not wash themselves, do not change their underwear, sleep with their clothes on. They lose diffidence, develop a disposition to impulsive actions and vagabondage, in some cases openly masturbate. The behavior becomes absurd; as a rule, the patients have neither any plans nor prospects, but it does not upset them, also they are not troubled by the fact that being young and physically healthy they live at their parents’ expense and do not help them at all.

Besides, the patients may develop absurd and strange interests, which do not correspond to their age and position, as well as a disposition to scholastic

fruitless judgments (philosophizing), contradictory statements. Their thinking is characterized by sliding down to an unexpected subject and breaks in thoughts. The patients' appearance is peculiar, their movements are awkward, expressiveness of mimic responses is lost, the voice becomes monotonous (a "wooden voice"). Productive symptoms (delusions and hallucinations) are seldom observed, they are rudimentary, short-term and do not produce any effect on the course of the disease. The prognosis is often unfavorable, because the simple form is diagnosed late and the patients are admitted to hospital already having signs of the defect formed.

The types in the course of schizophrenia

The types in the course of schizophrenia are distinguished depending upon the progression of the illness, the rate and degree of augmentation of schizophrenia symptoms, peculiarities in its clinical syndromes which prevail in the picture of the disease.

Process schizophrenia is characterized by progressively augmenting schizophrenic changes and absence of any spontaneous responses. Remissions usually result from treatment and last till supporting therapy is given. The degree of progression varies: from a slow course with slight changes in the personality to deep devastation and its destruction. Particularly malignant is the course of schizophrenia which began in children and youths: malignant hebephrenia, hallucinatory-paranoid, simple forms.

Paroxysmal progressive schizophrenia is characterized by a paroxysmal course. The attacks last from 2-3 weeks to a few months and alternate with light periods, remissions, whose duration ranges from 1-2 weeks to several months and even years. The quality of the remissions is various. They may be complete (a practically full recovery) or incomplete (with signs of schizophrenic defect or residual phenomena of the attack). With every new attack the quality of remission becomes lower, and the attack itself acquires

new unfavorable (hebephrenic, hallucinatory-paranoid, schizophasic) symptoms.

Recurrent (periodical) schizophrenia is characterized by attacks of atypical depressive or maniac phase with stable remissions. Eventually, the attacks become more frequent and prolonged. This course is typical for schizoaffective psychoses.

Types of remissions. Depending upon the degree of reduction of psychotic symptoms and expressiveness of dissociative-apathetic disorders, a remission can be complete, incomplete or partial.

Complete remission (remission A) is a complete reduction of productive psychotic syndromes with insignificant expressiveness of negative symptoms which practically do not change the patient's capacity for work, his family and everyday life; occupational reorientation is necessary only in some cases.

Incomplete remission (remission B) is a complete reduction of productive psychotic syndromes with moderately expressed changes necessitating rehabilitative measures: a change of profession (work with limited loads), or getting a job at special shops of industrial enterprises.

Remission C is a significant reduction of psychotic symptoms (residual delusions, which lost their actuality, and some hallucinatory phenomena are possible) with an expressed apathetic-dissociative defect plus a loss of capacity for regular and professional work. The patients are adapted to work at medical industrial workshops of mental and day hospitals.

Partial remission (remission D), an intrahospital improvement, is characterized by only an insignificant improvement of the state with some loss of actualization of psychotic phenomena. The patients are subject to further treatment at in-patient department.

The differential diagnosis of schizophrenia

The differential diagnosis of schizophrenia must be based, first of all, on specific negative symptoms: autism, emotional impoverishment and inadequacy,

reduced activity, disturbances of thinking, such as splitting, paralogism, philosophizing, symbolism. The expressed polymorphism and changeability of productive psychopathological symptoms make them less reliable diagnostic signs of the illness. Diagnosing also takes into account the dynamics of the disease characterized by a progressive course and augmentation of negative symptoms of deficit. Manifestations of the illness are often preceded by psychic traumas, previous brain injuries, infectious diseases, and intoxications. In this connection, schizophrenia has to be differentiated from reactive (psychogenic), organic (somatogenic, infectious) psychoses. Situational psychoses (reactive paranoid, reactive depression) are characterized by psychological clarity of morbid feelings; they reflect the contents of a psychotraumatizing situation and disappear after its solution. Typical for the course of exogenous-organic psychoses is prevalence of asthenic symptoms, hallucinatory (more frequently visual) disorders, syndromes of disturbed consciousness (delirious, twilight) and memory, personality changes by the organic type (Pic. 7).

Diagnosis	Etiology	Clinical Symptoms	Psychiatric Comorbidity
Velokardiofacial Syndrome	Deletion on 22q11 chromosome	Heart defects, cleft palate, atypical facial dysmorphism, impulsive behaviours, social adaptation difficulties	Attention deficit hiperactivity disorder, autism spectrum disorder, mood disorders, learning disability
Fragile-X Syndrome	Increase of CGG trinucleotide repeat on Xq27.3 locus	Elongated face, large ears, palate anomalies, macroorchidism, kardiovascular anomalies, aggression, impulsive behaviours	Autism spectrum disorder, intellectual development disorder
Multiple Sclerosis	Damaged myelin sheath of brain and spinal cord by autoimmune antibodies	Sensorial and motor symptoms, presenting with attacks	Mood disorders, psychotic disorders
Temporal Lobe Epilepsy	Abnormality in brain activity	Tonic clonic seizures, oral and manual automatisms, mood and dissociative symptoms up to 3 minutes	Mood disorders, psychotic disorders
Autoimmune encephalopathies	Otoimmune antibodies	Mesiotemporal seizures, short time memory impairment, irritability, generalised anxiety, delusions and halucinations	Psychosis, mood disorders
Thyroid Function Disorders	Hyperthyroidism, hypothyroidism or rapid changes of thyroid hormones	Hyperthyroidism/ hypothyroidism symptoms	Mood disorders, depression, psychosis
Systemic Lupus Erytematozus	Otoimmune antibodies	Dermatologic lesions, arthritis, systemic symptoms	Depression, mania, psychosis
Wilson Disease	Copper acumulation in the liver and basal ganglions	Liver function disorders, Kayser-Fleischer ring, dysarthria, neurologic symptoms	Various psychiatric symptoms such as depression, euphoria, sexual preoccupations, hebefrenia, catatonia

Pic. 7. The differential diagnosis of schizophrenia. Neurodevelopmental disorders and psychotic disorders due to other medical conditions[7]

[7] sourse: https://www.researchgate.net/figure/Differential-Diagnosis-of-Schizophrenia-Neurodevelopmental-Disorders-and-Psychotic_tbl1_289488861

The simple form of schizophrenia at certain stages of its course may resemble manifestations of psychopathy and protracted neuroses, asthenoapathetic depression. The differential diagnosis is facilitated by a careful study of the case history, dynamics and typical schizophrenic changes in the emotional and cognitive functions. Schizoaffective psychoses are differentiated from the manic-depressive one. Appearance of acute imagery delusions, hallucinations, delusions of persecution, phenomena of psychic automatism and catatonic disorders in the structure of an attack, as well as formation and augmentation of personality changes between attacks tilt the diagnosis in favour of schizophrenia.

Febrile schizophrenia has to be differentiated from symptomatic (somatogenic) psychoses. In all its cases, febrile schizophrenia begins with catatonic excitement or substupor with oneiroid cloudiness of consciousness, these symptoms being untypical for symptomatic psychoses, where the above disturbances develop at certain stages of the illness against a background of a severe somatic state, shortly before the lethal outcome. Febrile schizophrenia should be differentiated from the malignant neuroleptic syndrome with hyperthermia as a result of treatment with neuroleptics (particularly haloperidol and other derivatives of butyrophenone), often with large doses, but this syndrome may develop even after small doses in cases of sensitivity to the drug.

Postpartum psychoses, caused by puerperal sepsis, should be differentiated from schizophrenia provoked by pregnancy and delivery. The presence of delirious episodes and catatonic disorders at the height of amentia are the signs in favour of symptomatic psychosis, whereas the development of amentia after catatonic excitement is more typical for schizophrenia. If a psychosis develops 2-3 weeks after the delivery and later within an uneventful puerperal period, the diagnosis of postpartum psychosis is doubtful. Acute polymorphous schizophrenia may have much in common with infectious and

intoxication-induced psychoses. The final diagnosis is made in the process of a long-term supervision.

The differential diagnosis of schizophrenia must be carried out mainly in three directions distinguish from organic disease (trauma, intoxication, infection, atrophic processes, tumors), affective psychosis (in particular, bipolar afective disorder) and the functional psychogenic disorder (neurosis, psychopathy and reactive states).

Peculiarities of childhood-onset schizophrenia

The signs and symptoms of childhood schizophrenia are nearly the same as adultonset schizophrenia. Some of the earliest signs that a young child may develop schizophrenia are lags in language and motor development. Some children engage in activities such as flapping the arms or rocking, and may appear anxious, confused, or disruptive on a regular basis. Children may experience symptoms such as hallucinations, but these are often difficult to differentiate from just normal imagination or child play. It is often difficult for children to describe their hallucinations or delusions, making early-onset schizophrenia especially difficult to diagnose in the earliest stages. The cognitive abilities of children with schizophrenia may also often be lacking, with 20% of patients showing borderline or full intellectual disability.

Very early-onset schizophrenia refers to onset before the age of thirteen. The prodromal phase, which precedes psychotic symptoms, is characterized by deterioration in school performance, social withdrawal, disorganized or unusual behavior, a decreased ability to perform daily activities, a deterioration in self-care skills, bizarre hygiene and eating behaviors, changes in affect, a lack of impulse control, hostility and aggression, and lethargy.

Auditory hallucinations are the most common positive symptom in children. A child's auditory hallucinations may include voices that are conversing with each other or voices that are speaking directly to the children

themselves. Many children with auditory hallucinations believe that if they do not listen to the voices, the voices will harm them or someone else. Tactile and visual hallucinations seem relatively rare. Delusions are reported in more than half of children with schizophrenia, but they are usually less complex than those of adults. Other symptoms of the disorder include problems paying attention, impaired memory and reasoning, speech impairments, inappropriate or flattened expression of emotion, poor social skills, and depressed mood. Such children may laugh at a sad event, make poor eye contact, and show little body language or facial expression. Children with schizophrenia experience difficulty in managing everyday life. They share with their adult counterparts psychotic symptoms (hallucinations, delusions), social withdrawal, flattened emotions, increased risk of suicide and loss of social and personal care skills.

Treatment

The system of therapeutic measures in schizophrenia is conventionally divided into separate stages: controlling therapy is directed at regressing psychotic symptoms; stabilizing therapy is the period of restoration of the previous level of psychological, social and occupational adaptation; preventive (maintenance) therapy (Pic. 8).

Schizophrenics can be treated both as in- and outpatients. The treatment must be complex: with use of both psychoactive drugs and such methods of treatment which are directed at the normalization of the somatic sphere, vascular, neurodynamic and other processes. The treatment is to be provided proceeding from the basic psychopathological syndrome, the clinical form, course and stage of the disease, the patient’s age, his somatoneurotic state. Therapy with psychoactive drugs is the basic method of active (biological) therapy.

Pic. 8. Princepels of schizophrenia threatment[8]

At the mental disorders with prevalence of delusions, hallucinatory manifestations, expressed psychomotor excitement are indicated neuroleptics: risperidonum, quetiapinum, olanzapine, haloperidol, chlorpromazine, clozapine, fluanxol, clopixol, amisulpiride, etc. For schizophrenia and chronic delusions disorders, there is a need prolonged maintenance treatment. In this case, uses long-action neuroleptics: Clopixol-depot, Moditen-depot, Fluanxol-depot, Haloperidol-decanoate, Rispolept Konsta, Xeplion, Zyprexa Relprevv (1 injections are given every 2-4 weeks). Doses are selected individually depending on individual sensitivity. In cases when negative mental disorders are prevalent, antipsychotics with stimulating effect are prescribed, as well as atypical antipsychotics (risperidone, clozapine) (Pic. 9).

[8] sourse: https://www.verywellmind.com/schizophrenia-treatments-2330662

Antipsychotic drug name	Number of prescriptions	Dose range
Clozapine	8	50–700 mg/day
Amisulpiride	7	200–800 mg/day
Haloperidol decanoate	7	75–200 mg/month
Quetiapine	6	50–600 mg/day
Olanzapine	3	5–20 mg/day
Paliperidone	3	3–6 mg/day
Paliperidone depot	3	75–200 mg/month
Aripiprazole	2	10–30 mg/day
Olanzapine depot	2	210–405 mg/month
Risperidone depot	2	50 mg/month
Clotiapine	1	40 mg/day
Flupentixol	1	1 mg/day
Bromperidol decanoate	1	125 mg/month
Zuclopentixol depot	1	200 mg/month
Risperidone	1	4 mg/day

Pic. 9. The most common antipsychotic drugs which are used in schizophrenia treatment[9]

Treatment with neuroleptics may give rise to complications in the form of the neuroleptic syndrome: parkinsonism, akathisia, dystonic phenomena. Parkinsonism is controlled with correctors: acineton, ciclodol, triphen.

In recent years, atypical antipsychotics are used in therapy of schizophrenia: risperidone (Rispolept), ziprasidoni (Zeldox), olanzapine (Zyprexa), azaleptin (Leponeks), amisulpride (Solian), quetiapine (Seroquel), aripipraole (Abilify), paliperidonum (Invega) which, in contrast to typical neuroleptics, affect not only the productive symptoms, but atypical

[9] sourse: https://www.researchgate.net/figure/Antipsychotic-drug-prescriptions-in-schizophrenia-patients_tbl2_269715543

antipsychotics also reduce the negative symptoms as well as they lead to develop various complications very rarely. In this way, atypical antipsychotics have a positive effect on patients' quality of life. In the other hand some of them have a vide range of adverse effects (Pic. 10).

Table — Adverse effects of atypical antipsychotic treatments

Drug	EPS	Hyperprolactinemia	Weight gain	Sedation	Other
Clozapine	Absent	Absent	High frequency	High frequency	Agranulocytosis, seizures, hyperlipidemia, hyperglycemia
Risperidone	Low frequency	Frequent	Low frequency	Infrequent	
Olanzapine	Rare	Rare	High frequency	High frequency	Hyperlipidemia, hyperglycemia
Quetiapine	Absent	Absent	Infrequent	High frequency	
Ziprasidone	Rare	Rare	Absent	Low frequency	QTc interval prolongation
Aripiprazole	Rare	Absent	Rare	Infrequent	

EPS, extrapyramidal symptoms.

Pic. 10. The most common side effects of atypical antipsychotics[10]

Rehabilitation

Rehabilitation includes measures for preservation (in case of its loss – at least, partial restoration) of the patient's social status, including his capacity for work, family relations, an active life in the society. A complex of rehabilitative measures is conducted at all the stages of treatment. It consists of the maximally possible lessening of restrictive measures for the patients; e.g., their staying at some closed department or observation ward, as well as an active involvement of occupational, culture and group therapy, as acute manifestations of the illness are controlled. Therapeutic vacations with a possibility to spend weekends at home should be widely used, or the patients should be transferred to day hospitals. Hospitalization should last as little as possible, because a long-term stay at mental hospital may cause a loss of social

[10] sourse: https://www.psychiatrictimes.com/view/atypical-antipsychotics-treatment-schizophrenia-spectrum-disorders

skills and an ability to live independently, it suppresses the wish to work, it may break family relations, i.e. result in hospitalism.

Very important is to have an adequate job, which should correspond to the patient's state. Even in incomplete remission and maintenance therapy it is necessary that students go on their studies and working people work under relieved conditions (studies at night school, at home, work at home, at medical industrial workshops, work with an incomplete load). Labour restrictions should depend upon the sphere of activity or study.

The primary prophylaxis consists in sanitary-educational work: marrying schizophrenics should be informed about a risk of the disease in their posterity, a necessity to receive genetic consultations, as well as about a risk of falling ill as a result of using hashish or amphetamine. The secondary prophylaxis is aimed at prevention of relapses through maintenance treatment and a healthy way of life. The tertiary prophylaxis includes social-rehabilitative and therapeutic measures at the stage of remission with the purpose to prevent formation of a defect.

Forensic psychiatric examination. Accordingly, the law, the concept of insanity is defined as follows:

1. Insanity means the absence the capacity of correctly control one's own actions and be aware of them.

2. Person, who have been insane during thesocially dangerous unlawful action - could not be conscious of the actual nature and social danger of his actions (inaction) and control them caused by schizophrenia is not held criminally responsible,

3. The court assigns compulsory medical measures for a person who has committed under criminal law a socially dangerous act in the state of insanity

The medical labour examination. Expert is required to detailing examine of previous social-labor behavior of the patient with schizophrenia and the

prognostic value of his clinical condition to address the issue of his disability. All this will make the right expert conclusion. In case of a persistent reducing of capacity to work of the patient with schizophrenia, expert should also determine its degree.

Medical military psychiatric examination. People are suffering from schizophrenia are determined as unfit to military service.

Schizotypical disorder F21

Differences between schizophrenia and schizotypical disorders are far from being always marked. A supposition is made that a patient with schizotypical disorder has some genetical predisposition to schizophrenia, in a favourable social situation he is not decompensated and only subpsychotic manifestations are observed in him. In stress situations the patients may be decompensated, they develop short-term psychotic symptoms, the suicide rate being 10 %. The diagnosis of schizotypical disorder is based on the presence of at least 4 of the following signs in the clinical picture during more than 2 last years:

1) emotional coldness, not always adequate situations of personal contacts;

2) eccentric strange behaviour and appearance;

3) a tendency to avoid social contacts;

4) strange, often metaphysical thoughts which do not conform to subcultural norms;

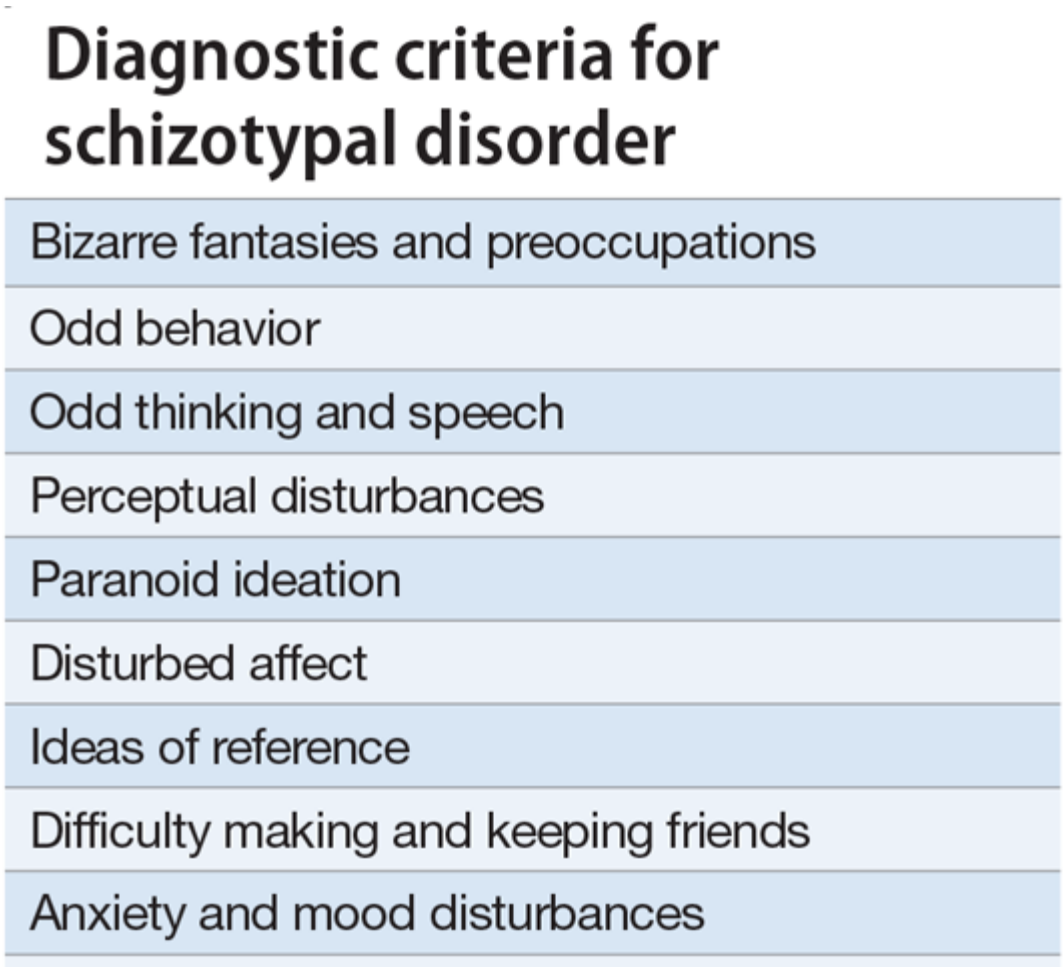
5) mistrustfulness, suspiciousness;

6) annoying reflections on one’s own personality with dysmorphophobic, sexual or aggressive contents;

7) unusual feelings, phenomena of derealization and depersonalization;

8) diffuse thinking which does not reach to the extent of non-continuity;

9) periodical transitory subpsychotic episodes (more frequently with illusions, hallucinations, delusion-like ideas) (Pic. 11).



Pic. 11. Main diagnostic criteria for schizotypal disorder[11]

The differential diagnosis of schizotypical disorders with schizophrenia and schizoid psychopathy is extremely difficult, therefore ICD-10 adequately does not recommend to widely use this item of the classification.

[11] sourse: https://www.mdedge.com/psychiatry/article/252216/schizophrenia-other-psychotic-disorders/differentiating-pediatric

Chronic delirious disorders F22

These are disorders with dominating, encapsulated and systematized delusions without any marked change in the personality. Their rate is 25-30 cases per 100,000 of population. The disease begins at a middle age, oftener at 30-40 years. The patients seldom take medical advice, more frequently they are sent by their relatives.

Often the onset of the disease is triggered by an unfavourable psychological situation. The patients may express delusions with various contents. The system of the delusions may have different degrees of their complex character. The illness is notable for absence of formal disorders of thinking, though delusions are often expounded loquaciously, thoroughly and whimsically. The patients may be aggressive and dangerous for other people. Suicidal tendencies are not rare. There is no criticism to delusions. Besides the acts and opinions reflecting the contents of delusions, the patients' behaviour does not differ from the normal one. Emotional feelings correspond to the contents of delusions, which most frequently are of a pure personal character. Delusions may be of the kinds described below.

Erotomanic delusions, delusions of love charm. The patients are convinced that some person with a high social status (some chief, celebrity, businessman, etc.) is in love with them, though often they are not even acquainted with him. The feeling is expressed in spiritual relationship and romantic love, rather than sexual attractiveness. Often the patients try to establish a contact with the object of their delusions. These disorders are more typical for women. Delusions of grandeur. The patients are sure that they have exceptional abilities and talent which are not recognized by other people. They declare that they have made some discovery important for the mankind, that they maintain special relations with celebrities or deities, often becoming leaders of religious sects. In delusions of jealousy (Othello's syndrome) the patients would look for adultery, spy on their spouses, often manifest

aggression with respect to their spouses or lovers. Delusions of persecution are often accompanied by litigious behaviour or aggressiveness towards the people who, as the patient thinks, harm him. Patients with hypochondriacal delusions are sure that they give off a bad smell, that the functioning of their internal organs is affected. They would visit various internists asking for help.

The psychosis lasts at least 3 months, or the whole life in some cases. The etiology of the illness is unknown; suppositions about its biological origin have been made. As a rule, the treatment is symptomatic, with administration of antipsychotic drugs and antidepressants. Suicidal and aggressive tendencies in the patients are indications for hospitalization.

Acute and transitory psychotic disorders F23

The onset of psychotic states is acute. The clinical picture is characterized by delusions, hallucinations, excitement, non-continuous thinking. The morbid state lasts less than 3 month. Acute and transitory psychotic disorders may end with a practically full recovery, a complete restoration of the capacity for work and socialization.

Primary polymorphic psychotic episode

A heterogeneous group of disorders characterized by an acute manifestation of psychotic symptoms - delusion, hallucinations and other perceptive disturbances, as well as a significant violation of general behavior. The psychotic state occurs for the first time in life and is characterized by an acute onset. Its appearance may be associated with acute stress, but often such psychoses begin endogenously and are determined by internal matters. The period from the onset of the first signs to the acute psychotic symptoms is less than 2 weeks. The clinical signs don’t meet the criteria that are typical for other psychoses (affective, organic, psychoactive substances induced, etc.). There are a lot of unstable psychotic symptoms that succeed each other or

coexist simultaneously (delusion, hallucinations, impaired thinking, psychomotor agitation, and others). Currently, this diagnosis is the most common during the first hospitalization of a patient with psychotic signs in a mental hospital. The frequency of diagnosis ranges from 4 to 6 cases per 1000 population per year.

Clinical signs

Usually the first psychotic signs are anxiety, insomnia, and confusion. Within two weeks, acute delusion ideas appear. Their structure is changing rapidly. The ideas of relationships, meaning, persecution, that everything around is specially staged as in a theater, false recognition and the delusion of a double (Capgras syndrome) arise against the background of a mythological symbolic misinterpretation of reality. Usually the patient finds himself in the center of the events.

	ICD-10 acute and transient psychotic disorders	DSM-5 brief psychotic disorder
Symptoms	Polymorphic, schizophrenic and predominantly delusional	Delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour
Onset	Acute onset (≤ 2 weeks)	Not specified
Duration	1 or 3 months	1 day to less than 1 month
Specify if:	with 'acute stress' within 2 weeks	with 'marked stressor' or onset 'within 4 weeks post-partum'
Exclusion	Substance-induced psychosis, organic disorders, manic and depressive episodes	Affective disorder, substance-induced psychosis, organic disorders, psychotic disorder not otherwise specified

Pic. 12. Diagnostic criteria of primary polymorphic psychotic episode[12]

Hallucinations, auditory complete and pseudohallucinations are not stable and quickly replace each other. Amnesia is absent, although the patient

[12] sourse: https://www.cambridge.org/core/journals/bjpsych-advances/article/acute-and-transient-psychoses-clinical-and-nosological-issues/BF0C03CD18DEEEE0D75C3BE555564307

does not immediately talk about the experience. He is gradually recalling it. The insight is absent. Some patients may have schizophrenic signs. The duration of the psychotic state is less than 3 months. If psychosis lasts over 3 months, the diagnosis should be reconsidered for another, considering the clinical signs and the genesis of mental disorder (including schizophrenia) (Pic. 12).

Prognosis

Recovery usually occurs within 2 or 3 months, sometimes within weeks. But in some patients one year after the development of the primary psychotic episode it's transformed into an affective disorder (approximately 10%), schizophrenia (approximately 25%), or have repeated psychotic episodes (approximately 10%). That is, acute psychotic attacks often turn out to be the initial stage in the development of various mental disorders.

Treatment

Treatment should include pharmacotherapy and psychosocial adaptation - psychotherapy, psychoeducation. Drug treatment should be started as soon as possible. Psychomotor agitation should be interrupted within the first 48 hours. In the acute period antipsychotic therapy is prescribed. Its purpose is to stop acute psychotic symptoms. After that the supportive treatment is prescribed for a long time to prevent repeated psychotic relapse. Psychotherapeutic intervention is mandatory. At the first stages this is mainly psychoeducation, conversation with the patient's relatives. It's aimed at changing the patient's maladaptive behavioral patterns, and work with patients' families to improve the social adaptation.

The criteria for the quality of treatment are clinical – the degree of psychopathological signs' reduction for at least 6 months and the mental state stability for 6 months; social - the degree of autonomous social functioning ability.

A. ***Acute psychotic disorders:*** There are disorders which have symptoms (e.g. delusions, hallucinations and disorganization symptoms) similar to schizophrenia, however do not meet the duration criterion. These disorders have been classified separately in DSM-5 and ICD-11. These disorders frequently are preceded by a **stressor** (stressful life event), have an acute onset and often resolve completely. These disorders may also be precipitated by **fever.**

In ICD-11, if the symptoms (delusions, hallucinations, disorganization) are present for less than one month, a diagnosis of **acute and transient psychotic disorder** is made.

In DSM-5, if symptoms (delusions, hallucinations, disorganization) are present for less than one month, a diagnosis **of brief psychotic disorder** is made; and if symptoms last between **1-6 months,** a diagnosis of **schizophreniform disorder** is made.

Treatment: Antipsychotics and benzodiazepines are used for the treatment of acute psychotic disorders.

B. ***Schizoaffective disorder:*** Schizoaffective disorder has features of bothb schizophrenia and mood disorders concurrently. Depending on whether manic episode or depressive episode is present along with schizophrenia symptoms, there are two subtypes:

- ***Schizoaffective disorder (Bipolar type or manic type):*** With manic symptoms
- ***Schizoaffective disorder (Depressive type):*** With depressive symptoms. ***Treatment:*** It involves combination of mood stabilizers, antipsychotics and antidepressants depending on the presentation. In schizoaffective (manic type episodes) a combination of antipsychotics and mood stabilizer is commonly used. In schizoaffective (depressive type episodes) a combination of antipsychotics, and antidepressants is often used.

C. ***Delusional disorder:*** These disorders are characterized by development of either a **single delusion** or a **set of related delusions,** which are usually persistent and sometimes are life long. Other psychotic symptoms like hallucinations, disorganization, negative symptoms are usually absent. If hallucinations occur they are for a very short duration, presence of frequent hallucinations goes against the diagnosis of delusional disorder. The following are the risk factors for development of delusional disorders:

a. Advanced age

b. Social isolation

c. Sensory impairment or isolation (e.g. auditory or visual disturbances)

d. Family history of delusional disorder

e. Recent immigration

f. Certain personality features, like excessive interpersonal sensitivity (even trivial interpersonal problems cause lot of negative emotions)

The following are the types of delusional disorder:

- ***Persecutory type:*** Delusion of persecution.
- ***Jealous type:*** Delusion of infidelity.
- ***Erotomanic type:*** Delusion of love.
- ***Somatic type:*** Patient may have delusion that he is infested by parasites **(delusional parasitosis),** that he has misshaped body parts (delusion of dysmorphophobia) or that his body has a foul odor **(delusion of halitosis).**
- ***Grandiose type:*** Delusion of grandiosity.
- ***Unspecified type:*** In patients where the above- mentioned categories are not applicable. Delusion of misidentification is an example of unspecified type. Delusion of misidentification can be of many types like:

Capgras syndrome: Patient believes that a familiar person has been replaced by an impostor. For example, a patient believed that his wife has been replaced by a stranger who looks exactly like his wife.

- ***Fregoli syndrome:*** Patient believes that a familiar persons are can change his physical appearance and disguise as a stranger, and that he can take multiple different appearances. For example, a patient saw a beggar, and claimed that his brother is following him in the guise of the beggar.
- ***Syndrome of intermetamorphosis:*** Patient believes that people can undergo changes in physical and psychological identity and become a different person altogether.
- ***Syndrome of subjective doubles:*** Patient believes that he has many doubles who are living life of their own.

The patients of delusional disorder are usually able to **function normally in domains which are unaffected by the delusion.** For example, a patient with delusion of infidelity may incessantly doubt his wife and fight with her, however he may be perfectly normal at work place. ***Treatment:*** Antipsychotics are the drug of choice.

Shared psychotic disorders (or induced delusional disorder): This disorder is characterized by spread of delusions from one person to another. The individual who has the delusion (the primary case) is typically the influential member of close relationship with a more suggestible person (the secondary case) who also develops the delusion. When two people are involved, the term **"folie a deux"** is used. Occasionally more than two individuals are involved (known as **folie a trois, folie a quatre,** etc.).

Attenuated psychosis syndrome: Attenuated Psychosis Syndrome has been included in DSM-5 as a condition that needs further study before it can be included as an official diagnosis. The proposed criterion for this condition include, the following:

1. At least one of the following symptoms is present in attenuated (less severe and transient) form, with relatively intact insight,—a. delusions b. hallucinations, c.

Disorganized speech . [Here attenuated means that, for example, if delusions are present patient may appear suspicious at times (transient) but not always and he may be made to question his beliefs (less severe, not fixed)]. Symptom(s) must have been present at least once per week for the past month.

Symptom(s) must have begun or worsened in the past year.

Symptom(s) is sufficiently distressing and disabling to the individual to warrant clinical attention.

Affective disorders

Affective disorders in the form of mania and melancholia were known in ancient times. They were vividly described by Hippocrates and regarded as separate diseases. On the basis of clinical observations and researches, Kraepelin (1896) concluded that maniac and melancholic attacks without a progressive course are the same disease termed by him asmanic-depressive psychosis. Still the modern psychiatry uses such designations as “affective psychosis”, “phase psychosis”.

Classification of affective disorders by ICD-10

F3 Affective disorders (mood disturbances)

F30 Maniac episodes

F31 Bipolar affective disorder **(BAD)**

F32 Depressive episodes

F33 Recurrent depressive disorder

F34 Chronic (affective) mood disturbances, including cyclothymia (F34.0) and dysthymia (F34.1)

F38 Other (affective) mood disturbances

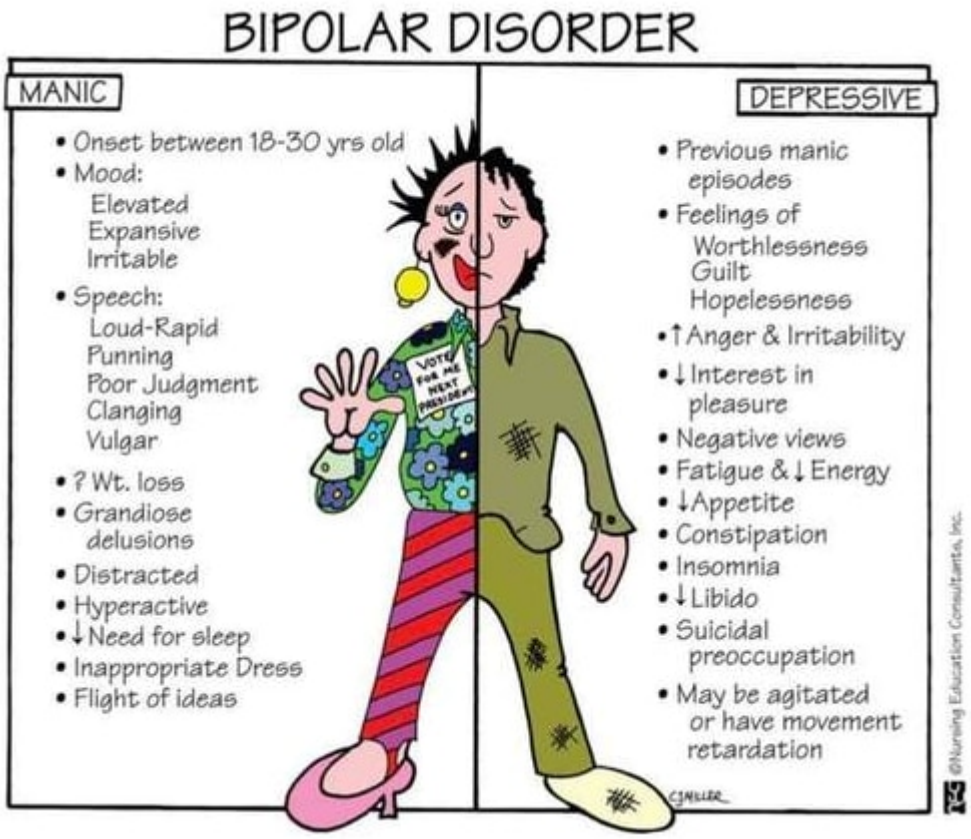
F39 Unspecified (affective) mood disturbances

Bipolar affective disorder

A bipolar affective disorder (BAD) is an endogenous disease characterized by alternation of outwardly contradictory states or phases, maniac and depressive, with presence of a light interval between them (the bipolar course). In other cases, the illness may manifest itself only by its maniac or depressive phases (the monopolar course). In any type of the course there is no progression and destruction of the personality. Bipolar affective psychosis is characterized by a seasonal prevalence in the appearance of phases (oftener in spring or autumn), the number of phases in different patients is not the same, the phases last from 3 to 6 months. The rate of bipolar affective psychosis in the population ranges within 0.07-7 %, depressive forms with a monopolar course being prevalent. Females fall ill 3-4 times more frequently than males, but the bipolar course of the disease prevails in males. Bipolar affective psychosis oftener begins at a mature age of 35-40 years, the onset of the bipolar disorder being somewhat earlier (20-30 years).

Clinically, manic-depressive psychosis manifests itself by affective, effectorvolitional disturbances (which at maniac and depressive phases are of the opposite character) and those of understanding, as well as by somatoautonomic symptoms demonstrating, as V.P. Protopopov showed, a higher tonus of the sympathetic autonomic nervous system (Protopopov's triad: spastic colitis, mydriasis, tachycardia) (Pic. 13).

The maniac phase (F30) manifests itself by three clinical signs: a) a disturbance in the emotional sphere: an increase of the vital emotion of joy (euphoria); b) a disturbance in the intellectual activity: an acceleration of the rate of associations, in severe cases reaching to "galloping ideas"; c) effector-volitional disturbances: a general increase of purposeful activity with a reduced concentration and a higher attractiveness of attention.



Pic. 13. Clinical signs of BAD[13]

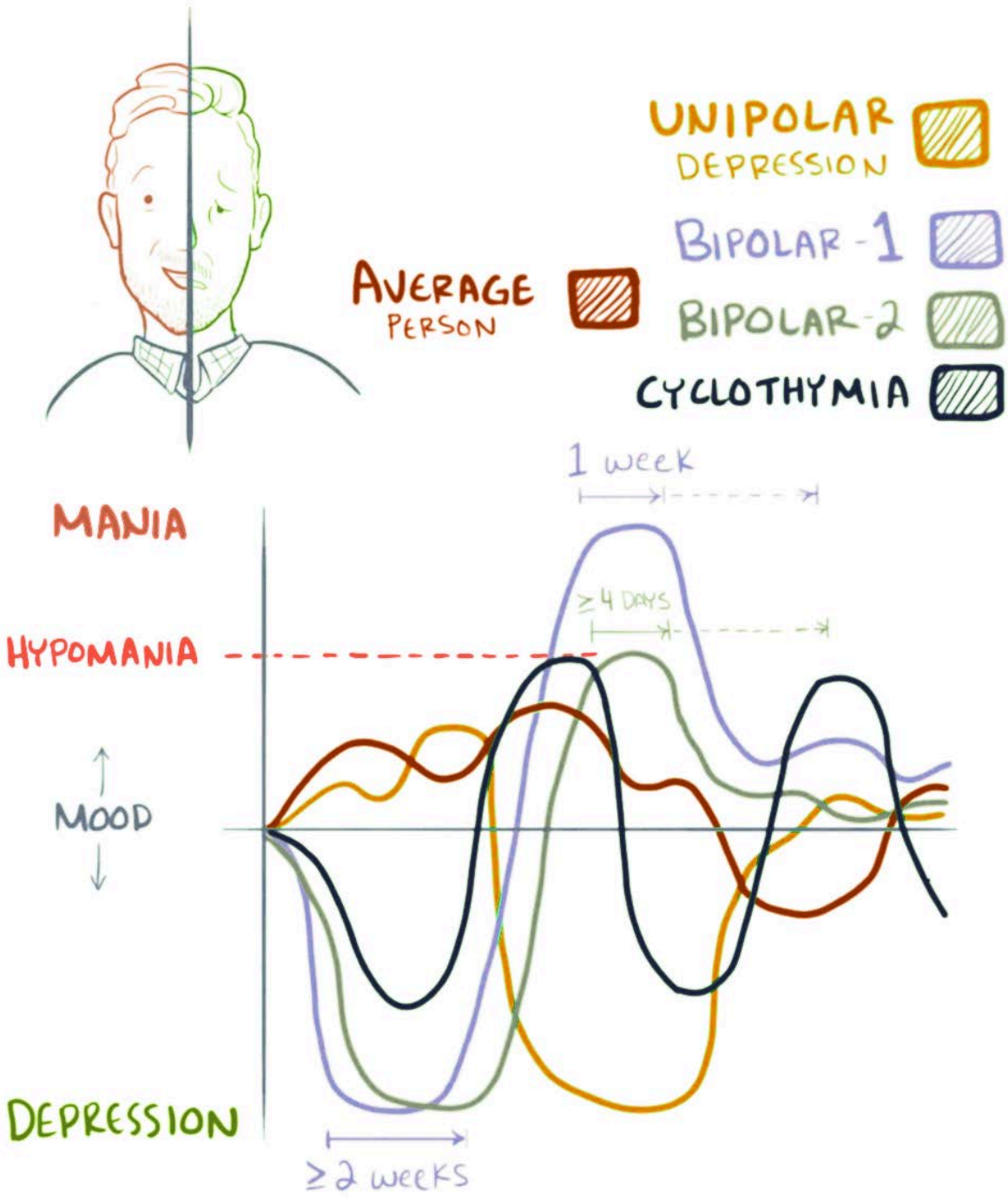
Clinically, maniac states manifest themselves by a higher, cheerful mood, which as a rule is displayed without any external apparent cause. The positive emotions of joy, happiness, general well-being are augmented, i.e. euphoria develops. The patients' environment is perceived by them through a prism of positive emotions. The patient sees it in attractive, delightful, charming colours, "as if through rose-coloured spectacles". Reactive emotions are not deep and unstable. The spirits remain high even when the patient receives some bad news or has misfortunes. The patient believes that everybody treats him well; he is pleasant and interesting for everybody. He is sociable, talkative, easily strikes up new acquaintances, visits his friends and relatives, and continuously amuses himself. The rate of his thinking is accelerated. The patient would talk much without a stop, sing songs. In severe maniac states the rate of thinking reaches

[13] sourse: https://www.indiatoday.in/information/story/here-s-all-you-need-to-know-about-bipolar-disorder-from-the-expert-1732981-2020-10-19

to “galloping ideas”. The speech is usually accompanied by active expressive mimics and gestures. The patients would overestimate their abilities and capacities, sometimes saying delusion-like ideas of grandeur, invention, one’s own superiority and exclusiveness.

The patients constantly demonstrate an urge to act (psychomotor excitement). Their attention is not stable, they are extremely distractible. Showing a higher interest in activities, they would undertake to do some work, drop it, being rapidly distracted and always in a hurry somewhere. Instincts in the patients at the maniac state are augmented. A higher erotism manifests itself by coquetry increase, mannered smart clothes and decorations, love-letters and search for amorous adventures. Augmentation of the food instinct manifests itself by voracity. The patients would much and irregularly eat, but do not gain any weight. Very typical for the patients is their indefatigability: being all the time in movements and actions, they do not display any signs of tiredness and weariness in spite of insufficient sleep for weeks and months. Such patients would sleep 2-3 hours a day. As a result of high spirits, reduced criticism and psychomotor excitement, the patient often gives hollow promises, undertakes higher engagements, lightly appropriates somebody else’s property, commits embezzlements in order to satisfy his needs and implement “far-reaching plans”, establishes irregular sexual relations. Criticism to their state is absent; the patients do not regard themselves as ill and refuse treatment.

Disturbances of perception are not deep and manifest themselves in the form of visual and auditory illusions, pareidoliae and metamorphopsiae (a symptom of “false recognition”). Memory becomes extremely retentive (hypermnesia), the patients recollect the pettiest details from their personal and social life, the books they have read and the films they have seen. The maniac phase of bipolar affective psychosis lasts 3-4 months.



Pic. 14. Differernces in levels of clinical signs in BAD type 1, type 2, unipolar depression and cylothymia [14]

At the maniac phase of bipolar affective psychosis, somatic and autonomic disturbances are observed; they are caused by a higher tonus of the sympathetic

[14] sourse: https://commons.wikimedia.org/wiki/File:Bipolar_disorder.webm

section of the autonomic nervous system (Protopopov's triad): tachycardia, higher blood pressure, loss of weight, a disturbance of menstrual cycle in women, insomnia. The patients do not make any complaints about their health, feeling cheerfulness and great strength. By the degree of expression of psychopathological symptoms the following mania are distinguished: mild maniac states (hypomania), mania without psychotic symptoms, mania with psychotic symptoms (Pic. 14).

Hypomania (F 30.0) is a mild degree of maniac state characterized by slightly high spirits, increased energy and activity of the patient, a feeling of full well-being, physical and mental productivity. The above peculiarities are observed not less than several days.

Mania without psychotic symptoms (F 30.1) is characterized by markedly high spirits, a significant increase of activity with a resultant violation of occupational activity and relations with other people; this state requires hospitalization. An attack lasts not less than one week.

Mania with psychotic symptoms (F 30.2) is accompanied by delusions of overestimation, grandeur and persecution, hallucinations, galloping ideas, psychomotor excitement. An attack lasts at least two weeks.

The depressive phase (F32) of manic-depressive psychosis manifests itself by a triad of disorders:

- a sharp strengthening of negative vital emotions (melancholia, grief, sometimes with a shade of fear, anxiety);
- a slower rate of thinking, its scanty contents, up to monoideism, development of delusions of being sinful and self-condemnation;
- a sharp oppression of the effector-volitional activity, a deep inhibition (up to stupor), riveted attention.

The central place in the clinical picture of the depressive phase is taken by a vital affect of melancholia, grief, sorrow. A morbid depression is

particularly augmented in the morning up to melancholia with despondency. The patients would complain of poignant melancholia with squeezing pains in the heart region, substernal heaviness, “precardiac melancholia”. It is impossible to distract the patient from this state and cheer up, under the influence of positive external stimulants the mood remains as it was before. The patients are inhibited (up to depressive stupor), not mobile and spend all the time in similar mournful postures. They would answer questions with a low monotonous voice, showing no interest in talks, express ideas of self-humiliation, selfcondemnation, being sinful, in severe cases these ideas become delusions. They regard themselves as criminals, wretched and useless people, some “worthless stuff for the society and family”, a source of various evils and troubles for other people nearby. The patients interpret their previous behavior in a delirious way, assigning themselves the most negative part. It is not in rare cases that the patients refuse to sit at a common table, to shake their interlocutor’s hand, to lie in bed, motivating it by the fact that they are not worth of it. As a rule, suicidal thoughts and attempts to realize them are observed. The patients do not make any plans for future as they do not see any prospects in it, they do not express any wishes but to die, but the latter may be concealed and dissimulated (Pic. 15).

The patients’ attention is concentrated on their own feelings, external stimulants do not cause any adequate responses. The instincts are suppressed (anorexia up to absolute rejection to eat, reduced libido, attempts of self-injuring and suicide). The patients do not feel the taste of their food, satiation, feeling of and saturation with sleep. Against a background of an increased depression and despair they may develop psychomotor excitement with suicidal attempts, a “melancholic explosion”.

Pic. 15. Main depression symptoms[15]

The patient would hit his head against a wall, scratch his face, bite his arms, etc. Suicidal attempts may be both impulsive at the moment of a melancholic explosion and more purposeful with preparation for a suicide.

[15] Sourse: https://believeperform.com/product/signs-and-symptoms-of-depression-2/

Sometimes the patients commit an “expanded suicide”, killing their children, old parents, and then themselves. Such actions result from delusions of having no prospects in the patient’s existence and of torments threatening his relatives for his own sins. Suicidal tendencies are more frequently realized at a period of reduced motor inhibition and constraint with preservation of melancholic feelings. Depressive patients need constant observation and control over their actions.

Along with augmentation of negative emotions there may be a loss of feelings when the patients say that they do not feel typical human emotions, they have become impassive automatons, insensitive to their relatives’ feelings, and therefore poignantly suffer from their own hard-heartedness, a symptom of “morbid mental anaesthesia” (*anaesthesia psychical dolorosa*); cenesthopathies and illusions are common. Depression is often characterized by such a symptom as distorted perception of time and space, as well as psychosensory disorders with resultant feelings of depersonalization and derealization.

Like in the maniac phase, the somatoautonomic symptoms are caused by a higher tonus of the sympathetic nervous system: a loss of weight, persistent insomnia, the sleep does not refresh and in the morning the patients feel much worse than in the evening, the blood pressure is increased, lacrimation is difficult, the patients would not weep

(grief, melancholia with “dry” eyes), they reveal dryness and bitter taste in the mouth, amenorrhoea in women.

Typically observed is **Protopopov’s triad:**

-mydriasis,

-tachycardia,

-spastic colitis.

The depressive phase often lasts more than 6-8 months. Depressive states occur 6-8 times more frequently than maniac ones. By the degree of their

symptom expressiveness, mild, moderate and severe depressions with nonpsychotic and psychotic symptoms are isolated.

Mild depressive episode F 32.0

Mild depressive episode (F 32.0) is characterized by low spirits during the larger part of the day, a reduced interest in the surroundings and a feeling of satisfaction, a higher fatiguability, tearfulness. The patients regard their state as a morbid one, but take medical advice not in all the cases. Mild depressive episode occurs in two variants: a) without any somatic symptoms (F32.00); b) with somatic symptoms (F32.01). The somatic symptoms are as follows:

- insomnia, wakening up 2 and more hours earlier than usual, or sleepiness;
- fatiguability, a loss of strength;
- a better or worse appetite, a loss of body weight or its increase without any relation to a diet;
- a reduced libido;
- constipations, dryness in the mouth;
- headache and pains in different areas of the body;
- complaints about the functioning of the cardiovascular, gastrointestinal, urogenital and locomotor systems.

Moderate depressive episode F32.1

Moderate depressive episode (F32.1) manifests itself by more expressed depressive symptoms.

Severe depressive episode

Severe depressive episode without any psychotic symptoms (F32.2) is characterized by an absolute violation of vital activity resulting from a severe depressive state, abrupt low spirits with a feeling of vital melancholia and a tint of some physical suffering (precardiac melancholia, expressed psychomotor inhibition). The patients would express ideas of being sinful, have suicidal thoughts and commit suicidal acts.

In ***severe depressive episode with psychotic symptoms F32.3,*** there are signs of severe depression whose structure includes delusions of being sinful, reference, persecution, as well as hypochondriacal ones. Auditory, visual, tactile and olfactory hallucinations may be observed. The patient would hear funeral singing, feel a putrid smell of his "decomposing body".

Depending upon the prevalence of some or other symptoms in the clinical picture of depression, the following variants of the latter are isolated: anxious-agitated, hypochondriacal, masked. Along with melancholia, the clinical picture of anxiousagitated depression includes anxious excitement. The patients would rush about, moan, hit their head, wring their hands, fret. In such states they would often commit suicidal acts, as their motor anxiety facilitates realization of suicidal intentions.

Hypochondriacal depression is characterized by numerous unpleasant sensations in different parts of the body. They do not have any definite localization and are not comparable with painful sensations in organic sufferings. The patients would feel some pressing, boring, arching pain. It seems to them that their nerves have swollen, the intestines have dried up, the stomach is reducing in size, the liver has been corroded. The patients' complaints are peculiar, diffuse and cannot be grouped within the framework of some concrete somatic diseases. But unpleasant sensations are not hallucinations by their nature. They are not interpreted in a delirious way like in schizophrenics.

Masked and latent depression

In masked depression, expression of the emotional component is insignificant, while motor, autonomic and sensitive disturbances prevail as depression equivalents.

The patients would complain of general malaise, a loss of appetite, pains in the spinal column, stomach and intestines, insomnia and a reduced capacity for work. The pains are tormenting, and it makes the patients take medical advice. The **"masks"** may be in the form of pathocharacterological disorders

(dipsomania, use of narcotics), asocial behaviour (impulsiveness, easy coming into conflicts, outbursts of aggression), hysterical reactions.

Diagnosing "latent depressions" it is necessary to take into account their following signs:

Presence of subdepressive states which are especially expressed in the morning.

Polymorphism, vagueness, abundance of persistent somatoautonomic complaints which cannot be grouped within the limits of some particular disease.

Disruption of vital functions (sleep, appetite, menses, potency, loss of weight).

Periodicity of the disorders, spontaneousness in their appearance.

Their seasonal character, mostly in spring and autumn.

Application of different methods of examination does not reveal any definite somatic disease.

Somatic therapy does not produce any effect.

The patient would be treated for a long period of time, persistently and without any result by doctors with different specializations, and despite failures would persist in visiting the doctors.

Along with typical maniacal and depressive attacks in bipolar affective psychosis, mixed states can be observed too and are characterized by coexistence of maniacal and depressive symptoms during an attack of the illness in the same patient. Several types of mixed states are isolated:

- depression with motor excitement and intellectual inhibition;
- maniacal stupor with motor inhibition;
- nonproductive mania: high spirits are combined with reduced psychic activity.

Mixed states can be separate phases of the illness, but more frequently are observed as a short-term episode between two opposite phases, during a transition from one of them to another.

Mild forms of bipolar affective psychosis are described under the name of **cyclothymia F34.0** and most often pass in the form of slightly expressed depressions with a relatively short-term course.

The variants of uniphasic affective psychosis in the form of sullen-irritable mood, which gradually develops, lasts about one year and gradually passes away, are termed dysthymia F34.1.

Age-specific peculiarities of affective pathology

Children of the preschool age do not reveal any clinically definite maniac endogenous or depressive phases, therefore they are partially assessed by the relatives and doctors in an inadequate way. Leading for children are somatic and autonomic symptoms. Thus, in depressions children reveal disturbances of sleep and appetite, listlessness, sluggishness, capriciousness, lost of interest in toys. Younger pupils study worse and develop inhibition. The child becomes shy and sullen, he looks pale and tired. No somatic pathology is revealed. Maniac states manifest themselves by excessive activity and behavioral disorders. The child is garrulous, constantly laughs, his face is hyperaemic, the eyes sparkle. Maniac states are more noticeable than depressive ones.

In teenagers, clinical manifestations of the disease acquire its typical signs, but along with the feeling of melancholia, sadness and depression adolescents develop a sullen dysphoric mood, conflict relations with their relatives and people of the same age, thoughts about their own inferiority, suicidal acts. It is not in rare cases that maniac states in adolescents are expressed through psychopathy-like forms of behavior: violations of school discipline, alcoholization, offences, aggression. These disorders mask the phase of bipolar affective psychosis.

The involutional age is characterized by prevalence of anxious-agitated or hypochondriacal depressions with a protracted course. Maniac states occur less frequently and are notable for complacency, fussiness and unproductiveness.

The course of bipolar affective psychosis may be various. Sometimes there is a regular alternation of the maniac and depressive phases separated by light gaps without any morbid symptoms (the bipolar course). In other cases one phase turns into the other one, and the latter is followed by a light gap. At last, instead of the consecutive alternation of the phases, any of them may be repeated after a light gap (the monopolar recurrent course). The prognosis in each particular attack is favourable, no changes in the personality take place and the patient returns to his previous labour.

Bipolar affective psychosis should be differentiated from the schizoaffective form of schizophrenia. Unlike manic-depressive psychosis, schizophrenia is typically characterized by paralogic and splitting thinking, autism, emotional impoverishment, personality changes after the return from psychosis.

In somatogenic, infectious and organic psychoses the patients are asthenic, easily get impoverished, often have syndromes of disturbances of consciousness and intellectual-mnestic disorders. Unlike endogenous depression, reactive one develops after psychotraumatizing factors, they find their reflection in the patients' sufferings. Endogenous depression is often seasonal, during its attacks there are daily fluctuations in the mood (the depression is more expressed in the morning hours, by the evening the mood becomes better). Presence of the seasonal character in its appearance, daily fluctuations, symptoms of sympathicotonia (Protopopov's triad), absence of any personality changes even after numerous attacks of the illness testify in favour of manic-depressive psychosis.

Etiology and pathogenesis of affective pathology

A bipolar affective psychosis belongs to diseases of unclear etiology, where hereditary aggravation is a predisposing factor. Thus, in case of one parent having the bipolar form of the disease, the child's risk to fall ill is 27 %,

with two ill parents the risk of developing affective disorders in their children increases up to 50-70 %.

V.P. Protopopov and his disciples' works are devoted to the study of the pathogenesis of bipolar affective psychosis. Protopopov V.P. attributed the mechanisms of the disease development to some pathology in the thalamohypothalamic areas of the diencephalon, where the central autonomic apparatus playing an important part in manifestations of affective life is located. He believed that the most typical for bipolar affective psychosis is a complex of symptoms united under the name of the sympathicotonic syndrome: tachycardia, dilatation of the pupils, spastic constipations, a loss of weight, dryness of the skin, an increase of blood pressure, a high level of sugar level in blood. He related all these changes to the central mechanisms and put down to a higher excitability of the hypothalamic region.

A significant part in the pathogenesis of bipolar affective psychosis is played by synaptic transmission disturbances in the system of neurons of the hypothalamus and other basal areas of the brain caused by a change in the neuromediated activity (noradrenaline, serotonin). Thus, the catecholamine hypothesis proceeds from the fact, that depression is connected with a functional deficit of one or several catecholamine neurotransmitters on certain synapses, while mania is connected with the functional abundance of these amines.

On the whole, the ***prognosis*** in **a bipolar affective psychosis belongs** is favourable. But in cases of a long-term course with phases having some psychotic symptoms, difficulties of the social character develop and the prognosis becomes worse. Assessing the prognosis, one should take into consideration the age of the illness onset and clinical manifestations of the first phase. Recovery is hardly probable with the bipolar type of the illness. If monopolar depressions begin early, the rate of phases at an old age reduces. With an early onset of monopolar mania, an absolute recovery may take place at the age of 50-60. With respect to the general course of bipolar affective

psychosis, it is impossible to make any absolutely reliable predictions for every case. Patients suffering bipolar affective psychosis often develop somatic diseases, such as hypertensive disease and diabetes, which worsen the prognosis too.

Treatment and prophylaxis

A bipolar affective psychosis is treated using biological therapy combined with psychotherapy and social therapy. As a rule, the treatment should be provided under inpatient conditions in view of suicidal tendencies of depressive patients or inadequate behavior of maniac ones. Prior to his admittance to mental hospital, it is necessary to provide the patient, his relatives or other people with continuous care and supervision. They should be explained a possibility of attempting suicide.

Antidepressants

Antidepressants are the treatment of choice for a vast majority of depressive episodes. Some of the commonly used antidepressants with their usual range of therapeutic dosage:

Generic Name	Usual Therapeutic Range (mg/day)
Agomelatin	**25-50**
Amitriptyline	**75-300**
Amoxapine	**150-300**
Bupropion	**150-450**

Citalopram	**10-40**
Clomipramine	**75-250**
Doxepine	**75-300**
Dosulepin/Dotheipin	**75-150**
Duloxetine	**30-120**
Escitalopram	**10-20**
Fluoxetine	**20-60**
Fluvoxamine	**50-200**
Imipramine	**75-300**
Lofepramine	**140-210**
Mianserin	**30-120**
Mirtazapine	**15-45**
Moclobemide	**300-600**
Nortriptyline	**150-300**
Paroxetine	**10-40**
Reboxetine	**10-1**
Sertraline	**50-200**
Tianeptin	**37.5**
Trazodone	**300-600**
Venlafaxine	**75-375**

An individualised choice has to be made in each patient, keeping these various factors in mind.

It should be remembered that it may take up to 3 weeks before any appreciable response may be noticed. Before stopping or changing a drug, the particular drug should be given in a therapeutically adequate dose for at least 6 weeks.

For the first, uncomplicated, depressive episode, the patient should receive full therapeutic dose of the chosen antidepressant for a period of 6-9 months, after achieving full remission. It is wise to taper the antidepressant medication, when the treatment is to be stopped after the continuation phase.

Electroconvulsive Therapy (ECT)

The indications for ECT in depression include:

Severe depression with suicidal risk.

Severe depression with stupor, severe psychomotor retardation, or somatic syndrome.

Severe treatment refractory depression.

Delusional depression (psychotic features).

Presence of significant antidepressant side effects or intolerance to drugs.

Severe depression with suicidal risk is the first and foremost indication for use of ECT. The prompt use of ECT can be life-saving in such a situation.

The response is usually rapid, resulting in a marked improvement. In most clinical situations, usually 6-8 ECTs are needed, given three times a week. When six ECTs are administered, the usual pattern is three ECTs in the first week, two in the second week and one in the third week.

However, improvement is not sustained after stopping the ECTs. Therefore, antidepressants are often needed along with ECTs, in order to maintain the improvement achieved. The safety of the ECT procedure has now been wellestablished.

ECT can also be used for acute manic excitement, if it is not adequately responding to anti psychotics and mood stabilizers.

Lithium (Li)

Lithium has traditionally been the drug of choice for the treatment of manic episode (acute phase) as well as for prevention of further episodes in bipolar mood disorder. It has also been used in treatment of depression with less success.

There is usually a 1-2 week lag period before any appreciable response is observed. So, for treatment of acute manic episode, antipsychotics are usually administered along with lithium, in order to provide cover for the first few weeks.

The usual therapeutic dose range is 900-1500 mg of lithium carbonate per day. Lithium treatment needs to be closely monitored by repeated blood levels, as the difference between the therapeutic and lethal blood levels is not very wide (narrow therapeutic index).

Therapeutic blood lithium = 0.8-1.2 mEq/L

Prophylactic blood lithium = 0.6-1.2 mEq/L

A blood lithium level of >2.0 mEq/L is often associated with toxicity, while a level of more than 2.5-3.0 mEq/L may be lethal.

Although lithium is indicated for therapeutic use in all manic episodes, the preventive use is best in usually those patients with bipolar disorder, in whom the frequency of episodes is 1-3 per year or 2-5 per two years.

The common acute toxic symptoms of lithium are neurological while the common chronic side-effects are nephrological and endocrinal (usually hypothyroidism).

The important investigations before starting lithium therapy include a complete general physical examination, full blood counts, ECG, urine routine examination (with/without 24-hour urine volume), renal function tests and thyroid function tests.

Antipsychotics

Antipsychotics are an important adjunct in the treatment of mood disorder. The commonly used drugs include risperidone, olanzapine, quetiapine, haloperidol, and aripiprazole. It is customary to use the atypical antipsychotics first, before considering the older typical antipsychotics.

Some of the indications include:

Acute manic episode

Along with mood stabilisers for the first few weeks, before the effect of mood stabilizers becomes apparent.

Where mood stabilisers are not effective, not indicated, or have signifi cant side effects.

Given parenterally (IM or IV) for emergency treatment of mania.

Recently, there has been some early evidence that atypical antipsychotics (e.g. olanzapine) might have some mood stabilizing properties.

Delusional depression

As stated above, antipsychotics are important adjuncts in the treatment of delusional depression. Once again, it is customary to use atypical antipsychotics such as olanzapine, quetiapine, risperidone, and ziprasidone first, although any antipsychotic can be used.

Bipolar depression

There is recent evidence that quetiapine has antidepressant efficacy in bipolar depression.

Maintenance or prophylactic treatment in affective pathology

Recent evidence shows that several atypical antipsychotics such as olanzapine, quetiapine and aripiprazole can be successfully used in the maintenance treatment of bipolar disorder.

Other Mood Stabilisers

The other mood stabilisers which are used in the treatment of bipolar mood disorders include:

1. Sodium valproate

For acute treatment of mania and prevention of bipolar mood disorder.

Particularly useful in those patients who are refractory to lithium.

The dose range is usually 1000-3000 mg/day (the therapeutic blood levels are 50-125 mg/ml).

It has a faster onset of action than lithium, therefore, it can be used in acute treatment of mania effectively.

2. Carbamazepine and Oxcarbazepine

For acute treatment of mania and prevention of bipolar mood disorder.

Particularly useful in those patients who are refractory to lithium and valproate.

Particularly effective when EEG is abnormal (although this is not necessary for the use of carbamazepine).

The dose range of carbamazepine is 600-1600 mg/ day (the therapeutic blood levels are 4-12 mg/ml).

The use of carbamazepine in treatment of bipolar disorder has recently declined, partly due to its potential for drug interactions.

Oxcarbazepine has a narrow evidence base and its use in bipolar disorder is quite recent.

3. Benzodiazepines

Lorazepam (IV and orally) and clonazepam are used for the treatment of manic episode alone rarely; however, they have been used more often as adjuvants to antipsychotics.

Lamotrigine is particularly effective for bipolar depression and is recommended by several guidelines.

T3 and T4 as adjuncts for the treatment of rapid cycling mood disorder and resistant depression.

Other Treatments

Psychosurgery is an extremely rarely used method of treatment and is resorted to only in exceptional circumstances.

In depressive episode, which is either chronic or persistently recurrent with a limited or absent response to other modes of treatment, one of the following procedures may very rarely be performed:

Stereotactic subcaudate tractotomy, or

Stereotactic limbic leucotomy.

In carefully selected patients, the results are reported to be satisfactory. However, in the current day and age, psychosurgery is hardly ever considered in routine clinical practice.

***Prophylaxis of relapses*.** Preventive therapy with lithium salts is effective for maniac attacks, and rarer for depressive ones. It begins with small doses of 300-600 mg/day, increasing them up to 900-1200 mg/day. Lithium concentration in blood should be 0.6-0.8 mM/l. Application of tricyclic antidepressants for supportive therapy and prevention is more expedient in monopolar depressions. In recent years with prophylactic purposes some anticonvulsants have been used: Finlepsin (carbamazepine), Depakine, Convuleks. An important part in preventing the illness is played by psychotherapy (supportive, cognitive, interpersonal, group ones), sanitary-educational work, genetic consulting, a healthy way of life.

CLINICAL CASES

Clinical illustration №1

Patient A., male, 32 years old.

He comes again, delivered by ambulance from home, accompanied by his wife, due to the deterioration of his condition.

Complaints: do not present.

Disease history. Heredity is burdened, the brother suffers from a mental illness. Early development without pathology. Secondary education. Graduated from 11 classes. Has a criminal record under Art. 117 for rape. Does not work. Currently, he is a disabled person of group II due to mental illness. Lives with a partner. No kids. Of the past diseases, colds, tonsillitis, he was operated on for a stab wound to his shoulder. TVS, viral hepatitis, TBI, venous disease denies. The epidemiological situation is good. He denies any drug allergies.

Denies taking drugs. Abuses alcohol.

Mentally ill for more than 20 years, the disease began with sleep disturbance, then he experienced fears, heard “voices” inside his head, heard music in his head. Since then, he has been treated 10 times in a psychiatric hospital. From about 15 years old he was a disabled person of group III, about 10 years old - a disabled person of group II indefinitely.

The clinical picture of his disease is dominated by hallucinatory-paranoid symptoms of paraphrenic content against the background of affective fluctuations. At 6 years ago, he was hospitalized due to the fact that he began to notice observation of himself from space, he heard "voices" that warned him that he was in danger. In the department, he stated that while watching TV, information was being transmitted to him, he felt a surge of energy in himself, he was motorically excited, demanded to let him go home immediately, because. he was given an hour to save his mother. Last hospitalization two years ago with a suicide attempt (drank 10 tablets of azaletol). After discharge, he was treated by

a psychiatrist on an outpatient basis, took supportive therapy (takes injections of haloperidol-decanoate 50 mg IM once every 3 weeks). The condition worsened a week before admission: sleep was disturbed, he talks to himself, laughs out loud, he was hospitalized.

PSYCHOSTATUS: He is conscious, correctly oriented, accessible to formal contact. He blames his mother for the hospitalization, “I just laughed at home, and my mother called an ambulance.” Emotionally inadequate. Mimicry is poor. He declares "I need to rest, I worked at home, I carried canisters." Deceptions of perception denies. He willingly talks about his first hospitalization, “then it was such a nightmare, I didn’t sleep at night for 1.5 months ... I fell asleep in the department and had a dream that there was nothing on the Planet ... I tell them,“ don’t you know who I am? bring the TV and I'll show you who I am." Easily irritated. He declares that he “hears a song in his head -“ no one writes to the colonel. He does not reveal his feelings to the end. Has no criticism. In the department, at first he was extremely aggressive, trying to go out the window. Didn't follow instructions. Extremely tense. Mimic is evil. He does not explain his behavior. Hides feelings. Does not communicate with patients. Secretive, answers questions in monosyllables. Shows no interest in conversation. Feelings are not disclosed. Reasonable thinking. He talks about boxing and swimming in cold water, says: "I'm a walrus." He denies wrong behavior and the presence of “voices”, says “I just remembered the song “no one writes to the colonel” and thought who the colonel is, maybe I am”, while laughing out loud. Rationalizes his aggressive behavior, "I wanted to look out the window." The behavior is formally ordered.

Against the background of the treatment, his mood improved, he became calm, his sleep returned to normal. Makes no complaints. Ordered in behavior. Friendly. He answers questions correctly, talks about his life. He speaks warmly of his mother and wife. Communicates with patients. Deceptions of perception

denies. Does not express crazy ideas. Suicidal thoughts are denied. There are no aggressive tendencies. Discharged from the department, accompanied by his wife.

Therapist: SARS.

Neurologist: There are no data for focal pathology.

According to the results of the examination, a clinical diagnosis was established:

Schizophrenia, paranoid form, with a mixed type of defect (emotional-volitional, psychopathic). Hallucinatory-paranoid syndrome. F 20.00

TREATMENT: chlorpromazine, halopril, cyclodol, clopixol-akufaz, clopixol-depot, symptomatic, physiotherapy.

Clinical illustration №2

Patient B. Male, 40 years old.

Enters again, transferred from the intensive care unit after a suicide attempt.

Complaints: dizziness, weakness, low mood.

Case history: Heredity is not burdened with mental illnesses. Early development b / o. He completed 10 classes. The patient was drafted into the army at the age of 18, but six months later he was discharged for health reasons. He worked as a laborer until the age of 35. He was married three times and has a daughter. Now he lived with a cohabitant, who was also treated many times in a psychiatric hospital. For the last 2 months he has been living with two tenants. He is a disabled person of group II due to mental illness indefinitely.

Of the past diseases: syphilis at the age of 25, was treated in a hospital, deregistered. TBI, viral hepatitis denies. He denies any drug allergies. The epidemiological situation is good. Operated on for stenosis of the throat (after a perfect suicide attempt), there is a tracheostomy.

He has been mentally ill since the age of 19, when for the first time a depressed mood was noted, he expressed delusional ideas of persecution. Then he was treated in the children's department. He was drafted into the army, because. hid his treatment from psychiatrists. During the service, ideas of persecution and mood swings reappeared. He was treated in a military hospital, was diagnosed with schizophrenia. The next inpatient treatment at the age of 20 with depressive-paranoid symptoms. He has had over 10 hospitalizations with hallucinatory-paranoid symptoms since then. His last hospitalization was a year ago, then he was spiteful towards his mother and cohabitant, hit her, threatened his mother to break her windows, declared that he wanted to hang himself, because. does not see the meaning of life. He threatened to blow up the house by setting fire to gas, did not open the door to his relatives, and runs around the city

with a video camera. He declared that he would "remove the deputies." In recent years, in the foreground in the clinical picture, a psychopathic type of defect, affective symptoms - manioform with aggressive tendencies or depressive symptoms, a history of two suicide attempts, a real one - 3 in a row. Deterioration is observed within a few days, having received pills at the day hospital department for the weekend, he took 40 tabs with a suicidal goal. cyclodol, 20 tab. triftazina and other medicines that were in the house. He was hospitalized in the intensive care unit with a diagnosis of acute household polydrug poisoning, hypovolemia. Suicide attempt." He was transferred for further treatment to the psychiatric department.

PSYCHOSTATUS: Conscious. Oriented all around. available to the contact. Answers questions in one word. Oppressed, depressed. The mood is sharply lowered. The patient does not deny suicidal intentions, "I wanted to die, I was tired of everything." He says that he has a large debt for utilities, that his telephone, gas and electricity are turned off, declares that his cohabitant left him. He does not regret what happened, says “I really wanted to die”, he cannot specify the exact amount of drugs that he drank, despite these statements he asks to call his mother to bring him cigarettes. Without criticism, he talks about 2 past suicide attempts, "once upon a time I got a knife in my throat, then I poisoned myself with pills." The facial expression is indifferent, the voice is quiet. Shows no interest in conversation. Crazy ideas, deceptions of perception does not reveal. He rationalizes his suicidal attempt, “it’s bad both morally and financially, how could I run an apartment like that in 2 years, I got into debt, and now I’ve seen the light, I looked into who I turned myself into, and turned the apartment.”

During the first month, the patient spends time in the ward, lies a lot. The background mood remains lowered, anhedonia is noted - he says that he is not happy with anything and that he does not want anything. Gradually, during the treatment, he became more active, his facial expressions became more active, he

began to take an interest in what was happening around him, he went for walks, watched TV. Analyzes a suicidal attempt, criticism of it has appeared.

Within a month, there is a significant improvement in the mental state, the mood has evened out, there is no depression, she talks with interest on everyday topics, asks the doctor for advice, makes plans after discharge, says “this is not a way out of my situation, I need to make repairs in the apartment and live.” In order to check the stability of his mental state, he was released on medical leave, after returning his mood was even, there were no signs of depression, he says that he began to clean the apartment, installed a toilet bowl, and evicted the tenant. Thinking is consistent. Memory, intellect are preserved. There are no aggressive, auto-aggressive tendencies. He categorically refuses injections of deposited drugs, he is set to take tablet forms of drugs. Discharged from the department independently.

Surgeon: Data for surgical pathology was not revealed.

X-ray: Lungs and heart - without pathology.

Neurologist: There are no data for focal pathology.

According to the results of the examination, a clinical diagnosis was established: Residual schizophrenia with pronounced affective fluctuations. depressive syndrome. Suicidal attempt. F 20.5

Treatment: clozapine, carbamazepine, truxal, amitriptyline, symptomatic, physiotherapy.

Clinical illustration №3

Patient C, male, 32 years old

He is delivered by ambulance due to deterioration of his condition, accompanied by his mother.

Complaints: “I choke, I have bad breath, I laugh in the mirror, I don’t sleep well.”

Case history: Heredity is aggravated by father's alcoholism. The patient is the eldest of 2 sons of his parents. Until the age of 19 he lived in country N. Parents are divorced. Lives with his mother and younger brother. Education 8 classes, studied mediocre. From childhood, he differed from his peers by inappropriate behavior. He worked at the plant "R", where he acquired the specialty of a mechanical assembly worker. Work experience 1.5 years. Often changed jobs due to low wages. Single. No kids. For more than 10 years he has been a disabled person of group III due to mental illness. Does not work. By nature closed, impressionable, impulsive. Didn't serve in the army. He was involved in adolescence for theft. At 22, he had a TBI (concussion). Transferred helminthiasis. TVS, viral hepatitis, vein diseases, operations are denied. Epidanamnesis is calm. Allergy anamnesis is not burdened.

Previously, he used psychoactive substances, smoked cannabis, injected homemade opiates. From the age of 24, he categorically denies taking drugs. Currently abuses alcohol, strong tea. Takes 1-2 times a month 250 ml of vodka. Combines the intake of vodka with the intake of barbiturates. 5 years ago, while taking alcohol and barbiturates, he was admitted to the intensive care unit, where he was, according to the patient, for 3 days.

Since the age of 21, he has been treated by psychiatrists. Initially, he was treated twice in a d / o with a diagnosis of "Borderline Personality Disorder, Affective Instability Syndrome". From the age of 25, psychotic disorders began

to be recorded. Closed, inactive, does not take care of himself. Expressed a lot of complaints of hypochondriacal content. He thought he needed a castration operation. Since the age of 26, he has been annually treated in a psychiatric hospital, initially with a diagnosis of "Mild mental retardation with behavioral disorders, complicated by the use of psychoactive substances." The diagnosis was then changed to F 20.0, the hypochondriacal variant. Recognized as a disabled person of the III group. Subsequently, annual hospitalizations in a hospital with predominantly delusional symptoms, mentism phenomena, and affective fluctuations. Last hospitalization over a year ago. After discharge, maintenance therapy was taken irregularly. This worsening of the state for several days, when thoughts began to get confused in the head, fear appeared, sleep was disturbed. The mother called an ambulance. Hospitalized.

PSYCHOSTATUS: Conscious. Oriented all around. Available for formal contact. His mood background is lowered. Depressed, tense, suspicious. Speech is monotonous and slurred. Thinking is amorphous, paralogical. It is fixed on the fact that something is stuck in the throat, “something is bothering me, so I am suffocating ... my spleen is also moving, it must be sick too.” "Voices" denies. Expresses crazy ideas of a hypochondriacal nature. There are no suicidal thoughts. There is no criticism. For the first time in the department, the background of mood remains reduced, sleep disturbance was noted. Separated. Does not seek communication. Statements of a hypochondriacal nature are preserved. Emotionally dull. Spends time within the bed, does not communicate with anyone. Calm. The behavior is formally ordered. On treatment, the patient's condition improved, sleep returned to normal. The background leveled off. Stopped paranoid symptoms. The presence of "votes" denies. Ordered in behavior. Asocial, suicidal tendencies does not reveal. Criticism is formal. From the department can be discharged accompanied by the mother.

Therapist: Chr. gastroduodenitis without exacerbation.

Neurologist: There are no data for focal pathology.

Based on the results of the examination, a clinical diagnosis was established: Schizophrenia, paranoid form, continuous flow with a pronounced emotional-volitional defect. paranoid syndrome. F 20.00

Treatment: triftazin, clozapine, cyclodol, azapine, physiotherapy.

Clinical illustration №4

Patient E., female, 32 years old.

He is admitted to a psychiatric hospital again, for treatment, due to a deterioration in his condition. She came to the emergency room on her own.

Complaints at admission: "I was nervous, became irritable, tearfulness appeared, I could not sleep."

Case history: Heredity is unfavorable - the mother's brother suffered from a mental illness. The patient is the only child in the family. Raised by mother. Early development without features. I went to school on time, studied well. She graduated from the 9th grade, electrical engineering college, hairdressing courses. Labor activity since 18 years. She worked as a waitress, hairdresser, furniture factory designer. Currently not working. Disabled group III mental illness. Married. No kids. Has no bad habits, "my husband and I are believers, we attend church." Throughout her life, she never suffered from anything special. TVS, TBI, venous disease - denies. Epidanamnesis is good. Allergy anamnesis is not burdened.

She has been suffering from mental illness since the age of 20, when she was first treated with acute hallucinatory-paranoid symptoms. Re-hospitalization a year later, when she lost sleep, refused to eat, declared that her mother wanted to poison her, experienced "voices" of imperative content. The diagnosis was established: "Schizophrenia, paranoid form", recognized as a disabled person of the III group. After discharge, she took Rispolept and Truxal. He notes that he has not taken maintenance therapy for the last year. Real deterioration during the week, she herself says that “difficult family circumstances, quarreled with her husband, disagreements arose, anxiety and irritability appeared,” she resumed taking Truxal, but does not notice any improvement - “I decided to seek help. Hospitalized.

PSYCHO STATUS: Upon admission, the consciousness is not changed, in place, time and own personality is oriented correctly. Available to a productive contact. The mood is uncertain. Speech is monotonous. Mimicry is impoverished. Thinking is autistic, amorphous. Rationalizes hospitalization: “I refused to take medication, felt good, got married ... it was my decision, I told the doctors that I take responsibility for myself, my husband understands me ... but recently difficult circumstances arose in the family, I was nervous, after which I she became ill, began to cry, get irritated, sleep worse, but there were no voices ... I told my mother that I needed to go to the hospital. He does not actively express delusional ideas, but paranoid tension and suspicion are noted in the conversation. Disorders of perception does not reveal. Emotionally flattened. Criticism is formal.

Ordered in behavior. Separated in the department. She believes that the deterioration of her condition is due to a misunderstanding with her mother - "she does not share our religion with her husband, vegetarianism." Notes an improvement in the state, "the irritation has already passed." Welcoming, somewhat mannered. Currently, he does not reveal any signs of active psychoproduction. There is an emotional-volitional flattening, a decrease in motivation to work.

Therapist: At the time of the examination, no pathology was detected.

P-graphy o.g.k. : Lungs and heart - without pathology.

Neurologist: There are no data for focal pathology.

According to the results of the examination, a clinical diagnosis was established:

Schizophrenia, paranoid form, episodic course with increasing defect. paranoid syndrome. F 20.01

Treatment: rispetril, cyclodol, vit. group B.

Clinical illustration №5

Patient F, female, 50 years old.

He enters again, this year for the first time, in the direction of a psychiatrist for the purpose of treatment.

Complaints: does not actively present.

Case history: Heredity is not burdened with mental illnesses. Born in a family of workers, the eldest of 2 children. As a child, she grew and developed normally. I went to school from the age of 8, graduated from the 8th grade of high school. Studied mediocre. After school, she graduated from a construction technical school, and then 3 courses from a construction institute. By profession a civil engineer. Labor activity since 19 years. She worked as an estimate engineer for 6 months, then as an engineer in a construction laboratory, then as a design engineer, then as a civil engineer. She worked at her last place of work for 17 years as a pumping unit operator at the Z. plant. The last 4 years does not work, is a disabled person of the III group. She is married, has 2 children, lives with her husband and youngest son in her own house. The financial situation is satisfactory.

Of the transferred diseases, she notes colds. Tuberculosis, hepatitis, TBI, venous disease denies. The epidemiological situation is good. Allergy anamnesis is not burdened. Bad habits: denies.

Впервые в психиатрической больнице лечилась в aged 20 years. Then she changed her behavior: she cried, she laughed. She said that she was bewitched, that her parents were “forged”. She began to inappropriately answer questions, laughed out loud inadequately. She was hospitalized due to this condition. The department stated that "the mother slipped pills and pancakes, but this will not happen again." She was anxious, suspicious, did not allow herself to

be examined. She said that she heard the voice of the “boss”, stated that the police were following her. She came out of psychosis with complete criticism. She received treatment with haloperidol, as well as 8 coma (insulin-comatose therapy). She was discharged with a diagnosis of "Schizophrenia, paranoid form, fur coat-like course." She was re-treated in the acute department three years later with a diagnosis of "Attack-like schizophrenia, paranoid attack." On the eve of this hospitalization (in a month) she gave birth to her first child. After giving birth, she changed her behavior, became rude, kicked her relatives out of the house, then cried, then laughed out loud inappropriately. She didn’t watch the child, demanded to remove the TV, because it seemed that “if the parents watch TV, they will end up in a lunatic asylum, she kicked out relatives, as they were strangely dressed.” She took triftazin, chlorpromazine. After discharge, she took maintenance therapy for a short time, then stopped. No more contact with psychiatrists. Coped with work, was adapted socially.

After discharge, she felt satisfactory, for more than 20 years she did not seek help from psychiatrists and did not take medication. The last hospitalization two years ago with a diagnosis of F 20.01 was due to inadequate behavior at work, she believed that “the boxer whom I saw on TV and fell in love with him should marry me”, believed that “at night the head of the shop rapes me and He fired his wife because of me." After discharge, she regularly took medication: quetiron 100 mg in the morning, melitor 25 mg at night. Deterioration of condition within 3 days: stopped taking medicines, closed in on herself, anxious, does not eat, does not sleep, in connection with which the husband turned to the teacher. psychiatrist and the patient was hospitalized.

ECG: Decreased voltage. Violation of intraventricular conduction. The predominance of the left ventricle.

Neurologically: There are no data for focal pathology.

PSYCHO STATUS: The patient is available for contact, but answers questions with delay, after long pauses, often leaves questions unanswered. Mimicry oppressed, suppressed. Experiencing auditory pseudo-hallucinations: “Thoughts in the head sound, get confused, voices order. govern." Autistic thinking, expresses delusional ideas of influence, “voices control”, but does not fully reveal his experiences. Tends to dissimulate symptoms. Mood at a depressive level, lethargic, apathetic. At the same time, she is anxious, immersed in her experiences. Outwardly untidy. Ordered. The dream is broken. Emotions are dull. Appetite is reduced. In the department, she periodically experiences auditory pseudo-hallucinations, is closed, uncommunicative, her mood is depressive. During treatment in a hospital, productive psychotic symptoms were stopped, without hallucinatory disorders, delusions were deactivated, affective disorders disappeared, the mood background leveled off, became stable. Ability to work is reduced, is a disabled person of group III. Discharged home, accompanied by her husband with improvement.

There were no side effects or complications during treatment.

Diagnosis: Schizophrenia, paranoid form, episodic course with increasing defect. Paranoid-depressive syndrome.

Treatment: triftazin, amitriptyline, eridon, aspirin, enalapril, cyclodol, sibazon.

TASKS AND TESTS

Materials for test control (level I and II)

1. ICD-10 contains all of the following forms of schizophrenia, except:
   A. Paranoid.
   B. +Paralytic.
   C. Catatonic.
   D. Hebephrenic.

2. Choose a non-existent clinical form of schizophrenia:
   A. Simple.
   B. Hebephrenic.
   C. Paranoid.
   D. Catatonic.
   E. +Manic.

3. Neuroleptics:
   A. Contraindicated with alcoholic and reactive psychoses.
   B. Prolonged use causes paresis and polyneuropathy.
   C. Incompatible with the consumption of cheese, beans.
   D. +May cause depression and increase depressive symptoms.
   E. None of the above.

4. Genetic factors lead to:
   A. +Bipolar-affective disorder.
   B. Affective shock reaction.
   C. Wernicke's encephalopathy.
   D. Progressive paralysis.
   E. Korsakovsky psychosis.

5. What mental disorders are most common in women in the postpartum period?

A. Dementia.

B. *Depression.

C. Amnesia.

D. Delirium.

E. Hypochondria.

6. The most depressive syndrome is characterized by the following sleep disorders:

A. +Early awakening and lack of sleep.

B. Daytime drowsiness.

C. Awakening in the morning.

D. Irritability and shallow sleep.

E. Nightmares.

7. Typical manifestations of mania:

A. Complacency, apathy, inaction.

B. Ideas of influence.

C. Illusions and hypnagogic hallucinations.

D. Autism, suspicion and stubbornness.

E. +None of the above.

8. Manic syndrome is characterized by everything except:

A. Euphoria.

B. Memory acceleration.

C. Hypermnesia.

D. +Confabulations.

E. Hypersexuality.

9. Which of the following symptoms can be attributed to the group of negative disorders found in schizophrenia?

A. pseudo hallucinations

B. delirium of influence

C. delusional relationship

D. emotional flattening *

E. true hallucinations

10. Which of the following symptoms can be attributed to the group of positive disorders found in schizophrenia?

A. memory loss

B. emotional flattening

C. hypobulia

D. decrease in intelligence

E. + pseudo hallucinations

11. What clinical sign indicates the formation of the features of a schizophrenic defect in a patient?

A. memory impairment

B. + decreased volitional activity

C. depressive state

D. the appearance of catatonic symptoms

E. fourteen

12. What disturbance of psychosensory synthesis is more typical for schizophrenia?

A. impaired color perception

B. impaired perception of the shape of objects

C. violations of the body scheme

D. + depersonalization

E. experiencing "already seen"

13. Which of the following thought disorders are characteristic of schizophrenia?

A. + broken thinking

B. incoherent thinking

C. perseverations

D. + autistic thinking

E. + resonant thinking

14. The onset of febrile schizophrenia is characterized by

A. + increased body temperature

B. + threat to the life of the patient

C. + trophic tissue disorders

D. + catatonic symptoms

E. convulsive syndrome

15. Within what disease is catatonic symptomatology most common?

A. affective insanity

B. epilepsy

C. + schizophrenia

D. Hysteria

16. Which of the following diseases, as a rule, tends to regress?

A. + traumatic brain injury

B. schizophrenia

C. alcoholism

D. oligophrenia

17. Specify among the listed emotional disturbances characteristic of schizophrenia

A. weakness

B. euphoria

C. + emotional inadequacy

D. complacency

E. + apathy

18. What form of schizophrenia is the most malignant and leads to pronounced personality changes?

A. paranoid schizophrenia

B. paranoid schizophrenia

C. + hebephrenic schizophrenia

D. schizoaffective disorder

19. What psychopathological syndrome does not occur in schizophrenia?

A. Apato-Abulic

B. senestopathic

C. Syndrome of mental automatism

D. + Korsakovs syndrome

20. Which of the following emotional disorders are characteristic of schizophrenia?

A. + inadequacy of emotions

B. weakness

C. + ambivalence

D. dysphoria

E. emotional lability

F. + emotional flattening

21. Which of the following outcomes of the disease is not characteristic of the paranoid form of schizophrenia?

A. + lethal outcome

B. going into long-term remission

C. continuous chronic course

D. access to apato-abulic defect

22. In what form of schizophrenia do apato-abulic disorders determine the clinical picture of the disease?

A. + simple form

B. hebephrenic form

C. paranoid form

D. catatonic form

23. The paraphrenic syndrome is characterized

A. dementia

B. amnesia

C. + megalomaniac nonsense

D. + pronounced fragmentation of thinking and absurdity of judgments

E. Transsexuals

24. The emotional sphere of patients with schizophrenia is characterized by

A. + progressive impoverishment of emotional reactions

B. + inadequacy of emotional reactions

C. + ambivalence of emotional reactions

D. bouts of dysphoria

25. Recurrent schizophrenia is characterized by

A. + monotony of seizures (like a cliché)

B. + favorable flow

C. + distinct affective disorders

D. Increasing deficiency symptoms

26. In sluggish schizophrenia,

A. + slow course with gradual development of personality changes

B. hallucinatory and delusional disorders

C. + predominantly neurosis-like and psychopathic disorders

D. significant depth of affective disorders (psychotic depression, mania)

27. Paroxysmal progressive schizophrenia is characterized by

A. + spontaneous remissions

B. only therapeutic remissions

C. + complication of symptoms with the next attack

D. same-type (like cliché) seizures

28. What syndrome is characterized by Protopopov's triad?

A. paraphrenic

B. paranoid

C. amental

D. + depressive

29. Which of the following is most characteristic of somatogenic depression?

A. daily mood swings

B. vital depression of mood

C. + aggravation of depression with aggravation of somatic condition

D. mournful feeling

E. delusional ideas of guilt

30. Select from the suggested symptoms the most characteristic somatic signs of depression

A. + weight loss

B. + tachycardia

C. + constipation

D. bradycardia

E. respiratory disorders

F. + amenorrhea

G. skin pigmentation disorders

31. Specify the characteristics of asthenic syndrome

A. + emotional lability

B. + increased fatigue

C. + hyperesthesia

D. stunned

E. hallucinations

32. Hypochondriacal syndrome may include

A. + excessive attention to health

B. + phobias with the experience of getting sick with an incurable disease

C. + delusional belief in a non-existent disease

D. anosognosic experience of illness

33. Bipolar affective disorder is characterized by

A. + preservation of working capacity in the interictal period

B. + tendency to relapse affective seizures

C. + possibility of transition from one phase to another without a light gap

D. formation of apato-abulic syndrome

E. occurrence of depressive symptoms in response to psychotrauma

34. Risk factors for suicidal behavior may include

A. + depression

B. + imperative hallucinations

C. memory loss

D. crazy ideas of love charm

A. + delusions of guilt

E. none of the above

35. The likelihood of suicidal behavior in mentally ill patients may increase if

A. + thoughts about the aimlessness of existence

B. + thoughts about the hopelessness of the future

C. + ideas of low value

D. none of the above

36. In what syndrome does the following triad of symptoms occur: elevated, joyful mood, accelerated thinking, increased motor activity?

A. paraphrenic

B. depressive

C. hypochondriacal

D. + manic

E. Paranoid

37. In what syndrome does the following triad of symptoms occur: a melancholy-sad mood, slow thinking, motor retardation?

A. manic

B. catatoяic

C. paranoid

D. + depressive

38. What syndrome is characterized by a paroxysmal dreary-evil mood with a tendency to aggressive actions?

A. depressive

B. obsessive

C. delirious

D. + dysphoric

E. for all indicated syndromes

39. Indicate the correct statements regarding delusional ideas in Bipolar affective disorder?

A. delusional ideas of persecution are characteristic

B. delirium is primary

C. + delusions correspond to affective disorder

D. + delirium is secondary

40. What group of syndromes does dysphoria belong to?

A. delusional

B. Syndromes of impaired consciousness

C. + affective

D. Catatonic

41. Which of the following signs, symptoms is characteristic, distinguishing masked depression from other depressions?

A. delusional ideas of self-abasement and self-blame

B. obsessive fears

C. daily mood swings

D. + predominance of somatic complaints

A. suicidal thoughts

42. Which of the following descriptions, definitions corresponds to the concept of masked depression?

A. the affective component of the depressive triad is expressed. The ideational component is weakly expressed. There is no motor retardation.

B. there is a pronounced motor and mental retardation. The affective component is weakly expressed.

C. + motor and mental retardation are not expressed. Depressive affect is weakly expressed. His place is taken by somatic complaints.

43. Which of the following signs, symptoms is characteristic, distinguishing masked depression from other depressions?

A. delusional ideas of self-abasement and self-blame

B. obsessive fears

C. daily mood swings

D. + predominance of somatic complaints

E. suicidal thoughts

44. Which of the following groups of drugs is most effective in the treatment of masked depression?

A. tranquilizers

B. psychostimulants

C. β-blockers

D. neuroleptics

E. + antidepressants

45. The classic manic triad includes:

A. + elevated mood

B. + acceleration of associations

C. + motor excitation

D. delusions of grandeur

E. disinhibition of desires

46. Depressive syndrome is characterized by:

A. + experience of longing

B. + motor retardation

C. pseudo hallucinations

D. + ideational retardation

E. + delusional ideas of self-deprecation

47. The severe depressive phase of Bipolar affective disorder is characterized by all of the following except:

A. the presence of a depressive triad

B. ideas of self-blame

C. + self-reassessment ideas

D. depersonalization

E. derealization

48. Which of the following depressions is most likely to commit suicide?

A. + masked depression

B. + anxious (agitated) depression

C. asthenic depression

D. tearful depression

49. Atypical signs of Bipolar affective disorder include:

A. + delusions of persecution

B. delirium of self-abasement

C. motor excitement

D. + auditory hallucinations

50. Clinical features of cyclothymia are:

A. + low intensity of affective disorders in phases

B. + experiencing the pain of a state of depression

C. experience of painful condition in mania

D. none of the above

Situational tasks (III level)

1. The patient is 47 years old. She has been ill for 12 years. Two years ago, she suffered a myocardial infarction. The first time she went to a psychiatric clinic with a sharp drop in mood, she was "confused" in her head, believed that the people around her were plotting evil, wanted to poison her. After the treatment, the condition normalized, but she became much less active and could not work. With the diagnosis of "Schizophrenia" she received the 2nd group of disability. She took maintenance therapy irregularly. The condition changed dramatically again: she became excited, multilingual, did not sleep at night, recited poems, heard "voices" in her head, felt the effect of a "laser" on her body and head. After discharge, she became calmer, but remained inactive, indifferent, emotionally cold.

A. Name the described syndrome.

B. For which disorder is this syndrome characteristic?

C. Under what disorders can this clinical picture be observed?

D. What is the prognosis of the disorder?

E. Recommended treatment.

2. The patient is 35 years old. His maternal uncle is schizophrenic. At the age of 20, the patient was first admitted to a psychiatric hospital in connection with ideas of persecution, relationships. A diagnosis of "schizophrenia" was made. Discharged in remission. Took supportive therapy. After 6 months, he stopped taking the drug on his own. After 2 weeks, a repeated attack of the disease was established. After discharge from the hospital, he received supportive therapy for 3 months, then stopped taking the medication. Another exacerbation after 3 weeks, was treated in a psychiatric hospital for 4 months, discharged with improvement.

A. Name the described syndrome and symptoms.

B. For which disorder is this syndrome characteristic?

C. What is the nature of the course of the disease?

D. What is the prognosis of the disorder?

E. Recommended treatment.

3. The patient is 19 years old. Six months ago, anxiety began to grow for no apparent reason. He said that he "lost the ability to comprehend", he could not grasp the meaning of what he read. All words began to be "searched for a second meaning". Success has decreased. It seemed that his fellow students suspected him of something, "considered him a fool." Lost former interests. He began to be indifferent to studies, did not take care of himself, cut off contacts with friends.

A. What disease should be thought of first of all?

B. What form of the disease does this patient have?

C. Give the scheme of treatment for this patient.

4. The patient is 30 years old and has not been registered with a psychiatrist before. He turned to a psychoneurological dispensary at the initiative of his relatives. Strange behavior appeared six months ago. The patient (a carpenter by profession) became interested in philosophy and parapsychology. He said that he had created a model of a new society, wrote letters to various authorities, and sent drawings of his projects. The conversation is sthenic, the affect is NOT expressive. Willingly talks about his "scientific research". Perception does not experience deception. He considers himself mentally healthy, convinced that he has made a discovery in social science.

A. What is the syndrome of this patient?

B. Which disease should be thought of first?

C. Give the scheme of treatment for this patient.

5. Student of a technical institute, 23 years old. The disease developed without apparent reasons. He became lethargic, lost interest in studying, in communication with acquaintances, in art and music, which used to be "the only way he lived". Auditory pseudo-hallucinations, delusions of persecution and hypnotic influence appeared. He claimed that his thoughts were "read by those around him." In practice, he was completely inactive and indifferent, almost constantly expressed nonsensical thoughts of various content. There is no criticism of the state.

A. Qualify the leading syndrome.

B. Formulate a possible diagnosis.

C. Give the scheme of treatment for this patient.

6. Student of the medical institute, 23 years old. Three years ago, she was in a psychiatric hospital due to severe depression. With this admission (during the session), an elevated mood is noted, she constantly sings, dances, reads poems, eats a lot, sleeps little, is erotic. He quotes poems learned in childhood. After recovery,

he remembers his "citation", however, he remembers only approximately the content. With full criticism refers to the transferred disease.

A. Qualify the syndrome:

B. Formulate a possible diagnosis:

C. Give the scheme of treatment for this patient.

APPENDIXES

The applications present tests and scales for validating the current mental state of patients.

Appendix №1

Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

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

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

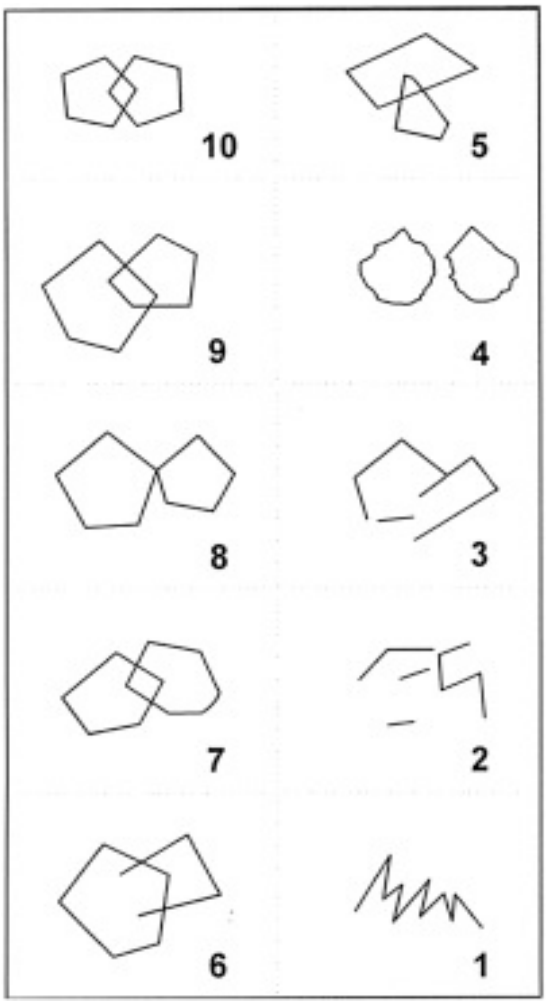
(Adapted from Rovner & Folstein, 1987)

Interpretation:

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

A maximum of 30 points can be scored in this test, which corresponds to the highest cognitive abilities. The smaller the test result, the more pronounced the cognitive deficit. According to various researchers, the test results may have the following values (pic. 16):

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



Pic. 16. Examples of validation of images of patients with different levels of dementia.[16]

[16] Sourse: https://www.researchgate.net/figure/Intersecting-pentagon-scoring-system_fig2_261139573

Appendix №2

The Clock-Drawing Test

The clock-drawing test is a simple tool that is used to screen people for signs of neurological problems, such as Alzheimer's and other dementias. It is often used in combination with other, more thorough screening tests, but even when used by itself, it can provide helpful insight into a person's cognitive ability.

How the Clock-Drawing Test Is Done?

The clinician (often a doctor, psychologist, or social worker) gives the person being tested a piece of paper with a pre-drawn circle on it and asks him to draw the numbers on the clock. She then tells him to draw the hands to show a specific time. There are several different times that people who administer this test may use, but many choose 10 minutes after 11.

Another method is to simply give the person a blank piece of paper and ask them to draw a clock that shows the time of 10 minutes after 11. Some clinicians also intentionally omit the word "hands" in their directions to avoid giving the test-taker a cue of what needs to be included in the drawing.

Test Scoring

There are as many as 15 different ways to score this test. As many as five, 10, or 20 points can be involved in some of the different scoring methods.

Some are quite elaborate and involve awarding points for the inclusion of every number, correctly ordered numbers, two clock hands, drawing the correct time, and for each of the correct numbers placed in the four quadrants.

However, a study published in the Danish Medical Journal outlines research that compared five of the most common ways to score the test. It concluded that the easiest scoring method provided results that were just as accurate as the more complicated scoring methods.

This simplest scoring method consists of giving one point if the task was completed correctly and zero points if the clock was not completed correctly.

The Alzheimer's Association also recommends this simple scoring method, concluding that a normal clock (or a score of one point) indicates the absence of dementia, while an abnormally completed clock is cause for further evaluation.

Benefits of the Clock-Drawing Test

The clock-drawing test has these advantages:

Fast screening tool: It is a very quick way to screen a person for possible dementia. It often requires only a minute or two for completion.

Easy to administer: It does not require much training to administer.

Well-tolerated: This test is easier to complete than the MMSE for people with short attention spans.

Free: Unlike some cognitive tests that require you to purchase a copy of the test and scoring tools, the clock-drawing test can be completed with only the cost of paper and a pen.

May be useful in developing countries: Because of the low cost and minimal training, this test can be used in countries with fewer resources.

Screening for delirium: This test has also been administered to patients in the hospital to assess for signs of delirium. Delirium is a sudden deterioration in someone’s cognitive ability. It can follow the use of anesthesia for surgery, for example, as well as be triggered by an infection or illness.

Executive Functioning Problems

One other very helpful aspect of this test, as published in the Canadian Medical Journal Association, is that it can detect problems in executive functioning even when someone scores well on the MMSE, a common screening tool.

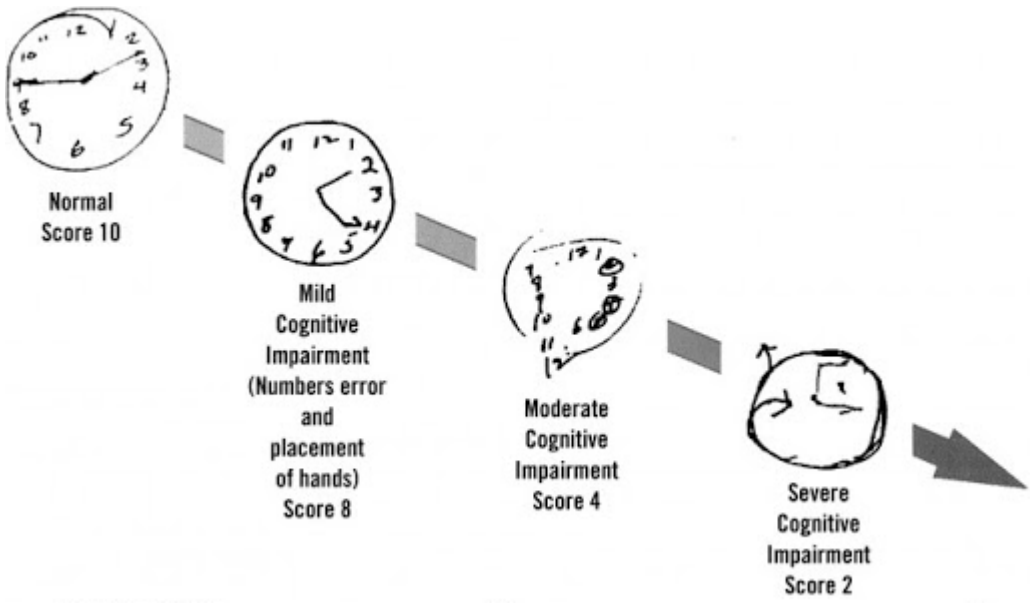
Executive functioning can be impaired before any memory problems are evident, and identifying this early allows early treatment. For example, your father could perform well on the MMSE, which would show that his memory still is quite intact, his language and calculation skills remain functional, and his orientation remains fairly normal.

You, however, may notice that his decisions are not always appropriate. He may be able to get dressed, but not be able to determine that he should wear a warm coat out if it is cold outside.

Often, family members are the first to suspect a cognitive impairment because they will see that evidence of poor executive functioning, while an MMSE test in a doctor's office might not catch this.

Performing the clock-drawing test is one way to identify people who may be experiencing early signs of dementia, such as decreased executive functioning, but may not be displaying memory disturbances yet.

Early detection is helpful because the medications that are currently available to treat Alzheimer's disease are generally more effective earlier in the disease process. It appears that they might preserve the current functioning for a limited time (pic. 17).



Pic. 17. Example of clock images of patients with different levels of dementia[17]

[17] Sourse: https://www.jabfm.org/content/16/5/423/F3

Appendix №3

POSITIVE AND NEGATIVE SYNDROME SCALE (PANSS)

RATING CRITERIA

GENERAL RATING INSTRUCTIONS

Data gathered from this assessment procedure are applied to the PANSS ratings. Each of the 30 items is accompanied by a specific definition as well as detailed anchoring criteria for all seven rating points. These seven points represent increasing levels of psychopathology, as follows:

1- absent

2- minimal

3- mild

4- moderate

5- moderate severe

6- severe

7- extreme

In assigning ratings, one first considers whether an item is at all present, as judging by its definition. If the item is absent, it is scored 1, whereas if it is present one must determine its severity by reference to the particular criteria from the anchoring points. The highest applicable rating point is always assigned, even if the patient meets criteria for lower points as well. In judging the level of severity, the rater must utilise a holistic perspective in deciding which anchoring point best characterises the patient's functioning and rate accordingly, whether or not all elements of the description are observed.

The rating points of 2 to 7 correspond to incremental levels of symptom severity:

• A rating of 2 (minimal) denotes questionable or subtle or suspected pathology, or it also may allude to the extreme end of the normal range.

• A rating of 3 (mild) is indicative of a symptom whose presence is clearly established but not pronounced and interferes little in day-today functioning.

• A rating of 4 (moderate) characterises a symptom which, though representing a serious problem, either occurs only occasionally or intrudes on daily life only to a moderate extent.

• A rating of 5 (moderate severe) indicates marked manifestations that distinctly impact on one's functioning but are not all-consuming and usually can be contained at will.

• A rating of 6 (severe) represents gross pathology that is present very frequently, proves highly disruptive to one's life, and often calls for direct supervision.

• A rating of 7 (extreme) refers to the most serious level of psychopathology, whereby the manifestations drastically interfere in most or all major life functions, typically necessitating close supervision and assistance in many areas.

Each item is rated in consultation with the definitions and criteria provided in this manual. The ratings are rendered on the PANSS rating form overleaf by encircling the appropriate number following each dimension.

SCORING INSTRUCTIONS

Of the 30 items included in the PANSS, 7 constitute a Positive Scale, 7 a Negative Scale, and the remaining 16 a General Psychopathology Scale. The scores for these scales are arrived at by summation of ratings across component items. Therefore, the potential ranges are 7 to 49 for the Positive and Negative Scales, and 16 to 112 for the General Psychopathology Scale. In addition to these measures, a Composite Scale is scored by subtracting the negative score from the positive score. This yields a bipolar index that ranges from –42 to +42, which is essentially a difference score reflecting the degree of predominance of one syndrome in relation to the other.

PANSS RATING FORM

		absent	minimal	mild	moderate	moderate severe	severe	extreme
P1	Delusions	1	2	3	4	5	6	7
P2	Conceptual disorganisation	1	2	3	4	5	6	7
P3	Hallucinatory behaviour	1	2	3	4	5	6	7
P4	Excitement	1	2	3	4	5	6	7
P5	Grandiosity	1	2	3	4	5	6	7
P6	Suspiciousness/persecution	1	2	3	4	5	6	7
P7	Hostility	1	2	3	4	5	6	7
N1	Blunted affect	1	2	3	4	5	6	7
N2	Emotional withdrawal	1	2	3	4	5	6	7
N3	Poor rapport	1	2	3	4	5	6	7
N4	Passive/apathetic social withdrawal	1	2	3	4	5	6	7
N5	Difficulty in abstract thinking	1	2	3	4	5	6	7
N6	Lack of spontaneity & flow of conversation	1	2	3	4	5	6	7
N7	Stereotyped thinking	1	2	3	4	5	6	7
G1	Somatic concern	1	2	3	4	5	6	7
G2	Anxiety	1	2	3	4	5	6	7
G3	Guilt feelings	1	2	3	4	5	6	7
G4	Tension	1	2	3	4	5	6	7
G5	Mannerisms & posturing	1	2	3	4	5	6	7
G6	Depression	1	2	3	4	5	6	7
G7	Motor retardation	1	2	3	4	5	6	7
G8	Uncooperativeness	1	2	3	4	5	6	7
G9	Unusual thought content	1	2	3	4	5	6	7
G10	Disorientation	1	2	3	4	5	6	7
G11	Poor attention	1	2	3	4	5	6	7
G12	Lack of judgement & insight	1	2	3	4	5	6	7
G13	Disturbance of volition	1	2	3	4	5	6	7
G14	Poor impulse control	1	2	3	4	5	6	7
G15	Preoccupation	1	2	3	4	5	6	7
G16	Active social avoidance	1	2	3	4	5	6	7

RECOMMENDED BOOKS

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

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

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

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

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

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