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PRACTICAL NOTEBOOK

ADULT PSYCHIATRY

6TH YEAR GENERAL MEDICINE

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CHAPTER I. I. THE ASSESSMENT OF PATIENTS SUFFERING FROM MENTAL DISORDERS

LEARNING OBJECTIVES:

1. ASSIMILATING THE CONCEPTS OF MENTAL DISORDERS
2. LEARNING HOW TO FILL IN THE PSYCHIATRIC MEDICAL CHART
3. LEARNING THE ASSESSMENT PROCEDURES OF THE MENTAL HEALTH STATUS OF AN ADULT PERSON.

QUESTIONS FOR REFLECTION:

1. *What is your opinion about the patient with a mental disorder?*

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2. *Based on which criteria do you evaluate your mental health status?*

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3. *What would be your expectations as a mental health service-user?*

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PRACTICAL EXAMPLES:

1. What are the most common prejudices about the "mentally ill"?

2. Try to role-play with a fellow colleague for 20 minutes. Play the role of either patient or examiner (by choice). Record your impressions and discuss with your role-playing partner.

I.1. PSYCHIATRIC DISORDERS

Psychiatry is the domain of medicine that studies and treats mental disorders. Due to the fact that diagnostic markers for mental illness have not been identified so far, the term **psychiatric (mental) disorders** was preferred instead of the old term of psychiatric illness. There are two instruments for the classification and description of mental disorders: ICD (*International Classification of Diseases*) developed by the World Health Organization and DSM (*Diagnostic and Statistical Manual of Mental Disorders*) developed by the American Psychiatric Association.

Mental disorders in adults can be classified into four main categories:

- Reactive disorders: acute stress reaction, post-traumatic stress disorder, adjustment disorders. In this type of mental disorders, the leading cause consists of a psychotrauma (natural hazards or man-made), or enduring changes related or not to the normal cycle of life that require an effort of adjustment (pregnancy, death of a family member, emigration).
- Neurotic disorders: anxiety disorders (panic disorder, generalized anxiety disorder, phobic disorders, obsessive-compulsive disorder and recurrent depressive disorder). In this type of mental disorders the etiology is multifactorial and there are triggers that intervene (stressful life events) that overlap on the personological vulnerability (personality disorders). In neurotic patients reality testing is preserved; they are aware of the disorder (insight) and willing to follow the treatment that was prescribed.
- Psychotic disorders: schizophrenia, schizoaffective disorder, persistent delusional disorders, acute and transient psychotic disorders, recurrent depressive disorder, bipolar disorder. In this type of mental disorders the etiology is multifactorial and there are triggers that intervene (stressful life events, substance abuse) and overlap on a genetic vulnerability. Reality testing is lost in patients with psychotic disorders, meaning that they have no insight (awareness of the disorder) and rarely are willing to follow the prescribed treatment.
- Personality disorders are characterized by the global accentuation of personality traits. The patient is egosyntonic (pleased with himself), although his/her behavior is rigid, predictable and maladaptive.

Beside these four big categories, other types of pathologies are described, emerging from the instincts (e.g. eating disorders, disorders of the sexual instinct) or from the impulse control area (kleptomania, pyromania, trichotillomania). There are, however, nosological entities having an organic determinism (mental retardation and dementia) or being induced by psychoactive substances (drug addictions).

Mental disorders may manifest themselves in a single episode of the disorder, or they can progress over multiple episodes occurring and subsiding

in time. Such episodes reflect the individual's vulnerability. Initially, the episodes may resolve spontaneously, thus delaying the addressability of the patient to the doctor. In case of psychotic disorders, over time, episodes become more difficult to treat, they have incomplete (defective) remissions and accentuate the individual's vulnerability for a recurrent disorder. Personality disorders are a type of non-evolutive psychiatric pathology.

Certain mental disorders manifest with symptoms that have an equivalent in normality (e.g. sadness is the normal equivalent for depression). The pathological aspect is given by the greater intensity and the prolonged duration of the manifestation (weeks or months). Accordingly, the individual's functioning in the family, in society, or at work is seriously impaired. Other mental disorders represent milder forms of some major mental disorders (e.g. cyclothymia and dysthymia to bipolar disorder and recurrent depressive disorder, respectively).

Generally, neurotic disorders can be treated in the outpatient care units with psychotropic treatment and psychotherapy. Admittance into a hospital is required for establishing the correct diagnosis or due to a greater severity of the clinical features (depression accompanied by suicidal thoughts). Psychotic disorders require hospitalization during the episodes of the disorder. The treatment of psychotic disorders is based predominantly on administering psychotropic treatment (medication). The treatment of personality disorders is extremely difficult and is based mostly on the psychotherapeutic treatment, which shows questionable efficacy.

Mental disorders can sometimes be accompanied by self-harm or hetero-aggression (aggression directed towards other people), but this is not a rule.

Finally, psychiatric pathology manifests itself through nosological entities called mental disorders, for which the existence of an organic underlying cause could not be proven and no specific diagnostic markers exist. This pathology is not the result of deliberate simulation and cannot be attributed to a general medical condition or to the effects of intoxication with / withdrawal from drugs of abuse, medication or toxic substances. The intensity of symptoms is sufficient to cause impaired family, social, academic or occupational functioning.

I.2. THE PARTICULARITIES OF THE MEDICAL RECORD IN PSYCHIATRY

The psychiatric record, used in hospital psychiatric units, represents the most important document that contains all the medical data of the hospitalized patients. The medical record has three major facets: it is a medical-scientific, a judiciary and an accounting document. Since 2003, the National Health System, in addition to the general clinical record, has introduced the mandatory electronic collection of clinical data on patients in all hospitals of Romania. In addition to other nonspecific headings common to other medical specialties, the psychiatric record contains a number of specific categories, allowing the collection of information that completes the actual clinical picture with diachronic (longitudinal) biographical and familial perspectives, as well the description of the patient's socio-cultural background. For psychiatric disorders a longitudinal perspective on the individual's biographical development can provide valuable information as well as the period before onset.

1. The first part of the medical record comprises of the **personal identification** data of the patient; this data has limited value and relative relevance to the development of the diagnostic's algorithm:
    - The patient's name - may be indicative for the person's ethnicity, specifying that certain psychopathological issues occur more frequently in certain ethnic groups (e.g. depression and suicide in the Hungarian population and the Ganser syndrome in the Roma population);
    - Date of birth - onset of certain psychiatric disorders is correlated with certain age groups (e.g. onset of schizophrenia in a younger age group or the onset of neurodegenerative dementia in elderly);
    - Home address, to which it is appropriate to add a telephone number, where the desired caregivers can be contacted. In people from urban areas an increased prevalence of anxiety disorders was noticed, while somatoform disorders are more common in rural areas, in people with a lower level of education;
    - Occupation and place of work – the existence of a job can be an indicator of better premorbid professional features;
    - Level of education;
    - Identity documents;
    - Status and category of medical insurance;
2. **Admission type** - may be in emergency, or through a referral from the general practioner or a specialist having an outpatient practice etc.
3. **Criteria for admission** - emergency, diagnostic, treatment etc.

4. **Diagnosis of the reference** - made by the physician that directs the patient to the psychiatric hospital; in this situation, as well in patients at onset of their disorder, the diagnostic validity may by less relevant.
5. **Diagnosis at admission** - carried out by a psychiatrist who attends the patient after he arrives at the hospital.
6. **Diagnosis after 72 hours** – made by the attending psychiatrist.
7. **Diagnosis at discharge** - will include:
    - Primary diagnosis: the diagnosis that led to the hospitalization of the patient; it presents with two perspectives: a transversal perspective that refers to the diagnosis of the current episode (e.g. manic episode with psychotic symptoms) and a longitudinal perspective (in case of multiple episodes) of the disorder in which the current episode occurs (e.g. bipolar disorder).
    - Secondary diagnosis can be both mental (e.g. anankastic personality disorder) and surgical (e.g. peptic ulcer).
    - DIAGNOSTIC CLASSIFICATION SHALL BE IN ACCORDANCE WITH THE W.H.O. MANUAL OF DIAGNOSTIC - ICD-10 (International Classification of Diseases, 10th edition)
8. Under **Grounds of admission** the doctor must write down the way the patient was referred to the psychiatry unit, the type of admission, whether the patient is admitted willfully, details about the people that accompanied him to the hospital (it is sometimes necessary to contact them to provide information about the patient's condition prior to hospitalization) and the clinical picture upon admission, when both subjective symptoms and objective signs of behavior should be mentioned.

   While taking the *medical history* the following categories will be filled across all clinical specialties:
9. **Family history** - all psychiatric and chronic medical disorders of the blood relatives of the patient will be mentioned. The psychiatrist will ask about cases of suicide or alcohol addiction in the patient’s family.
10. **A history of personal - physiological** (birth, psychomotor development, bio-psychological crisis periods, menarche, menstrual cycle, Pregnancies / Births / Abortions) and **pathological** (abnormal development, somatic, brain trauma, etc.) **events.**
11. **Living and working environment** – the number of family members, type of dwelling and number of rooms that the patient disposes of should be documented, as well as whether they live in proper housing conditions (whether the house is heated, if they have hot water or shower facilities, etc.), details on the working conditions (for example, whether they work

in shifts, whether they are forced to endure bad weather or other environmental stress factors) will be mentioned.

12. **Addictive behavior (smoking, alcohol consumption etc.)** - the number, type and frequency of cigarette smoking should be mentioned and, also, the quantity, quality and frequency of alcoholic beverages.
13. **Medication administered before admission (including hormones and immunosuppressive drugs)** - drugs administered for any diseases from which the patient is suffering will be recorded. It should be taken into consideration that some treatments may induce psychiatric symptoms (e.g. alpha interferon and prednisone can lead to depression). Also, the prospect of drug interactions between already prescribed medication and psychiatric medication should be envisaged (treatment with isoniazid or anticoagulants).
14. **History of the illness** – should be structured according to the number of episodes to date:
    - If the patient is at the first episode, specify when and how the onset occurred (sudden or insidious), and whether there were any trigger factors (e.g. stressful life events, life changes, etc.).
    - A list of symptoms with a dynamic quotation of the intensity by time intervals of 2-3 days should be performed throughout the period of the hospitalization (for e.g. severe + + +, moderate + +, mild +, questionable presence + / -, no symptom -).
    - If the patient has had several previous episodes of the same psychiatric disorder, the first episode onset, duration, clinical pictures and context (onset circumstances) will be mentioned. Afterwards, the subsequent episodes will be mentioned - context, onset, clinical presentation (list of symptoms, duration and intensity), admissions, response and therapeutic adherence, intervals between episodes - including maintenance treatment, any disabilities or restrictions in social engagement. Finally, the current episode will be described – onset, circumstances of the onset, evolution until examination, along with a list of symptoms (with the mentioning of their intensity in dynamic).

9. **General clinical examination, laboratory investigations and the current Mental State Examination** (to be discussed)
10. **Stage diagnosis**
11. **Investigation plan**
12. **Therapeutic strategy**
13. **Individualized program for social and professional reintegration**
14. **Epicrisis (the discharge summary)** with additional stating of the case manager, the outpatient manager and therapeutic recommendations at discharge.

While taking the patient's history (anamnesis), additional *biographical* data specific for the psychiatric recording should be added:

15. Family of origin:

- Historical region / county in which the patient was born, if the family of origin was established legally or not, number of siblings and the patient's rank (first, second);
- The mother will be described – her age at the patient's birth, her behavior and occupation. Whether the patient has any information about the context of his birth should also be mentioned (perinatal complications), along with details about the psychomotor development (any speech impairment, gait difficulties, as well as any difficulties encountered in primary school in relation to learning to write, read or calculate etc.);
- The father will be described - his age at the patient's birth, his behavior and occupation;
- It should be mentioned how the patient perceived his parents' marital relationship (harmonious or disharmonious - for example, with many conflicts);
- Details about the patient's relationship with his parents and siblings should be mentioned (harmonious versus disharmonic - for example one of the parents had a hyper-punitive behavior towards the patient, the lacked of affection etc.).

16. Educational cycle – should be detailed regarding school cycles - primary, secondary and, potentially, university. School results will be checked with the account of grades, because, due to the current psychiatric illness, the patient could retrospectively underestimate (e.g. depression) or overestimate his intellectual abilities (e.g. manic episode).

17. Vocational route - all jobs will be listed up to date and possibly, also, the reason why the patient has changed several jobs (e.g. alcohol or the problematic nature of the patient).

18. Erotic and emotional relations – the age when the patient began his sexual relationships, whether the patient was stable or quickly bored in a relationship (e.g. borderline personality types);

19. Own family - the age when the patient got married should be mentioned, as well as the age of the partner (same, older or younger), the motivation behind the decision to get married (love, at the urge of the parents, etc.), the course of marriage (harmonic versus disharmonic marital relationship). In case of previous marriages, the reason for the divorce will be investigated (e.g. alcohol abuse or the problematic nature of the patient or spouse).

20. Military service – for men belonging to the generation when this was mandatory, it should be mentioned whether the military service was

fulfilled, the manner in which the patient initially adjusted to requirements of the military regime (e.g. anxiety or depression at the beginning of the **military service**). In case that the patient wasn't incorporated in the army, the reasons why this happened should be mentioned (e.g. medical reasons, perhaps even psychiatric reasons);

21. **Premorbid personality type** - this box usually relies on self-appreciation and all personality traits of the patient should be mentioned. It is preferable that the personality picture be completed with data from relatives, because it is possible that the patient does not recognize his/her negative personality traits. Sometimes we can record the patient's hobbies that can provide limited information on their structure of character (e.g. preference for solitary activities for those with schizoid traits).
22. **Stressful life events –** the significant events in the patient's life should be stated, by dividing them into types of events related to a significant loss (real or symbolic) that may induce depression, as well events related to significant threats that can trigger anxiety.

I.3. ADULT MENTAL STATE EXAMINATION

The Mental State Examination refers to the mental state of the patient at the time of evaluation. It constitutes an important and characteristic part of the psychiatric medical record. On average, a patient's mental state examination takes about 30-40 minutes.

The psychiatric examination consists of the following elements:

I. <u>The general description of the patient</u>

- **Nonverbal behavior: grooming, gait, gestures**
  - <u>Clothing</u>
    - Colors: dark, grey – in *depression*; vivid, discordant – in <u>mania</u>.
    - Unusual/bizarre combinations in *schizophrenia* (sometimes with unusual accessories that have symbolic significance – i.e. a scarf tied on his forehead as a symbol of royalty), in *schizoid personality* or in *dementia* (indicating apraxia);
    - Unsuitable for one's age – may indicate emotional immaturity;
    - Unsuitable for one's gender –ex. *transsexuals* and *transvestites*;
  - <u>Personal hygiene</u> is usually neglected in *depression* (sometimes), *schizophrenia,* in *alcohol addiction* or *dementia.*
  - <u>Gait</u>: Unusually slow *(depression),* unusually fast *(mania).*
  - <u>Expressiveness of mimic and gestures</u>
    - Psychomotor restlessness: *anxiety*, *mania, delirium, catatonic agitation;*
    - Psychomotor inhibition: *depression, catatonic stupor;*
    - Stereotypies and perseverations;
    - Echomimia, echopraxia, echolalia: *catatonic schizophrenia;*
    - Mannerisms: *hebephrenic (disorganized) schizophrenia;*
    - Extrapyramidal reactions to incisive neuroleptics: tremor, akathisia, and tardive dyskinesia.
  - **Posture – the non-verbal expression of affect:**
    - <u>Depressive posture</u>: head bent, downward gaze, hands on their lap, the corners of the lips facing downward;
    - <u>Anxious posture</u>: tense posture, uptight mimic;
    - <u>Catalepsy from the catatonic stupor</u>: waxy flexibility – holding the same position of the head or arms for a long period of time, even if it is uncomfortable;

- Acute dystonia: sustained muscle spasm: opistotonus, trismus, torticolis, oculogyric crises (included in the extrapyramidal syndrome induced by incisive neuroleptics);

- **Significant factors during the interview:** hyperactivity (e.g. in *mania*), dialogue reluctance, lack of concentration of attention, distractibility of attention, attitude towards the interviewer (e.g. suspiciousness, seeking an exchange of roles, ambivalence, ambitendency), discourse coherence (is impaired severely in *mania* or in *schizophrenia*).

I. Establishing mental contact depends upon:

- **The patient's attitude towards the psychiatrist:** can be cooperative, evasive (avoiding clear responses), hostile, aggressive or claiming attitude;
- **The psychiatrist's attitude towards the patient**: related to the quality of care;
- **Speech:** spontaneity, the rate of responses, vocabulary, tone of voice, the quality of speech, soliloquy (the patient speaks to himself), neologisms (the patient invents new words), word salad (in *schizophrenia*), poverty of speech (in *schizophrenia*).

II. Sleep rhythm

- Insomnias –of falling asleep: in *anxiety*; of late night awakening: in *depression*;
- Hypersomnia: e.g. *narcolepsy*;
- Parasomnias (qualitative disturbances): e.g. *somnambulism, pavor nocturnes (night terrors), nightmares*.

III. Insight: present (in *neuroses*) or absent (in *psychoses* – even if the presence of auditory commenting hallucinations or paranoid delusions is admitted, these being harmful symptoms, the patient does not admit the disorder).

IV. Mental State Examination on functional levels

1. The present state of consciousness: The level of alertness (e.g. in the state of *obnubilation)*; Self or environmental awareness – the temporal and spatial orientation, to self (auto) or others (allo);

2. Instinctual levels

a) Eating instinct: anorexia nervosa/hyperphagia/bulimia;
b) Sexual instinct: sexual dysfunction, paraphilias;
c) Vital instinct: attempted suicide;
d) Gregarious instinct:

- Diminished social contact, social withdrawal: in *depression, in schizophrenia;*
- Increased social contact, hyper-sociability: in *mania*.
- Inappropriate social contact: in *intellectual disabilities, dementia, confusional states;*

e) Maternal instinct: abandonment/infanticide.

3. Affective (mood) level

- Quantitative disorders: depression, mania, anxiety, phobia;
- Qualitative disorders: Affective incongruence; Affective ambivalence; Affective inversion;

4. The intellectual-cognition level

a) Attention (prosexia) – attributes: concentration≠ dispersal; persistence ≠ mobility;

- Hypoprosexia of concentration and persistence (in *depression* and *anxiety*) / of dispersion and mobility (in *depression*);
- Hyperprosexia of concentration and persistence (in *depression* for negative events and for one's own suffering) / of dispersion and mobility (in *mania* and *anxiety*).

b) Perception

- Quantitative disturbances: Hypoesthesia (in *obnubilation, confusional states, sense organs deficit, fatigue*); Hyperesthesia (in *migraines*);
- Qualitative disturbances:
  - Illusion: the perception with object, but without isomorphism (with the attribution of another significance to the object): optical illusions, in hypnagogic states, hypnopompic states, but also in pathology – in schizophrenia – the body scheme illusion;
  - Hallucination: the clear perception, projected outside the body, without object and without criticism; hallucinations are: visual, auditory (appellative, commenting, imperative, offensive), tactile, olfactory, gustatory - in *schizophrenia*;
  - Pseudohallucination: the clear perception, projected inside the body, without object and with no criticism; in *schizophrenia*;
  - Hallucinosis: clear perception, outside the body, without object, but with criticism – in *old people with atherosclerosis*.

c) Memory: Hypomnesias – for storing new information (in *depression* or *anxiety*) / for evoking information (*obnubilation, depression*); Amnesia – in *dementia;* Hypermnesia – for storing new

information (are not pathological) / for evoking information (*mania*, *drug addictions*).

d) Thinking

- Quantitative disturbances: flight of ideas *(mania)* bradypsychia *(depression*, ethanol *intoxication*), thought blocking *(schizophrenia)* – sudden interruption of the flow of thought; mentism - the sudden appearance of a large number of thoughts that unravel quickly and out of control.
- Qualitative disturbances:
  - Obsessive idea (obsessive-compulsive disorder, depressive rumination, in schizophrenia – with bizarre character);
  - Delusional idea: a pathological belief without real background evidence that cannot be contradicted with logical arguments and that has a parasitic character. (e.g. persecution, prejudice, surveillance, poisoning delusion – in *schizophrenia;* guilt, uselessness, incapacity delusion – in *depression*);
  - Prevalent idea: starting from a true fact, but dominating life and subordinating other ideas. Logical arguments are recognized and accepted.
- Formal disturbances: digressive thinking (speech with many deviations from the topic, but with the return to the original theme), circumstantial (strong adhesion to the topic of speech), ideas and verbal dissociation (the thinking process and speech lose their coherence);

e) Intelligence – measured by IQ (normal: 70-130).

5. Volitional level: refers to deliberation, decision, persistence in the act and passing to act - inability of making decisions, impulsivity (lack of deliberation), abulia (lack of will)

4. Spiritual-value level –moral consciousness – all the values and moral norms underlying social functioning.

a) Absence of moral conscience – in *antisocial personality disorder.*

b) Low self-esteem (*depression*) or high self-esteem (*mania*).

MENTAL STATE EXAMINATION – GENERAL RULES:

1. Mental examination is preceded by the somatic examination of the patient and is complemented by various paraclinical tests, such as neuroimaging, in order to exclude an organic pathology and a drug-induced pathology.
2. In order to avoid loss of relevant symptoms that results in an incomplete psychiatric examination and diagnosis, it is useful to examine the patient using the functional levels: instinctual, emotional (affective), cognitive, volitional, and spiritual.
3. An inquiry on the main syndromes should be completed: anxiety/phobic, depressive/manic, obsessive-compulsive, hallucinatory, delusional, etc.
4. The patient's history is detailed concurrently with the psychiatric objective examination (the dialogue with the patient is conducted simultaneously with observing the nonverbal language: attitude, posture, hygiene, mimic etc.). For example, the existence of hallucinations or delusions may be suggested by a behavior motivated by these.
5. The patients' history must be supplemented with information taken from people who know them, so as to validate or to increase the amount of data received from patients. This is important for psychotic patients that conceal or deny psychotic symptoms, patients who minimize or deny their addictive behavior, or patients with personality disorders who may mimic (patients with antisocial personality disorder) or amplify (patients with histrionic personality disorder) clinical symptoms in order to obtain a benefit.
6. Investigation of psychotic symptoms or drug related problems raises the following difficulties:
    a. The patient has no awareness of the disorder, and therefore does not report any symptoms spontaneously.
    b. The patient does not trust the interviewer and hides or denies symptoms.
    c. The patient is visibly hostile towards the psychiatrist and does not cooperate, giving vague, evasive answers, or completely denying symptoms.

In these cases, a diplomatic, calm and perseverant attitude of the interviewer is important, as well as the correlation of data obtained from the patient and caregivers, friends, colleagues, or neighbors.

7. The examiner should adjust:
    a. The tone and rhythm of questioning to the patient's emotional state.
    b. The questions should be in the limits of understanding for the patient's specific culture.
8. Some questions about intimate relationships, drug use, suicidal thoughts or "unusual" (psychotic) symptoms could be considered offensive or too

direct by the patient. In this case, they can be reformulated or preceded by introductory elements to alleviate undesirable impacts (e.g. some people use alcohol to lower sadness).

9. Questions should be open, to allow the patient to start and give details.
10. Writing down words and expressions used by the patient is important, but this should be done in a way that does not raise suspicions.
11. During the investigation of delusional ideas, the patient's cultural background must be taken into account, along with the traditions and beliefs that he/she was raised in and to which he/she adheres. In this respect, the information provided by others is essential.
12. The delusional and hallucinatory symptoms should be approached by using a "neutral benevolent" attitude. The examiner should be patient and serious when the subject describes the hallucinatory experiences or when he/she exposes his/her delusional beliefs. The examiner might require more explanations or might communicate his/her perplexities related to the patient's beliefs and experiences, but without obviously expressing his/her approval or disapproval.

THE OBJECTIVE MENTAL STATE EXAMINATION

Level	Investigated functions	Symptoms
Present mental state	The level of alertness Self-awareness and environmental awareness	Insomnia, obnubilation, nightmares Temporal-spatial orientation-auto-(self) and allo-(others) psychic
Instinctual level	Eating instinct Sexual instinct Vital instinct Gregarious instinct Maternal instinct	Anorexia/hyperfagia/bulimia Sexual dysfunctions, paraphilia Suicide attempt Social isolation/sociability Abandonment/infanticide
Affective level	Mood Affective reactions	Depression, mania, anxiety, phobia, irritability, Affective hyper/hypoexpressivity Labile affect, Affective incongruence Affective ambivalence, Affective inversion
Cognitive and intellectual level	Attention Perception Memory Thinking Intelligence	Hypo/hyperprosexia Illusions, hallucinations Hypo/hypermnesia for storing new information or for evocation Coherence (dissociation), fluency (thought blocking), volume (mentism), speed (tachy/bradypsychia), abstract/concrete, content (delusion, obsession, stereotypes) Vocabulary, level of instruction
Volitional level	Deliberation, decision, acting out, and persistence in act	Incapacity of making a decision Impulsivity (the lack of deliberation) Abulia (the lack of will)
Spiritual values level	Moral norms, social conduct norms, creativity	The lack of moral consciousness Self-esteem (culpability or megalomania)

I.4. INVESTIGATIONS AND TESTS FOR ADULT PSYCHIATRIC PATIENTS

In the clinical practice of adult psychiatry, psychological tests are used to clarify the diagnosis, whenever the information obtained from taking the medical history, doing the objective examination and obtaining details from caregivers (hetero-anamnesis) are insufficient or conflicting. Laboratory tests and neuroimaging are also used to exclude any organic or substance-induced pathology.

Psychological tests are of several categories:

- Projective tests (Rorschach, Szondi) are useful when the diagnosis is unclear: they offer indices for psychosis or for organicity, whenever the information provided by anamnesis or hetero-anamnesis is unclear.
- Cognitive tests that investigate the cognitive functions of the prefrontal cortex (executive functions, working memory). They are used especially in psychotic patients (schizophrenia, bipolar disorder).
- Intelligence tests (*Raven's progressive matrix, Wechsler Adult Intelligence Scale*)
- The cognitive functioning deficit: *Bender-Gestalt, Rey complex figure test.*

Scales that quantify the intensity of symptoms and treatment responses are also useful. These instruments regard the general psychopathology (e.g. *Brief Psychiatric Rating Scale* – BPRS), or the specific psychopathology:

- Depression: self-evaluation scales (*Beck Depression Inventory*), or hetero-evaluation scales (*Hamilton Depression Rating Scale - HAM-D, Montgomery-Asberg Depression Rating Scale - MADRS*)
- Anxiety: *Hamilton Anxiety Scale – HAM-A*
- Obsession and compulsion: *Yale–Brown Obsessive Compulsive Scale - YBOCS*
- Cognitive deficits: *Mini Mental State Examination - MMSE*
- Schizophrenia symptoms: *Positive and Negative Symptoms Scale* - PANSS
- Personality traits: *Personality Assessment Schedule - PAS, Minnesota Multiphase Personality Inventory – MMPI*

Laboratory tests are carried out for:

- the exclusion of an organic disease (especially endocrine ones): thyroid hormones
- detecting the consumption of substances (toxicological exams from blood or urine)

- highlighting the consequences of acute or chronic alcohol consumption (gamma GT, transaminases, macrocytic anemia, hyperuricemia)
- highlighting the side effects of psychotropic medication (blood count alterations, transaminases, prolactin levels)

Electrophysiological exams: the most used are electroencephalography (EEG) and electrocardiogram (ECG). At times, the polysomnography can be useful.

- EEG is useful to detect irritation and the slow waves that indicate an organic sufferance (epilepsy, tumors).
- ECG excludes heart disease (tachyarrhythmia) or highlights the potential side effects of psychotropic medication (QTc prolongation with a risk of the installation of *torsades de pointes*).
- Polysomnography is used especially for research purposes. It highlights the changes in the sleep architecture (decreased REM sleep latency, REM sleep and NREM sleep ratio).

Brain neuroimaging is useful for excluding organic pathology (tumors, abscesses, cysts, stroke, head trauma, normal pressure hydrocephalus, and demyelization).

- Magnetic resonance imaging (MRI) has the advantage of better resolution and lack of radiation.
- Computed tomography (CT) is cheaper, but has a lower resolution. It is especially useful for highlighting cerebral vascular pathology (ischemic strokes appear as hypo-dense formations, while hemorrhagic strokes appear as hyper-dense lesions).
- Functional brain neuroimaging (PET, SPECT) shows the functionality of different brain regions and is mainly used in research.

In diagnosing dementia, the brain scan shows cortical atrophy that can be predominantly temporal-parietal-occipital (in Alzheimer's dementia) or predominantly frontal (frontal Pick dementia). Signs of cortical atrophy are:

- Expansion of the space between the skull and brain
- Ventricular enlargement (*ex vacuo*)
- Enlargement of the brain’s gyri.

CHAPTER II. THE MAIN SYNDROMAL AND NOSOLOGICAL ASPECTS IN PSYCHIATRY

CONTENT:

- GLOSSARY OF DEFINITIONS
- THE MAIN PSYCHIATRIC SYNDROMES
- THE DIAGNOSIS IN PSYCHIATRY
- THE MAIN PSYCHIATRIC DISORDERS

II.1. DEFINITION GLOSSARY

ABULIA / AVOLITION: the absence of will.
AFFECTIVE AMBIVALENCE: the simultaneous presence, in the same person, of two opposing feelings.
AFFECTIVE INVERSION: the unjustified change of love feelings towards a familiar person into feelings of hate.
AGITATION: a state that is characterized by an unpredictable and senseless, but troublesome psychomotor restlessness; it may be accompanied by verbal or physical aggressiveness.
AGORAPHOBIA: the fear of being in a situation or a place from which the subject cannot escape or cannot be rescued from, in case of a panic attack (the fear of large, crowded spaces, means of transport, tunnels, bridges, the fear of being far away from home – a non-secure environment).
AKATHISIA: psychomotor restlessness induced by antipsychotic treatment.
ALOGIA: a speech with poor informational content.
ANHEDONIA: losing the capacity of feeling joy in situations in which the subject previously would have felt pleasure.
ANXIETY: the fear without an object. It refers to the anticipation of an imminent danger that can't be specified by the subject.
AUTOMATISM (MENTAL): the conviction that one's feelings, thoughts or actions do not belong to the subject anymore, but are imposed from outside and in opposition to his/her will (delusion of xenopathic influence). It is frequently associated with the loss of personal thought intimacy in the context of the PASSIVITY SYNDROME.
BULIMIA: eating behavior that is described as ingesting large quantities of food (sometimes sweets) over a very short period of time.
COMPULSION: internal constraint put into practice (acts) with a repetitive, ritual-like character, used as a fighting mechanism against obsessions or for preventing a future negative event.
CONFABULATION: the compensatory covering of a mental gap with fabricated, imaginary events, but which the subject believes to be true (memory hallucination).
DELIRIUM: in a limited sense = an acute and reversible confusional state characterized by a predominant temporal and space disorientation, sometimes visual or scenic hallucinations resembling a dream accompanied by anxiety with psychomotor agitation. In a wider sense = confusional state.
DELUSION: the pathological conviction (absolute, impossible to counteract with logical arguments or by evidence), that appears in clear consciousness. When community also shares the subject's convictions, therefore having a cultural or a religious aspect, a delusion will not be diagnosed.

DELUSIONAL MOOD: anxious mood that precedes the onset of a delusion (and it is secondary to the perception of bizarre environmental or of one's own body's changes).
DELUSIONAL REMEMBRANCE (MEMORY): a real memory that is reinterpreted by the subject from his delusional perspective.
DEPERSONALIZATION: the impression of bizarre changes of one's own body, of detachment from one's body or one's feelings or experiences.
DEREALIZATION: the subject perceives the environment as being alien, unreal, and artificial. People are perceived as artificial or devitalized.
DISORGANIZATION (IDEATIONAL AND VERBAL DISSOCIATION): lack of thought and verbal coherence (the subject jumps from one idea to another without a logical connection between topics).
DISSOCIATION OF THE CURRENT STATE OF CONSCIOUSNESS: the disintegration of the existing functional units between perception, memory, self-awareness (self-identity), the environment and the motor behavior of the subject. The dissociative disorders include: depersonalization, derealization, dissociative amnesia, dissociative fugue, and dissociative stupor.
DYSMORPHOPHOBIA: perceiving one's own appearance as changed, ugly, with the deformation of physical features.
DYSPHORIA: irritable bad mood.
DELUSIONAL PERCEPTIONS: delusional interpretation of a real perception.
ECHOPRAXIA, ECHOLALIA, ECHOMIMIA: imitating other people's gestures, words or mimic.
EGODYSTONIC and EGOSYNTONIC: the feeling of self-disharmony and self-harmony respectively.
FLIGHT OF IDEAS: the apparent incoherent speech, secondary to the inability to talk in the (alert) rhythm in which the subject thinks.
HALLUCINATION: a perception without an object projected outside the body and not criticized by the subject.
HYPEREMOTIVITY: an affective reaction, which is disproportional to the intensity of the stimulus.
HYPOPROSEXIA of concentration: the reduction of the ability to focus one's attention.
ILLUSIONS: perceptions with an object, but with its distortion, in terms of shape, size, form/substance relation, generating a false identification of the object. The subject criticizes these perceptions.
INCONGRUENCE/DISCORDANCE (AFFECTIVE): paradoxical affective reactions, which are incongruent with the nature of the stimulus (joy after sad news, sadness after good news).
IRRITABILITY: the predisposition to explosive reactions, in disproportion to the stimulus' intensity on the background of an apparent calm.

LABILE AFFECT: the abrupt passing from one affective experience to the opposite one.
MANIA: abnormal mood characterized by pathological happiness. The pathological character is justified by the intensity, duration, manner of appearance and reactivity.
MANNERISMS: exaggerated mimic and gesture expressivity that has lost its functional significance (mimics and gestures made without any reason).
MYTHOMANIA: the evocation of some true memories to which the subject adds involuntary fictional details of imagination, thus making the exposure more spectacular (memory illusion).
NEGATIVISM: passive (the subject does not respond to a salute or a command) and active (the subject executes the opposite of the command).
PANIC ATTACK: a short, intense and paroxysmal episode of fear, accompanied by autonomic symptoms.
PARANOID DELUSION: a delusion with a persecutory theme.
PHOBIA: a pathological fear with an object, perceived by the subject as irrational, and accompanied by the behavior of avoidance of the phobogenic object or by a self-securing behavior.
OBNUBILATION: low level of the current state of consciousness, characterized by reduced alertness, associated with a decline of mental functions and the lack of clarity in thinking.
OBSESSIONS: recurrent and persistent ideas, images, doubts, tendencies towards acting (absurd, inacceptable, auto or hetero-aggressive), and ruminations producing sufferance by parasitizing the process of thinking. The subject admits that the obsessions are pathological.
PERSEVERATION: the senseless repetition of some initially adequate gestures or words.
RUMINATIONS: the tendency towards prolonged, repetitive and sterile thinking about certain events or ideas (religious, metaphysical etc.).
SOLILOQUY: talking alone
STEREOTYPES: the senseless repetition of some words or movements.
STUPOR: the total or almost total loss of spontaneous movement and the marked decline in responsivity towards the environment.
THOUGHT BLOCKING: the abrupt interruption of the ideational flux, without an external cause. It can be associated with the theft of thoughts.
VERBIGERATIONS (PALILALIA): the senseless repetition of some sounds or words.
WAXY FLEXIBILITY: passively maintaining an imprinted position for a long time. It is associated with hypertonia (rigidity).
WORD SALAD: severe disorganization, where the grammar structure of the sentence is lost.

II.2. IMPORTANT SYNDROMES IN PSYCHIATRY

DEFINITION: a syndrome consists of signs and symptoms that are frequently associated with each other and that have a common functional background and an inner coherence.
ATTENTION: the syndrome does not represent a diagnosis of disorder, because it can have several etiologies and, also, because multiple syndromes can be found in an episode of a disorder.

1. Conversion and dissociation syndrome
2. Panic attack syndrome
3. General anxiety syndrome
4. Phobic syndrome
5. Obsessive-compulsive syndrome
6. Depressive syndrome
7. Manic syndrome
8. Hallucinatory syndrome
9. Delusional syndrome
10. Transparency-influence syndrome
11. Macro-syndromes in schizophrenia: positive, negative, disorganization, catatonic
12. Confusional syndrome (Delirium syndrome)
13. Dementia syndrome

DIDACTIC OBJECTIVES:

1. THE UNDERSTANDING AND ASSIMILATION OF THE SYNDROME CONCEPT

2. THE ASSIMILATION OF THE MAIN PSYCHIATRIC SYNDROMES

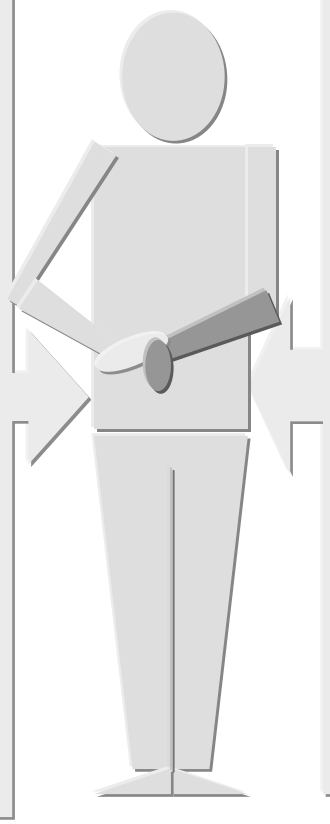
3. THE SIGNIFICANCE OF THE MAIN PSYCHIATRIC SYNDROMES

4. CONVERSION AND DISSOCIATION SYNDROME

SOMATIC CONVERSION OF THE MENTAL SUFFERING SYNDROME

Neurological complaints without organic foundation:

glove or socks hypo-/anesthesia (does not respect dermatomes),
blindness, tunnel vision, diplopia,
aphonia, paralysis with normal reflexes,
lump in the throat
pseudo-epileptic seizures,
impaired balance,
generalized tremor



DISSOCIATION OF THE CURRENT STATE OF CONSCIOUSNESS SYNDROME

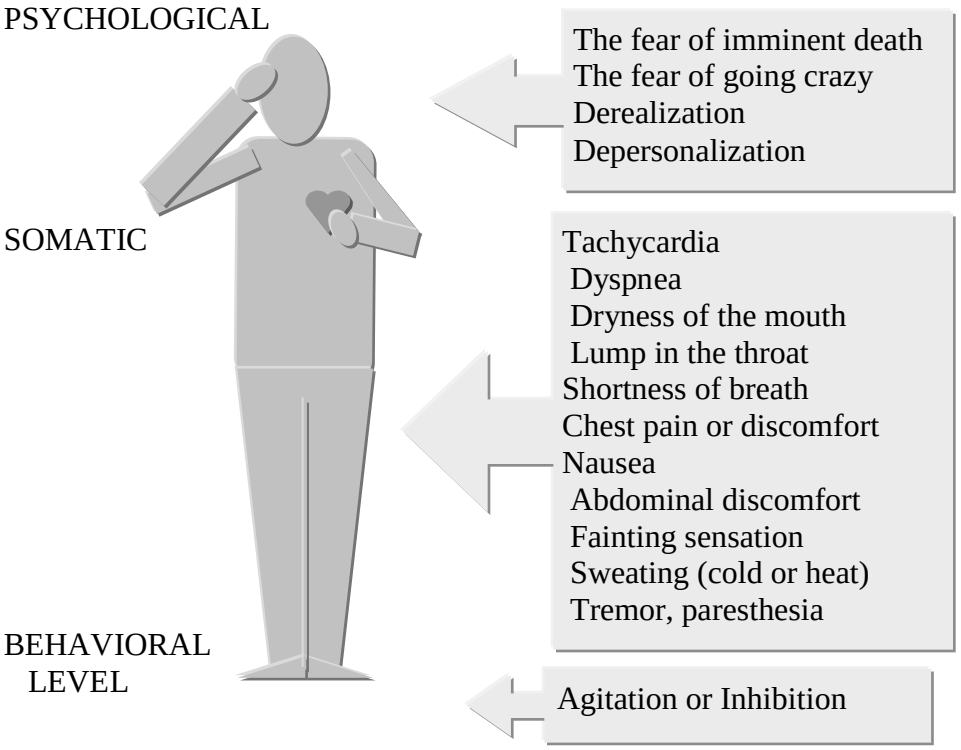
! It has no connection to the ideational-verbal dissociation from schizophrenia

Dissociative amnesia
global or partial (selective for negative events)
Twilight state with automatic behavior manifested through psychogenic fugue and amnesia of the episode (because of the narrowing of the current state of consciousness)

These episodes are frequently accompanied by:

- Evident discrepancy from organic diseases
- Predisposing background: histrionic personality (increased predisposition to suggestion)
- Paradoxical tolerance (*la belle indifférence*) because of the conversion of the psychological suffering into body sufferance (primary benefit)
- The special context in which it appears: in the presence of a third person (secondary benefit), after conflicts /frustration

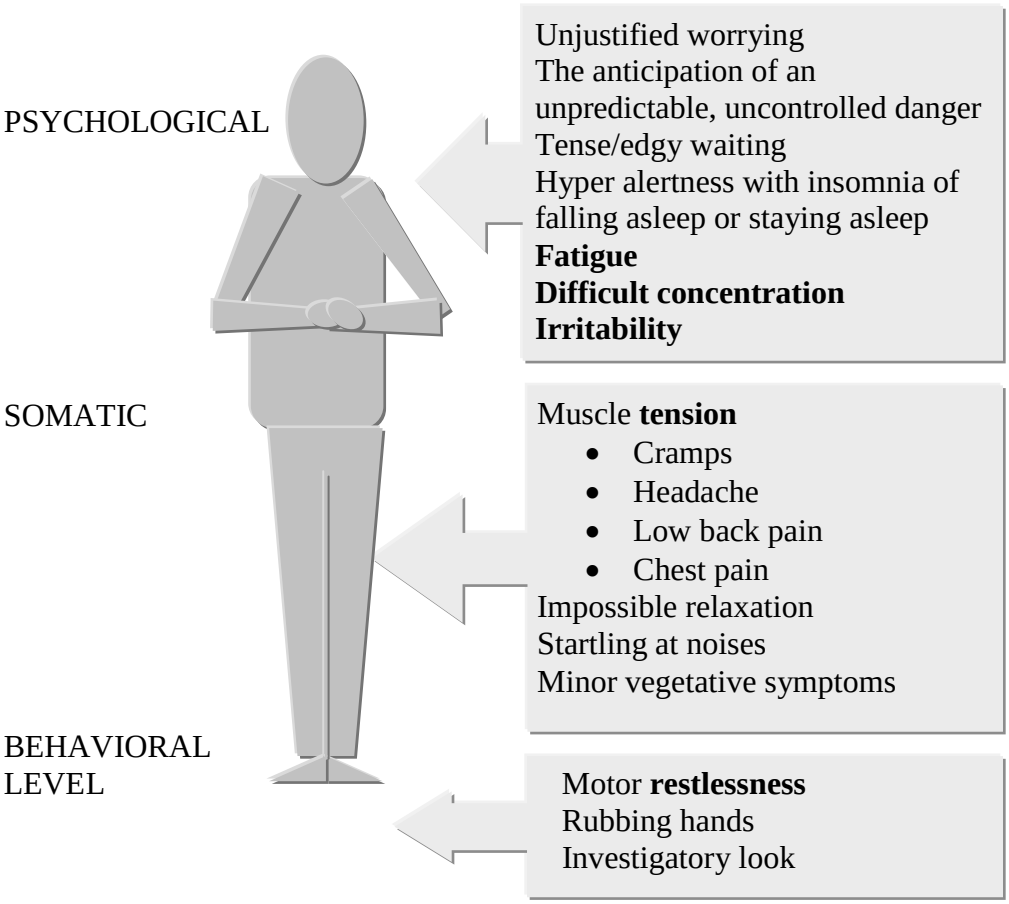
14. PANIC ATTACK SYNDROME



Panic attacks are encountered in:

PANIC DISORDER	PHOBIAS
Unpredictable panic attacks	Panic attacks in case of exposure to phobogenic objects or situations
Recurrent panic attacks > 4/ month	Avoidant or securing behavior
The fear of new attacks and their implications	Anticipatory anxiety in the case that a phobogenic situation can't be avoided

GENERALIZED ANXIETY SYNDROME

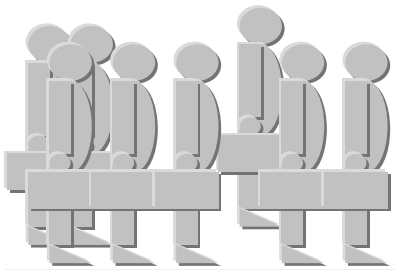


It is encountered in GENERALIZED ANXIETY DISORDER when:
- the syndrome has a DURATION of over 6 months, and
- the WORRYING has no object

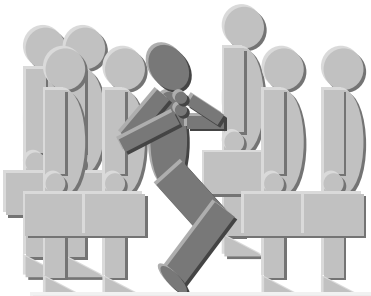
When the WORRYING has an object, such as:
- the appearance of a new panic attack (panic disorder)
- the fear of feeling embarrassed in public (social phobia)
- contamination (obsessive-compulsive disorder)
- separation from the house or close relatives (separation anxiety)
- weight gain (anorexia nervosa)
- multiple somatic complaints (somatization disorder)
- serious illness (hypochondria)

PHOBIC SYNDROME

PHOBIA = a pathological fear with an object (exaggerated, in terms of the danger level of the object), and of whose irrational character the subject is aware.



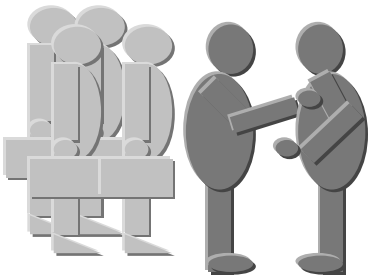
The presence of the PHOBOGENIC OBJECT / SITUATION
e.g. crowds



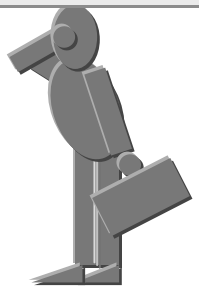
PANIC ATTACK
situational (at the encounter with the phobogenic object / situation)

PHOBIC SYNDROME

AVOIDANT BEHAVIOR of the phobogenic object /situation or SECURING BEHAVIOR (companion)



ANTICIPATORY ANXIETY when the phobogenic object / situation can't be avoided



OBSESSIVE-COMPULSIVE SYNDROME

OBSESSIONS are:
- thoughts
- doubts
- ruminations
- impulsions
- obsessive phobias

with a content of:
- contamination
- ordering, symmetry, precision
- sexual
- aggressive
- religious

and a character that is:
- penetrating
- persistent
- recurrent

Obsessive impulsions are tendencies to acts which are generally absurd, blasphemous, self- or hetero-aggressive, which the subject never puts into practice, however fearing that he/she will put them into practice.

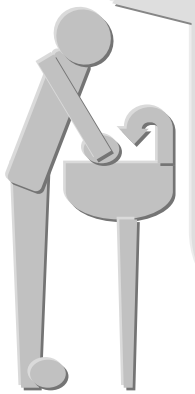
they take control over the mind

- **They belong** to the subject

(they are not introduced in the mind from a distance, as in the case of the transparency-influence syndrome)

- considered to be **absurd** (in contrast with the case of delusional ideas)
- perceived as **unpleasant**

(because of their PARASITIC character)



COMPULSIONS (rituals) are physical or mental acts, like:
-washing
-check-ups
-collecting items
-avoidance
-counting (arithmomania)

These acts have an **excessive, repetitive and stereotypical** character.

fight

If the subject tries to ignore the obsessions and to resist doing the compulsive act, an intense state of ANXIETY appears.

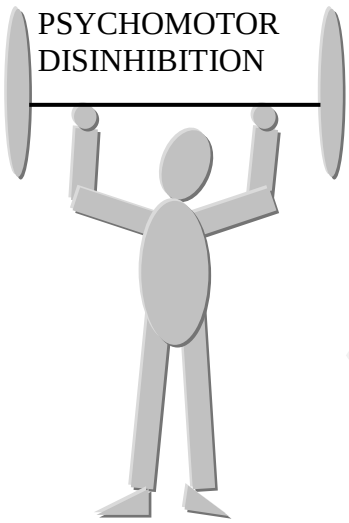
Compulsions sometimes represent a fight strategy against obsessions, reducing the anxiety generated by them, but not for long, because doubts appear regarding the correctness of the way the ritual was carried out, especially in the case of automatic acts that are done while aware, and which can be easily forgotten.

DEPRESSIVE SYNDROME

PSYCHO-MOTOR INHIBITION

INSTINCTUAL LEVEL
Social isolation
Loss of appetite with weight loss
Diminished sexual appetite
Diminished maternal instinct
Suicidal ideation
AFFECTIVE LEVEL
pathological sadness
irritability (+/-)
COGNITIVE LEVEL
Attention: the concentration of attention on the hurtful past
Perception: diminished
Memory: storing and evoking of sad events
Thought: slow, with a sad content, pessimistic, guilt, hopelessness, incapacity delusion, hypochondriac delusion (cancer, syphilis, AIDS), Cotard delusion (denial, immortality, enormity)
VOLITIONAL LEVEL
prolonged deliberation
difficulty in starting an action
APPEARANCE
clothing neglect, dark colors
SPEECH
bradylalia, laconic, latency in responses, whispered
MIMIC and GESTURES EXPRESSIVITY
Depressive face, depressive posture
HYPOKINESIA up to stupor (melancholic stupor)
BEHAVIOR
Inhibited
SLEEP
Awakening (late night) insomnia (3-4 am) without falling asleep again
Nightmares with morbid content (dead relatives, cemeteries)

MANIC SYNDROME



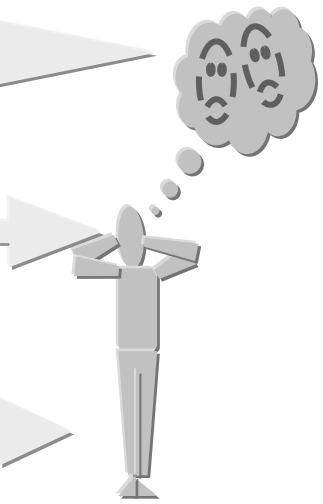
INSTINCTUAL LEVEL
increased sociability and familiarity
bulimia
hypererotism (increased libido)
AFFECTIVE LEVEL
pathological happiness
irritability (+/-)
COGNITIVE LEVEL
Attention: disperse and mobile
Perception: vivid
Memory: difficult storing, easy evocation
Thinking: accelerated ideational flux up to flight of ideas, optimistic ideation, megalomaniac delusion (illustrious personality, illustrious family, omnipotence, omniscience), delusion of wealth, messianic delusion, or of social reform
VOLITIONAL LEVEL
hasty deliberation
the lack of perseverance in an act
extravagant APPEARANCE with excessive makeup, excessive jewelry, clothing with vivid colors
SPEECH
tachylalia, logorrhea, apparently incoherent (flight of ideas) telegraphic expression, high tone of voice
MIMIC and GESTURE EXPRESSIVITY
hyperexpressivity
HYPERKINESIA up to psychomotor agitation
BEHAVIOR
expansive, uncensored
SLEEP
Reduced need for sleep

HALLUCINATORY SYNDROME

PERCEPTION WITHOUT OBJECT (the object does not exist)

ABSENCE OF CRITICISM (the subject is convinced that the object does exist / (**HALLUCINATION**)
WITH CRITICISM (**HALLUCINOSIS**)

SPATIAL PROJECTION in relation with the patient's body
Exterior – **HALLUCINATION**
Interior - **PSEUDOHALLUCINATION**



THE DIAGNOSTIC INTERPRETATION OF HALLUCINATIONS

AUDITORY
Schizophrenia
Commenting
Imperative (dangerous for the patient or others)
Injurious
Epilepsy

OLFACTORY
GUSTATIVE
Epilepsy (uncinate crises)
Psychoses (with secondary poison delusion)

VISUAL AND TACTILE
organic cause or substance withdrawal/ intoxication (alcohol)
- delirium tremens

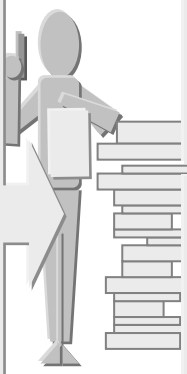
NON-PATHOLOGICAL
When one falls asleep =**hypnagogic**
When one awakes = **hypnopompic**
It last for several seconds

HALLUCINATORY BEHAVIOR

The patient speaks with the auditory hallucinations or turns his/her head in the direction from where he/she hears the voices.
The patient looks horrified at the visual hallucinations (sometimes scenic hallucinations similar to dreaming) and he seems to participate to the scenic visions
The patient defends himself from the zoomorphic hallucinations (flies, bugs, rats, serpents) that attack him or that he feels under the skin (he scratches and cleans himself).

DELUSIONAL SYNDROME

DELUSION: absolute conviction (that can't be countered by logic or evidence) in a false idea, *that occurs on a clear consciousness state (differential diagnosis with delirium). It must be interpreted according to the traditions in which the subject grew up and at which he/she adheres.*



DELUSIONAL EXPERIENCES
- delusion
- delusional disposition
- delusional perception
- delusional remembrance

SYSTEMATIZED delusion: delusional themes bind to each other in a coherent delusional system (paranoia)
UNSYSTEMATIZED delusion: delusional themes do not bind logically to each other (schizophrenia)

DELUSIONS IN PARANOIA
- Prejudice delusion (malpractice, inheritance, pension, inventions)
- Megalomania
- Persecutory delusion
- Reference delusion: news, people relate to the subject (radio, TV, press)
- Erotomanic delusion
- Jealousy delusion

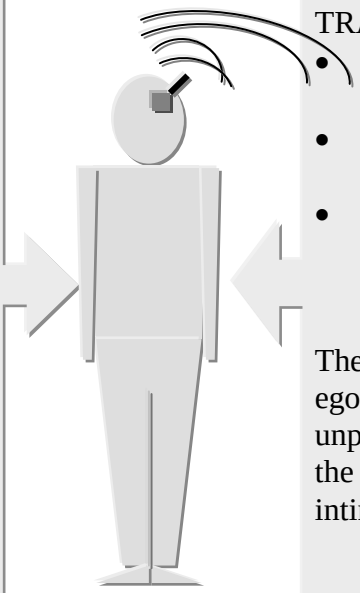
DELUSION IN SCHIZOPHRENIA
- Paranoid delusion (persecution, poisoning, surveillance delusion)
- Xenopathic influence delusion (passivity syndrome or mental automatism)
- Mystical delusion
- Demonic possession delusion
- Grandiosity delusion

THEMES OF MANIC DELUSION
(Megalomaniac delusion)
- Illustrious personality / family
- Omnipotence, omniscience
- Wealth
- Social and/or religious reform

THEMES OF DEPRESSIVE DELUSION
- Self-deprecation (uselessness, incapacity)
- Guilt
- Financial ruin
- Severe or shameful disease (hypochondriac delusion)
- Negation, immortality, enormity (Cotard triad)

PASSIVITY SYNDROME
(MENTAL AUTOMATISM, TRANSPARENCY – INFLUENCE)

INFLUENCE:
It is exercised on:
- thoughts
- behavior
examples:
- thought theft
- thought insertion
- imposition from distance of thoughts or acts that the patient considers to be foreign (xenopathic influence) and from which he dissociates himself



THOUGHT TRANSPARENCE:
- Reading one's thoughts
- Thought broadcasting
- Hearing own thoughts like an echo

The experience is egodystonic, with the unpleasant feeling of the loss of mental life intimacy.

ATTENTION!
The experience is egodystonic (it is unpleasantly felt) and passive (the patient is the subject of the influence, not its author).
Imposed acts must be differentiated (behavior control – delusion of control) from executing orders that are received through imperative auditory hallucinations (in the case of imperative hallucinations the patient executes the order given by the voices).
In this sense WE SHOULD ALWAYS ASK ABOUT THE METHOD BY WHICH THE INFLUENCE IS IMPOSED:

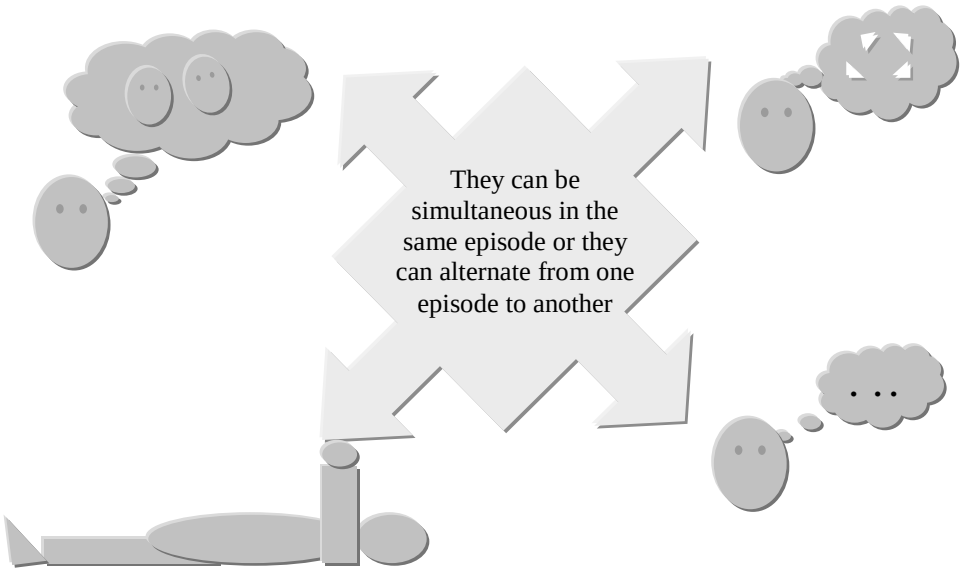
- spells, incantations (especially in rural environment)
- telepathy, biocurrents
- electromagnetic waves or electronic devices (radio, TV, computer, implanted chip), especially in the urban environment.

SYNDROMES IN SCHIZOPHRENIA

PRODUCTIVE (POSITIVE) SYNDROME

Hallucinatory syndrome
Delusional syndrome
Passivity syndrome

DISORGANIZATION SYNDROME
Dissociation (ideas/speech)
Bizarre behavior,
Ambivalence,
Affective incongruence



CATATONIC SYNDROME

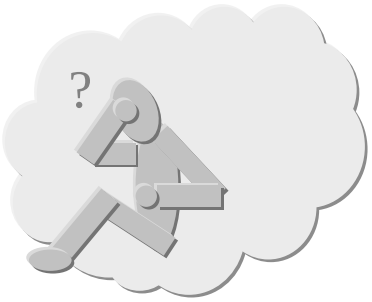
Hypertonia with waxy flexibility
Stereotypy
Suggestibility
Negativism
Psychomotor inhibition or agitation

DEFICIT (NEGATIVE) SYNDROME
Social withdrawal
Grooming neglect
Affective bluntness/flattening
Alogia, Abulia/avolition

CONFUSIONAL SYNDROME (DELIRIUM)

CHARACTERISTICS

- acute onset
- short evolution (≠ dg. with dementia)
- oscillatory intensity
- inversion of the sleep cycle
- attention disorder with secondary amnesia (≠ dg. with dementia)



SOMATIC SYMPTOMS

AUTONOMIC NERVOUS SYSTEM WITHDRAWAL SYMPTOMS

INTOXICATION SYMPTOMS

FOCAL NEUROLOGIC SIGNS

MENINGEAL SYNDROME

FEVER

ASTERIXIS

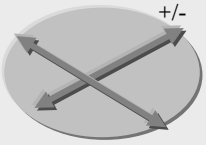
LABORATORY INVESTIGATIONS

PSYCHOLOGICAL SYMPTOMS

SELF AND ENVIRONMENTAL CONSCIOUSNESS DISORDER + ALERTNESS DISORDER

DISORIENTATION FOR **TIME OTHER PEOPLE**

+/-



SPACE OR SITUATION

Anxiety with motor restlessness

visual, tactile hallucinations

or

Obnubilation with Motor inhibition

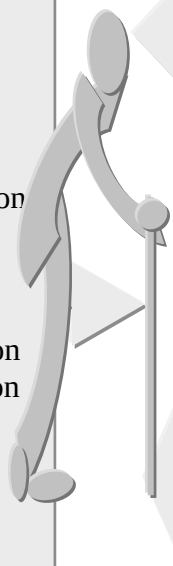
ACUTE ORGANIC SYNDROME = DELIRIUM = CONFUSIONAL STATE

DEMENTIA SYNDROME

COGNITIVE: progressively irreversible manifestations that dominate the clinical picture:

- Attention: concentration decreases
- Perception: +/- illusions, or hallucinations
- Memory: initially, short term storing amnesia (the acquisition of new memories), then
- evoking amnesia Korsakov syndrome
- Temporal-spatial disorientation auto/allopsychic disorientation
- Thinking:
  - slow
  - restrictive
  - concrete
  - incoherent
  - delusion of prejudice secondary

memory deficit) with hostility against the family members or neighbors.



AFFECTIVE

- depression
- anxiety
- irritability
- labile emotions
- catastrophic reaction
- affective bluntness

BEHAVIOR

- Indifferent to the examiner
- Absurd
- Nocturnal restlessness
- Disinhibition

SPEECH

- Echolalia
- Perseverations, stereotypes
- Verbigeration
- Mutism

Alzheimer's dementia:
Initially, short-term storing amnesia, then evoking amnesia
„3 A syndrome": aphasia, agnosia, apraxia; anosognosia
Finally, cachexia, sphincterian incontinence

Prefrontal dementia (Pick)
Apathic mood, abulia/avolition on which outbursts of irritability or euphoria appear
Disinhibition on the instinctual level (eating, sexual) and behavior, anosognosia

Vascular dementia
Cognitive deficits
- in several areas,
- with an acute onset (preceded by the cerebral stroke),
- with fluctuating intensity of symptoms over hours or days
- with a stepwise aggravation

Focal neurological signs: pyramidal, pseudobulbar, or extrapyramidal syndrome
Awareness of the cognitive deficit is preserved, with a catastrophic reaction = crying when realizing the deficit)

QUESTIONS:

1. Which of the following defines an obsessive experience?

a) An 18-year-old girl preoccupied with being overweighed tries several strategies such as vomiting, and using laxatives or diuretics.

b) A first year philosophy student preoccupied by thoughts imposed against his will by external malevolent forces.

c) A 30-year-old nun tormented by the tendency to curse God during the religious services she attends.

d) A 39-year-old passionate poker player preoccupied by financial problems after repeated game loss.

e) A 32-year-old man preoccupied by the idea of setting fire to the forest outside of town, in order to attend to the live spectacle of a fire.

2. A psychotic patient that has just broken a plate is asked why he did it. He ensures that he did not want to break it, but that Mike told him to do this. Mike is an imaginary person that the patient often speaks to. The patient's behavior is due to:

a) Passivity /Transparency-influence syndrome

b) Obsessive-compulsive syndrome

c) Hallucinatory syndrome with imperative hallucinations

d) Paranoid delusional syndrome

e) Manic syndrome with psychomotor agitation

3. You are called to consult a patient that does not move or talk. At the raising of his arm you note hypertonia with maintenance of arm position. The behavior of the patient is due to the following type syndrome:

a) Hyperglycemic coma

b) Melancholic stupor

c) Hypoglycemic coma

d) Catatonic stupor

e) Selective mutism

II.3. THE DIAGNOSIS IN PSYCHIATRY

CONTENT:

- DIAGNOSIS APPROACH
- DIAGNOSIS CRITERIA
- SYMPTOM SEVERITY CRITERIA
- THE SEARCH OF VULNERABLE AND PROTECTIVE FACTORS (MULTI-AXIAL FORMULATION OF THE DIAGNOSIS)

DIDACTIC OBJECTIVES:

1. THE ASSIMILATION OF DIAGNOSIS CRITERIA IN PSYCHIATRY

2. THE ASSIMILATION OF THE DIAGNOSIS APPROACH IN CLINICAL PRACTICE

3. THE AXIAL DIAGNOSIS FORMULATION IN PSYCHIATRY

DIAGNOSTIC CRITERIA

CLINICAL PRESENTATION

A minimal number of symptoms from a list with several symptoms

Or the DURATION
- of the episode (schizophrenia >6 months)
- of symptoms (obsession > 1 hour)
Or the FREQUENCY (panic disorder: > 4 panic attacks per month)

INTENSITY OF SYMPTOMS

Individual's functional impairment in the/at:
- family
- society
- working place / school

DIFFERENTIAL DIAGNOSIS

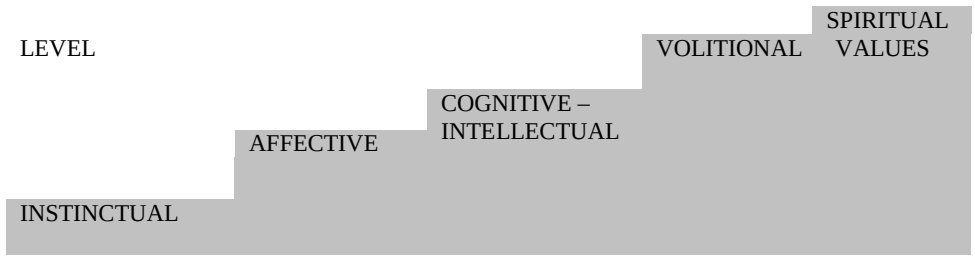
Exclusion of:
- other mental disorder
- organic disorder
- drug misuse
- malingering (lying about having symptoms / premeditated simulation)

DIAGNOSTIC APPROACH

			DISORDER
		EPISODE	The notion implies:
	SYNDROME	The notion implies:	**Vulnerability** **Onset** **History**
SYMPTOMS	The notion implies: **Symptoms are associated with one another, having a common cause and an internal coherence.**	**One or several syndromes** **Onset** **Intensity** **Duration** **Treatment**	**Evolution** **Complications** **Prognosis** **Treatment**

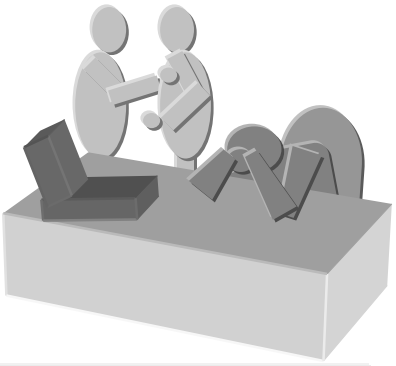
If this is the diagnosis approach used in clinical practice, using during the mental examination questions related with the functional levels offers the following advantages:

- It offers a search algorithm for symptoms that does not allow any omissions. This is very important in cases where there are COMORBIDITIES.
- It offers a logical order in the written or oral formulation of the mental examination.

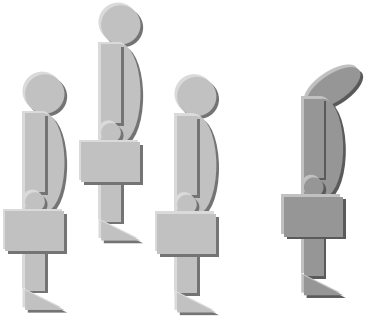


SYMPTOMS SEVERITY CRITERIA

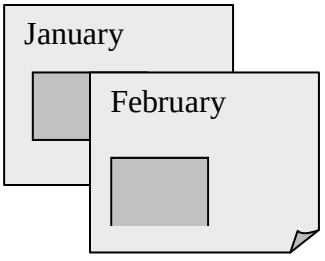
Family functioning impairment



Work place functioning impairment



Social functioning impairment



Duration since the onset of symptoms

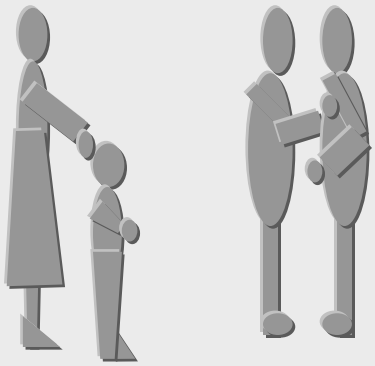
Many psychiatric symptoms have an equivalent in normality, like sadness, which is the equivalent, in normality, for depression. Depression is a mood disorder, characterized by pathological sadness. The pathological character is given by:

- its high intensity
- the prolonged duration
- the onset modality: apparent absence of triggers (stressors)
- the lack of reactivity: when encouraged or when hearing good news

THE SEARCH OF VULNERABILITY AND PROTECTIVE FACTORS

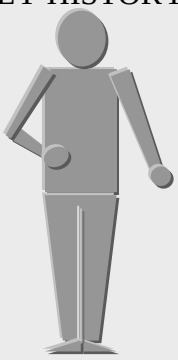
PROTECTIVE FACTOR
SOCIAL SUPPORT NETWORK

FAMILY AND / OR FRIENDS

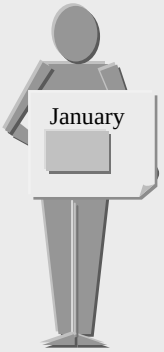


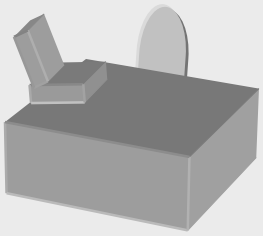
BACKGROUND
VULNERABILITY

- PERSONALITY
- MEDICAL / PSYCHIATRIC PERSONAL AND FAMILY HISTORY



CURRENT VULNERABILITY (CIRCUMSTANTIAL)





Lodging situation
Familial situation
Professional situation
Age

MULTI-AXIAL DIAGNOSIS FORMULATION (ACCORDING TO DSM)

The accounting of vulnerability factors is used in the multi-axial diagnosis formulation:

AXIS I	PSYCHIATRIC / MENTAL DISORDER
AXIS II	PERSONALITY DISORDER INTELLECTUAL DISABILITY
AXIS III	ASSOCIATED SOMATIC DISEASES with or without connection to the mental disorders
AXIS IV	PSYCHO-SOCIAL AND ENVIRONMENTAL STRESS FACTORS (psychotrauma, stressful life events, conflicts, frustration, ineffective social support network)
AXIS V	GLOBAL FUNCTIONING EVALUATION (GAF SCORE)

EXAMPLE:
I. RECURRENT DEPRESSIVE DISORDER
II. OBSESSIVE-COMPULSIVE (ANANKASTIC) PERSONALITY DISORDER
III. PECTORAL ANGINA
IV. PROBLEMS AT THE WORK PLACE
V. A GAF SCORE OF 10 (FAILED SUICIDAL ATTEMPT)

QUESTIONS

1. At a general practioner's office a 30-year-old woman presents herself with falling asleep insomnia. The doctor prescribes a hypnotic and schedules her for the next appointment. The doctor's attitude is:

a) Correct, the patient is prescribed an adequate treatment for her symptom.
b) Incorrect, because the doctor should have asked the patient if she works in shifts or if she takes other drugs.
c) Correct, because the doctor must see a large number of patients and does not have time to go into details, when he is not confronted with an organic disease or emergency.
d) Incorrect, because the doctor should have investigated a potential anxiety syndrome.
e) Incorrect, because the doctor should have investigated a potential organic cause (rebel cough produced by a lung disease).

2. The family brings a young man for a consultation, because he started to spend money excessively over the last weeks. Initially, he borrowed from colleagues or relatives, but now the parents accuse him of stealing money from home. The parents noticed that their son started to frequently drink alcohol. The young man is in a good mood and he moves around a lot. Lately, the parents noticed that he lost a lot of weight and that he has insomnia. He has a lot of energy and good school results, but his colleagues complain that he has been restless lately, avoids them and believes police follows him. Additionally, the relationship with the parents has been tense for a long time; the young man has affective inversion towards them.

a) The young man has a manic syndrome with incongruent delusions due to bipolar disorder; therefore he will receive antipsychotic treatment.
b) The young man has a manic and a paranoid syndrome, constituting a schizoaffective disorder and he will receive antipsychotic treatment.
c) The young man is a user of stimulant drugs (cocaine or amphetamines), which he associates with alcohol, and therefore must be referred to a DETOX center.
d) The young man has no mental or somatic disease, but he wants to take revenge on the parents, whom he describes as cold and disengaged.
e) The young man has a paranoid syndrome (delusion of being followed and secondary anxiety) that he tries to `treat` with alcohol, and therefore it is possible that this is a schizophrenia onset.

II.4. PSYCHIATRIC NOSOLOGY

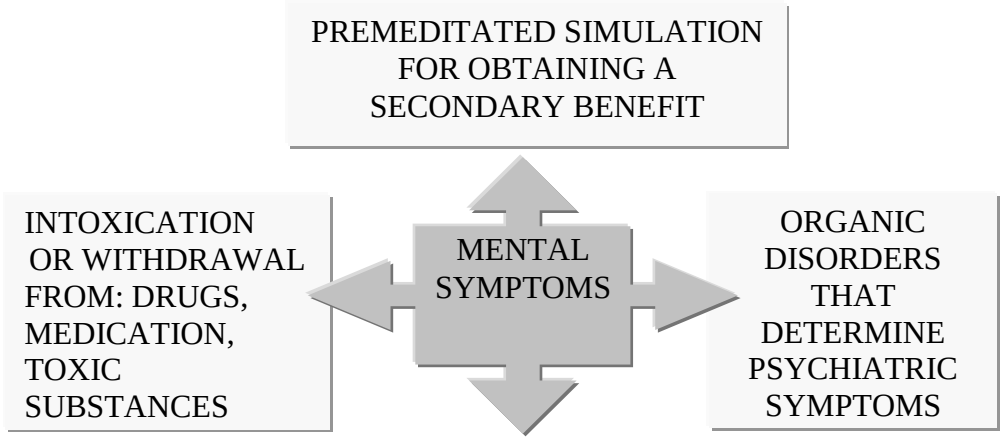
CONTENT:

1. DIFFERENTIAL DIAGNOSIS AND THE NOSOLOGICAL CLASSIFICATION IN PSYCHIATRY
2. ANXIETY DISORDERS
    a. GENERALIZED ANXIETY DISORDER = GAD
    b. PANIC DISORDER = PD
    c. AGORAPHOBIA
    d. SOCIAL PHOBIA
    e. SIMPLE PHOBIAS (SPECIFIC)
3. CONVERSION, DISSOCIATIVE AND SOMATIZATION DISORDERS
4. OBSESSIVE-COMPULSIVE DISORDER
5. PERIODIC AFFECTIVE DISORDERS
    a. RECURRENT DEPRESSIVE DISORDER = RDD
    b. BIPOLAR DISORDER = BD
6. SCHIZOPHRENIA
7. PSYCHOPATHOLOGICAL REACTIONS
8. INTELLECTUAL DISABILITY (MENTAL RETARDATION)
9. PERSONALITY DISORDERS

TEACHING OBJECTIVES:

1. THE ASSIMILATION OF FUNDAMENTAL NOTIONS CONNECTED TO PSYCHIATRIC DISORDERS
2. THE EXEMPLIFICATION OF THE PSYCHIATRIC DISORDERS THROUGH CLINICAL VIGNETTES
3. THE UNDERSTANDING OF PSYCHIATRIC CASES FROM A PSYCHOPATHOLOGICAL PERSPECTIVE

THE DIFFERENTIAL DIAGNOSIS AND NOSOLOGICAL CLASSIFICATION IN PSYCHIATRY



MENTAL DISORDERS

PSYCHOPATHOLOGICAL REACTIONS	NEUROSES	PSYCHOSES	PERSONALITY DISORDERS
<u>Acute:</u> Acute reaction to stress -emotional stupor -dissociative fugue -hysterical fainting -explosive crisis <u>Sub acute</u>: Anxious-paranoid reaction Bereavement Ganser reaction Posttraumatic stress disorder <u>Prolonged</u> Adjustment disorder: - with anxiety - with depression - with conduct disturbance - with anxiety and depression - with emotional and conduct disturbances	Depressive n. Anxious n. - Panic disorder - Generalized anxiety disorder Phobic n. - Agoraphobia - Social phobia - Simple phobias (specific) Obsessive-compulsive n. Hysterical n. - Conversion - dissociative disorder - Somatization disorder	Bipolar disorder Recurrent depressive disorder Schizophrenia Schizo-affective disorder Acute and transient psychotic disorders (brief) Persistent delusional disorder - paranoia - paraphrenia - shared psychotic disorder	Personality disorder: Schizoid Paranoid Histrionic Emotionally unstable Antisocial Anankastic Dependent Anxious – avoidant

GENERALIZED ANXIETY DISORDER, PANIC DISORDER, AGORAPHOBIA, SOCIAL PHOBIA, SIMPLE PHOBIAS

Personal data	**Reasons for admission**
Gender: Female > Male Average age for onset: 20 years GAD, 25 years PD Current residence Place of birth Profession Civil state Religious confession	- Insomnia for falling asleep - Panic attacks - Fear of leaving the house Emergency (?): yes in case of panic attacks Alone / Brought
Family history	**Family of origin**
Psychiatric: GAD: important genetic factor PD: week genetic factor Other than psychiatric	- Overprotecting mother - Sometimes tensed family atmosphere with fights between parents to which the children assist.
Personal history **Instructive - professional cycle**	**Own family**
Living conditions: secondary consumption of alcohol for courage, coffee consumption accentuates anxious symptoms **Work conditions** **Support network**: in case of agoraphobic individuals, that refuse to get out of their house, the dependency on members of the close entourage appears.	**Premorbid personalities** Perfectionist (anankastic) Psychasthenic Anxious-avoidant - Self insecurity, feelings of inferiority - New social relations avoidance because of fear of critic or rejection

Psychiatric history (other episodes)
Childhood: +/- separation anxiety, +/- school phobia
The fear of sleeping alone in bed (the child sleeps with one of the parents)
The fear of sleeping alone in the room or with the door closed
The fear of darkness (sleeping with light switched on) - simple phobias

Adolescence: +/- social phobia

Young adulthood: unpredictable panic attacks that lead to a behavior of avoiding more situations or places, resulting in the onset of agoraphobia. Agoraphobia without panic attacks exists.

Adulthood: generalized anxiety episodes with or without panic attacks,
+/- hypochondriac ideas
+/- depression
+/- secondary alcoholism

Present episode	possible: diagnosis	Generalized anxiety disorder Panic disorder Agoraphobia, Social phobia, Simple phobias

Onset	Clinical picture	Treatment
Simple phobias: at school Social phobia: 15- 20 years GAD: ~20 years PD: ~25 years Agoraphobia: 15 –35 years	<u>Generalized anxiety sd.</u>: insomnia of falling asleep, unjustified worrying, fatigue, muscular tension, irritability, psychomotor restlessness, difficult concentration <u>Panic attack sd.</u>: the fear of imminent death, tachycardia, sweating, dyspnea, lump in the throat, trembling, fainting sensation <u>Phobic sd.</u>: phobogenic object, panic attack, avoidance/securing	1. drugs - anxiolytics - antidepressants 2. psychotherapy - supportive, techniques for controlling the respiratory frequency (in PD) - for relaxation: autogenic training, music-therapy (in case of GAD) - behavioral: systemic desensitization (phobias) - cognitive

Case P.S., 32-year-old female

She visits the psychiatrist because of marked fatigue, irritability, insomnia of falling asleep, unjustified worrying. She had the symptoms for several months, but she can't fight them anymore. Her pathological personal history is insignificant.

Her family of origin: the sole child of a legally constituted family. Her parents have a higher education. They have a harmonious relationship, are overprotective and have stimulated the academic performances of their daughter. The father suffers from ischemic heart disease.

Her own family: she is married for two years with a work colleague. Her husband is two years older than her and wants to have children. The wife prioritizes her career. Lately, small conflicts appear in the relationship with the husband that tells her she has become extremely irritable.

Professional and instructive cycle: 12 grades (school + theoretical high school), chemistry university studies. She currently works as an engineer in chemistry.

Clinical presentation: the patient complains of restlessness, especially in the evening: "then I can't stay still". Frequently during the evening, she feels an intense and brief fear, accompanied by palpitations, weakness in the arms and legs and a lack of air. She noticed that, lately, she would get upset very easily, which distresses her. She falls asleep with difficulty, after at least one hour in bed. If, during the day she tries to keep busy, in the evening, in bed, she is assaulted by waves of worrying, regarding the future that she sees as unsecure. She says that "I have always lived in the future and I have never enjoyed the present". She doesn't feel rested after sleep. Sometimes she has nightmares that she is being followed and doesn't succeed to run as fast as she would in reality "it's like I run in slow motion". At work her colleagues complain that she always frowns and is tense. She wouldn't have come to a psychiatrist if the symptoms wouldn't have worsened over the last few weeks, when problems at work were added (staff cutbacks), as well as family issues (her father had to be admitted into hospital, several times, because of prolonged angina crises).

Premorbid personality: the patient describes herself as preoccupied by order and cleaning. At home she was told that her kitchen looks like a laboratory. She doesn't own carpets with fringes because she would be obsessed to arrange them. She can't stand lint. She believes in a well-done thing even if that requires a longer time. She often leaves work later than her colleagues. She often verifies her own work and the work of her subordinates. She doesn't easily delegate her responsibilities. She does it only with colleagues that she considers as serious as her.

CONVERSION, DISSOCIATIVE AND SOMATIZATION DISORDERS

Personal data	**Reasons for admission**
Gender: Female > Male Onset age: under 30 years old Current address Birth place Profession Civil state Religious confession	Generalized trembling, headache or rebellious fatigue, paresthesia „spasmophilia fits” amnesia syndrome, psychogenic flight/fugue multiple somatic complaints without an organic cause Emergency: yes- frequently brought by the ambulance Alone / Brought –frequently brought
Family history	**Family of origin**
Psychiatric: Other than psychiatric:	Frequent, unhappy childhood with arguments between parents and with physical abuse.
Personal history **Instructive and professional cycle**	**Own family** Frequently, manipulative behavior. The husband or the children take over all the activities that the patient should do in the household.
Living conditions: **Work conditions:** **Free time**: **Support network**: insufficient, because of the superficial relations with others (low capacity of affective transfer)	**Premorbid personality** Histrionic personality - attention capturing selfishness with - the need to be loved, admired and in the center of attention - high predisposition to suggestion - sociability, hyper-expression and manipulating behavior - low tolerance to frustration

Disorder history (Previous episodes)

+/- repeated parasuicide attempts: there is no real intention to die, but only to impress the entourage; the act is usually impulsive and done in front of the person with whom the subject is in conflict; the methods used are not dangerous: overdose with harmless drugs, the superficial cutting of the wrist. The patient takes precautions to ensure he/she is found in time or they leave the used bottle of drugs in plain sight.
+/- explosive hysterical crises or hysterical fainting after frustration or conflicts; repeated and long admissions in psychiatric hospitals. The patient insists to be treated and assumes the role of an ill person.

Current episode	Diagnosis: Conversion disorder Dissociative disorder Somatization disorder	
Onset: Frequently after a conflict or a frustration. The symptoms are impressive for the entourage. The ambulance frequently brings him. The patient seems indifferent - „la belle indifférence" - regarding the intensity of the symptoms and he/she abandons him/herself in the doctor's care.	Clinical picture <u>Somatic conversion syndrome</u>: paresthesia or anesthesia that does not respect the dermatomes, paralysis with unmodified reflexes, blindness, pseudo epileptic seizures <u>Dissociative syndrome</u>: global or selective amnesia, psychogenic flight <u>Somatization syndrome</u>: multiple somatic complaints that belong to multiple organs and systems: pain, digestive, neurological or sexual symptoms.	Treatment 1.psychotherapy - centered on the symptom (simple or armed suggestion) - analyzing the intrapsychic conflict 2. drug treatment in case of a psychiatric comorbidity

Case of A.M., 39-year-old woman.

The patient is brought by her family to the otolaryngologist because she can't speak anymore. After excluding an organic illness in the vocal region, and when discovering a history of a stressful life event in the past few days, she is suggested to see a psychiatrist after the neurologic consultation (a central nervous system illness was excluded). The psychiatrist discovers that she understands everything she is told, but responds only with her hands and lips incapable to communicate verbally. The data obtained from the husband revealed that she grew up in a family with 5 children. She was the youngest child and, for the most part, she was neglected in her education. A grandmother that fulfilled all her desires mostly looked her after. As a child, she was lively. She suffered from enuresis. She was capricious and wanted to obtain everything she desired, otherwise she would cry and make a scene. Her colleagues liked her because she had initiative and knew how to tell a story. When she was 15 years old, her teachers and parents noticed that she had a relationship with an older boy, which ended in a melodramatic scandal. Afterward, she developed into an ambitious girl, wanting to go to medical school. She didn't succeed at the admittance exam, so she got a job as a programmer at a computing center. She gets married at 23 to a doctor and they have a daughter. The marriage is not happy and they break up after 3 years. The child stays with her. She remarries at 29 with a work colleague, a clerk who is 10 years older than her, described as a calm and peaceful man that is preoccupied with the child's upbringing. They don't have other children. She is an overprotecting mother. She likes to be in the spotlight and she holds various social functions. At 36 she is suspected of a breast tumor. After multiple examinations, the doctors decide that the tumor is benign. A year later, her husband suffers a heart attack. She takes care of him with devotion and he recovers. Over the next year both of her parents die. At work, the department is reorganized and she is moved to another sector. Previously envied, her colleagues now complain about her attitude. She is dismissed from her position. Her menstrual cycle becomes irregular. Insomnia appears. She feels that no one understands and supports her. She feels pity for her own situation. In this context, her 15-year old daughter runs away from home with a boy. When hearing this news, she `faints`. After that, she runs away from home and wanders the streets until late at night, when her husband finds her on a bench in the cemetery. Returning home, for the next few days she complains of headaches. She can't eat anything, and feels like she can't move her legs and doesn't get out of bed. The doctor doesn't find any explanatory neurological causes. After a while, her daughter returns home and, among other `explanations`, she tells the patient that she was a bad and selfish mother. In the middle of this discussion the patient's voice suddenly stops. She couldn't speak ever since.

OBSESSIVE-COMPULSIVE DISORDER

Personal data	**Reasons for admission**
Gender: male = female Average onset age: 20 years old Current address Birth place Profession Civil state Religious confession	- The consequences of the obsessions and/or compulsions: being late at work, losing too much time with the rituals. - Depression Emergency yes/no Alone / brought
Family history Psychiatric: Tics disorder (Gilles de la Tourette) Obsessive-compulsive disorder Anankastic personality disorder Other than psychiatric: chorea	**Family of origin** A perfectionist (anankastic) member in the family
Personal history **Education and professional cycle** The individual usually has a good socio-economical level.	**Own family** Usually single
Living conditions **Work conditions** **Free time (hobby)** **Social support network** Obsessions and rituals that can sometimes occupy all day and parasitize day-to-day activities.	**Premorbid personality** Perfectionist (anankastic) - preference for order in time (planning) and space - high moral standards for self and others - devotion to work, sacrificing free time/leisure for work - the impossibility to delegate responsibilities - rigidity, stinginess (parsimony)

History of the disorder (previous episodes)

Childhood: TICS (sometimes)

Adolescence, young adulthood: OBSESSIONS + ANXIETY +/- COMPULSIONS

Adult: OBSESSIVE – COMPULSIVE EPISODES +/- DEPRESSION

Current episode	Diagnosis : Obsessive-compulsive disorder	
Onset Acute, after a stressful event, but frequently chronic In men the onset is at a younger age.	Clinical picture <u>Obsessive syndrome:</u> obsessive ideas, obsessive ruminations, obsessive impulsions, obsessive doubts, obsessive phobias with an intrusive, persistent, recurrent and egodystonic character <u>Compulsive syndrome:</u> behavioral acts (washing, verifying, avoiding, collecting) or mental (counting: stripes, poles, trees, etc.) that have an excessive, repetitive and stereotypical character =rituals <u>Anxiety</u> in case of retaining from compulsions <u>Depression</u>	Treatment 1. Medication: Antidepressants - Clomipramine - SSRI: Sertraline Fluvoxamine Anxiolytics antipsychotics – in severe cases 2. Psychotherapy Cognitive – behavioral therapy 3. ECT (electroconvulsive therapy) in case of failure with drugs - and psychotherapy 4. Psychosurgery (in exceptional cases)

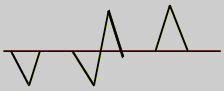
Case G.E., 42-year-old man, mechanical engineer

He presents to the psychiatrist on his own after having attempted to do so 5 times previously and leaving before his turn came. He has a correct, proper attire and carries a notebook where he has synthesized his symptoms and which he shows to the doctor. The patient repeats the things he said; just to be sure he made himself clear. He is well oriented in time, space and memory. He has insight on his mental illness and doesn't see the possibility of overcoming this state. He especially complains of insomnia, insecurity, difficulties in making decisions, thoughts and intentions (to act) that come unwittingly and cannot be controlled, as well as excruciating checking (when leaving home, he must go back 3-4 times to check if the door is closed, if the light is off or if the water is turned off). The patient was born in a legally constituted family as an only child. His father was rigid and always claimed strict discipline: mealtimes were fixed during the well-established hours of playtime; he was not to be late in the evening, after a certain hour. The mother was overprotective, but mostly anxious than affectionate. The grandmother raised him. He proved to be a stubborn child. Between the ages of 6 and 7, he had developed facial tics. He was a good and hardworking pupil. He always received prizes, being presented as a good example. He has no medical history. He doesn't abuse alcohol. He attended the Polytechnic University with good results. He didn't play any sports and did not learn to dance. As an engineer, he took his job very seriously, so if he began something, he wanted it to be well done. He got married at 25 with a colleague, mostly at her initiative. They had a boy. After growing up, the son became disobedient, which led to family quarrels. The family relationship worsened, because of his gloomy temper and because he did not like any social encounters. The wife always complains of his lack of interest for the family. Divergences appeared regarding the child's education. At work he is appreciated and he is promoted to a management position. He takes his work seriously and spends most of the time in the department. He is always troubled by the insufficient organizational order, the excessive clutter in certain sectors and he notices indifference and frivolity in subordinates. He seeks to compensate these deficiencies through his own labor. He works late hours. At night, he thinks of ways to solve these problems. He cannot sleep and gets up early. His appetite decreases. He becomes unsure of himself, he checks if he did something right or wrong several times, or whether he did something or not. Accidentally, work issues come to mind that he cannot escape. Sometimes, also unintentionally, he starts counting telegraph poles. He becomes sad and loses weight. He starts to think he might be sick (cancer, or a chronic infection?!). He washes his hands 10-20 times a day and checks everything. While crossing a bridge, he thinks, "what if I would jump?" In the tram, he has the impulse to curse others and refrains with

MOOD DISORDERS

Personal data Sex: Female >male (RDD) Female = male (BD) Average age of onset 40 years old (RDD) / 30 years old (BD) Current address Place of birth Profession Civil state Religious confession	**Reasons for admission** - memory and attention disorders - somatic suffering: psychalgies, sexual dysfunction - loss of appetite, weight loss Emergency - melancholic stupor - suicide attempt - manic episode Alone / Brought
Family history Psychiatric: BD, RDD, alcoholism Other than psychiatric	**Family of origin** - the loss of one's mother under the age of 11
Personal history Secondary depression: - Multiple sclerosis, stroke - phlebothrombosis (BD) Actively investigate: - cardiac disease - closed angle glaucoma - prostate adenoma - epilepsy **Education and professional cycle**	**Own family** - Conjugal problems over a long period of time - The lack of a supportive relationship with another adult - Bereavement or loneliness (older people) - Caring for 3 or more children under the age of 14
Living conditions Sometimes, secondary alcoholism (using alcohol as a ‚solution to the problem'). Poor living conditions. **Work conditions:** unemployment or retirement (older people) with a budget cut and social status loss. **Free time**: it is important to investigate for anhedonia **Social support network**: is frequently missing	**Premorbid personality** Vulnerability for depression: Perfectionist traits (especially) Dependent personality traits Anxious – avoidant traits Histrionic traits

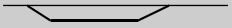
History of the disorder (previous episodes)


BD type I (depressive, manic, mixed episodes)


BD type II (depressive and hypomanic episodes)


Cyclothymia (subdepressive and hypomanic episodes)


RDD (depressive episodes)


Dysthymic disorder (long subdepressive episodes)

Current episode	Diagnosis: RDD, BD, dysthymic disorder, cyclothymic disorder	
Onset <u>Exogenous depression</u> Psychotrauma related with loss (bereavement) – reactive depression The accumulation of stressful life events in a vulnerable personality – neurotic depression <u>Endogenous depression</u> Apparent lack of triggers – RDD <u>BD</u> Sleep deprivation Stimulating substance abuse (cocaine)	Clinical picture - Depressive syndrome or manic syndrome or mixed syndrome with/without psychotic symptoms (delusions which are congruent or sometimes incongruent with the mood) - Depressive syndrome with melancholic stupor - Manic syndrome with psychomotor agitation - Depressive-anxious syndrome (mixed insomnia and restlessness)	Treatment Depressive episode 1. Medication: antidepressants +/- mood stabilizers +/- antipsychotics 2. Failure to drug treatment: ECT 3. Cognitive psychotherapy (Beck) Manic episode: antipsychotic + mood stabilizer

Case I.G., 33-year-old female, married

She is admitted in emergency, at the request of her family, for irritability, sadness, tearfulness, ideas of guilt and worthlessness.

Personal history reveals pathological seizures at 9 months. She is diagnosed with a mental disorder 11 years ago.

Family of origin: born in a legally constituted family, second-degree brotherhood, youngest child. Good relationships within the family. The mother is described as sociable (resembling the patient). The father is described as a patient, perseverant man.

Own family: the patient is currently married for the second time. The first husband is described as quarrelsome and sometimes violent. Affirmatively, he subjected her to various sexual assaults. The divorce was six years ago, due to "inconsistencies of character".

Professional instructional cycle: graduated high school. Currently she is practicing as an educator.

Premorbid personality: the patient describes herself as having an emotionally unstable nature.

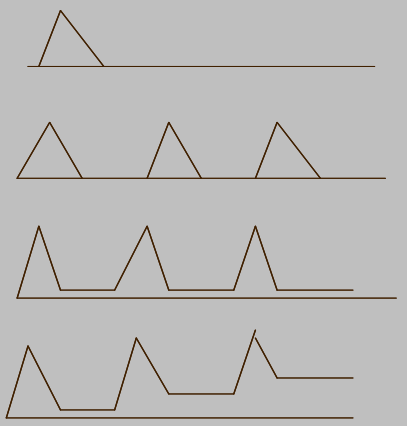
Stressful life events (SLE): the divorce (6 years ago), the separation from the second husband (two weeks before the current admission)

History of mental disorder: the patient is at the 6th hospitalization in a psychiatric clinic. The first admission was 11 years ago. Current symptoms include marked sadness (with tearfulness), ideas of guilt ("because she is sick") and worthlessness, anhedonia, low self-esteem, mixed insomnia. These symptoms alternate with periods of exaggerated cheerfulness and continuous enthusiasm (with an "intense wish to work"), increased vital energy with an uninhibited and uncontrolled behavior (excessive loans, involvement in unrealistic projects, reckless driving). During this period, the patient talks a lot, shifts from one idea to another, cannot concentrate, and has a reduced need for sleep (wakes up after only a few hours of sleep, with much energy).

Sometimes, during the day, she hears voices of men and women, which tell her nice things (praise). Socio-professional activities of the patient are disturbed, as confirmed by the investigation conducted by the social worker. These periods of mood changes (cycles) last 3-4 days. From the patient’s reports, after a conflict with the former spouse, she destroyed a number of things in the house. The patient has no insight when examining the current mental illness. The adherence to therapy is reduced; the patient does not take the maintenance treatment prescribed by her doctor.

SCHIZOPHRENIA

Personal data	**Reasons for admission**
Gender: Female = Male Onset age: 15-35 year old Current address Birth place Profession: rarely one finishes their studies and gets a job Civil state: rarely married Religious confession: important to investigate in case of mystic delusion	• Psychomotor agitation • Bizarre behavior • Impaired academic or professional functioning **Emergency**: frequent Involuntary admission: necessary sometimes Alone / **brought**: by the family or the police
Family history Psychiatric: schizophrenia, schizoid personality disorder Other than psychiatric	**Family of origin** High emotional expression (conflicts, rejection)
Personal pathological history - pre/perinatal suffering **Personal physiological history:** women - last menstrual cycle **Educational and professional cycle** Rarely, university studies	**Own family** Frequently, the patient is not married. The existence of a supportive family is a positive prognosis factor.
Living conditions: frequently, as a result of the deterioration due to the disorder, the subject can't live independently and requires a protected home. **Work conditions:** frequently, retirement or participation to occupational therapy activities and protected workshops is imposed. **Free time:** the disorder predisposes the patient to the loss of interest for any activity **Social support network**: frequently, the patient is rejected by the family	**Premorbid personality** Schizoid personality traits are investigated: - affective coldness - indifference to critic or praise - lack of interest for social relations, sexual activities - preference for solitary and abstract activities - behavior and clothes are nonconformist, eccentric

<table>
<tr><th colspan="3">History of the disorder (previous episodes) – 5 year study</th></tr>
<tr><td>  </td><td>22% of cases

35% of cases

8% of cases

35% of cases</td><td>1 episode with complete remission

>episodes with complete remission

>episodes with complete remission

>episodes, incomplete and defective remissions</td></tr>
<tr><td>Current episode</td><td colspan="2">Diagnosis: paranoid, disorganized (hebephrenic), catatonic or undifferentiated schizophrenia</td></tr>
<tr><td>Onset
insidious with <u>deficiency symptoms:</u>
- social withdrawal
- attention and memory disorder
<u>subacute</u> <u>with derealization depersonalization anxiety</u>
acute: with <u>productive symptoms</u>
- delusions
- hallucinations
- psychomotor agitation
- bizarre behavior</td><td>Clinical picture
Productive syndrome:
- paranoid delusion
- transparency-influence syndrome
- auditory hallucinations
Disorganization syndrome
- ideational-verbal dissociation
- affective incongruence or ambivalence
- bizarre behavior
- mannerisms
Deficiency syndrome
- social withdrawal
- affective bluntness
- alogia, abulia
Catatonic syndrome</td><td>Treatment
1. Drugs
For delusions, hallucinations, dissociation, psychomotor agitation:
conventional or atypical antipsychotics
For negative symptoms:
atypical or bimodal neuroleptics - in low doses
2.Failure in drug treatment: ECT
3.Psycho-social rehabilitation programs</td></tr>
</table>

Case D.V., 22-year-old male, student in the 2nd year at Polytechnics, single

Overview: negligent attire (poor hygiene, unshaven, dirty hair) with an expressionless look, stereotypical gestures, immobile mimic, bizarre, unhappy of the fact that he is brought to the doctor, without an evident opposition. He is tall and slim; suffers from insomnia, speaks in a distant and "cold" way with an air of misunderstood superiority. The dialogue with the doctor is established with difficulty.

Reasons for admission: the patient doesn't complain spontaneously about any symptoms. He thinks he is not ill. His parents say that he had a progressive decline in intellectual performance; he repeated the second academic year, dropping out at the middle of the year. He prefers to stays in the house and doesn't want to see anyone; he smokes a lot, drinks large quantities of coffee. For several weeks, he only washes sporadically and refuses to see his parents; receives food through the slightly open door, and after eating (little), he puts the dirty dishes in the doorway.

The patient has an asthenic constitution. He was a child with appropriate psychomotor development, withdrawn, shy, avoiding direct confrontation with those in the play group. Good student with above average academic results, not interested in girls, he prefers to read than to go to a meeting with colleagues.

History of the disorder: his parents retrospectively recognize changes in his behavior, which occurred two years ago and they interpreted as a consequence of an emotional disappointment. He became more withdrawn, a daydreamer, careless, giving the impression that he is concerned with some problems. This event occurred in the first year of college, and was correlated with fatigue after the exam, a difficult adjustment to academic demands. His passion for poetry and philosophy resulting in buying philosophical and poetry books dates from the same time. In the second year of college (technical profile), his parents have noticed a lack of interest for the subjects taught at school. The young man became "sloppy" and detached from the friends who used to visit him, considering him unable to sustain an intellectual discussion. Concerns outside the university occupied most of his time, with a new orientation toward philosophy. He repeats the academic year, but his intellectual abilities decrease gradually, he becomes stereotypical, poor in ideas. In the philosophical area, he uses concepts and categories without any real content. He is incapable of understanding and reformulating problems. The psychological tests reveal accurate and consistent answers to questions with a low degree of difficulty. As the level of abstraction increases, clear deficiencies and logical inconsistencies appear (such as in an example of the interpretation of his own poem "The hallmark of Brancusi is a man and a woman, but each of them is a different plan. Because it means remoteness and near... the sun is androgynous").

Case I.D., 18-year-old man, unqualified worker, single

He is brought as an emergency, by the ambulance; he was restrained, after breaking the TV, some windows and the curtains inside the house.

Overview: barely dressed, blood stains on his shirt, abrasions and cuts on the anterior region of both thighs and arms; messy hair, a "dumb" laugh expression, unmotivated and obscene gestures, contrasting restless mimics, spitting, swearing. He laughs "meaninglessly", uses vulgar words, his movements are uncontrolled and pointless. He doesn't answer questions, struggles and screams, kicks his legs and arms, and has chaotic motions. Irritated, excited, he doesn't seem to notice the world around him; his eyes are staring into space. Monosyllabic noises or words used are put together without any connection, anarchic, incoherent. Showing aggressive anger without a specific object, he breaks and hits everything around him. He requires restraint and neuroleptic sedation. A few days after admission, while still agitated, even after neuroleptics administration in high doses, his state changes, he becomes lethargic, quiet, stays in bed longer, and doesn't communicate. He remains immobile in bed, refusing to eat, initially resisting to be fed. After receiving short, simple orders, he does the opposite. If they say "open your mouth", he clenches his jaws. After a day, he doesn't get up from bed, not even for his biological needs. If he is taken out of bed and someone raises his hand, he keeps it in the same position for a long time. He looks like a wax doll, and people can imprint any movement on him (waxy flexibility). He sleeps in strange positions, with the head suspended in the air above the cushion ("mental pillow"). After applying ECT (electroshocks), his condition improves, and he starts to feed himself, gets out of bed. Reasons for admission: a condition of intense psychomotor agitation, verbal incoherence, marked aggression. History of the illness: sudden onset, the previous day, with restlessness, anxiety, and bizarre behavior. There were no traumatic psychological reasons or ingestion of toxic substances to explain his present state. He did not excel in academic achievement as a student, being less than mediocre. He was born from a casual relation with a man whose personal history his mother does not know. He was a playful child. At the age of 18, not fully matured, he left school after graduating only 8 grades. He changed three jobs as a seasonal laborer. He used to play with kids younger than him, and has lately been attracted particularly to violent groups of teenagers; he skips work, and goes to the movies. He comes back late at night. He was fined for disturbing the peace, in the company of other unemployed young people. Psychological examination: psychomotor agitation, verbal incoherence, inconsistency, stereotypes, catatonic stupor, negativism, and catalepsy.

Case M.D., 43-year-old female

She is hospitalized at the insistence of the family doctor remarking oddness in the patient's behavior. In the first days of hospitalization, the patient's attitude is reluctant; she avoids talking to the psychiatrist about her "real" problems. Gradually, after several meetings with her doctor, she decides to "talk". The family and personal medical history are insignificant. Over the last several years she changed. Although she used to be a passionate reader, lately she ceased to read. She is increasingly concerned with issues related to the supernatural. She claims to have the ability to communicate with spirits, and, especially, the spirit of her husband (who died ten years ago) at night, when he visits her room. She knows it's him by following some signs known only to her. She believes he comes to warn her, knowing that she is the holder of a great secret – she knows about the ability of some plants that could heal cancer, but hasn't got the courage to divulge this secret, for not endangering her son's life. She feels persecuted; she knows that people disguised as foreign agents and spies, watching her actions, track and verify her, she feels controlled by all the cars in the city. At work and at home she is influenced by electromagnetic radiation, whose sources are all the wires and nails from the walls therefore dismantles all of them at home and at the workplace. Furthermore, at home she took out the floor to find bugs, which would read thoughts. She hears voices commenting on her actions, she sees strange beings that appear whenever someone wants to talk about what is happening to her. Even the physician is afraid to speak of what is happening to her, because she "sees" a threatening being behind the doctor. This fantastic universe took place in parallel with the patient's daily life and, for a while, allowed a long and satisfactory insertion into her social and professional life. When the fantasy world of the spirits overlapped reality, the patient arrived at the hospital feeling particularly disturbed by "outside influences", a reaction of emotional anxiety with insomnia, restlessness, and fatigue. Psychological examination: clear consciousness level with good orientation to self and others. She presented auditory hallucinations (nocturnal noises, voices that comment and threaten her actions). On the thinking level, a relatively well-systematized delusion is now present, with a fantastic theme: communication with spirits, holding a secret of global importance, delusions of external influence. The existence of the mental automatism syndrome is demonstrated both by the feeling and belief that the patient's thoughts are recorded and the consequences of these experiences: removing the floor, removing nails and electrical wires from the walls. The patient's insertion in a fantasy delusional network does not offer insight. She reaches the psychiatry hospital only when she feels exhausted by the "influences" and the "following". Her mood becomes intensely depressed, anxious, with high anxiety states at night, in the moments when she feels the presence of spirits.

PSYCHOPATHOLOGICAL REACTIONS

Personal data Gender: Female = male Onset age: any age Current address: relocation, emigration (in case of adjustment disorders) Place of birth Profession: military that participated in wars, peace missions, special missions (in cases of PTSD) Civil state: frequently, single Religious confession (sometimes religious conversion or a faith loss)	**Reasons for admission** • Panic attacks • Psychomotor agitation • Anxiety with insomnia • Recurrent nightmares • Depression • Sedatives, alcohol, drug abuse **Emergency**: **yes** / no Alone / brought: Brought by the family or the police
Family history: Psychiatric: Other than psychiatric:	**Family of origin:** Family abuse (in case of PTSD)
PPH: childhood trauma (in case of PTSD) somatic disorders (in case of adjustment disorders) **Education and professional cycle**	**Own family** The separation from a family member through divorce or death Pregnancy, raising a small child
Living conditions: disadvantaged social class (in the case of adjustment disorder) **Work conditions:** dismissal**,** promotion, retirement **Free time:** **Social support network:** absent or inefficient	**Premorbid personality:** dependent, paranoid, emotionally - unstable

History of the disorder

Psychological trauma (psychotrauma): extremely impressive event, when the subject might feel threatened with sudden death, severe psychological injury, loss of physical integrity. There may be situations that arise in wars or revolutions, situations in which the person is attacked directly (physical attack, robbery, assault, rape), terrorist attacks, torture, imprisonment, car or train accidents, witnessing violent death or injury of those close, natural disasters

Significant life changes (puberty, aging, promotion, retirement, emigration, divorce, bereavement)

Self-limited evolution: max. 1 month (acute stress reaction), under or over three months (PTSD), 6 months - 2 years (adjustment disorder)

Current episode	Diagnosis: acute stress reaction, posttraumatic stress disorder, adjustment disorder	
Onset -acute: hours, a day after a psychotrauma (acute stress reaction) - subacute: after a psychotrauma, latency time up to 6 months (PTSD) - subacute: up to 3 months after an important life event (adjustment disorder)	Clinical picture Acute stress reaction: intense panic attack with detachment, derealization, depersonalization, psychomotor agitation or inhibition. Posttraumatic stress disorder: - anxiety - avoidance of people or situations correlated with the trauma - dissociative amnesia - flashbacks - repeated nightmares Adjustment disorder: - anxiety, depression - conduct disturbances - mixed picture	Treatment 1. anxiolytic, antidepressant drugs 2. psychotherapy: supportive therapy crisis intervention abreaction group therapy

Case T.M., 50-year-old man, accountant, widower

The patient is brought to the psychiatrist by his colleagues after his performance at work declined. He isolates himself and recently comes to work after drinking alcohol.

From his personal history, we learn that the patient survived an accident. He was driving with the wife and daughter. His wife died in the accident, while the patient and daughter survived.

After four months of an apparently calm recovery after the accident, the patient developed sleep disorders with superficial sleep and recurrent accident related nightmares. He startles at noises and becomes restless at night. In addition, he avoids all situations that might trigger memories of the accident. He no longer drives and no longer uses this means of transport with other drivers. He avoids talking about what happened that day and, interestingly, when asked by relatives, he appears to have difficulties remembering details about the day of the accident, despite the fact that he was not in coma. Sometimes, memories of the accident arise suddenly as flashbacks, tormenting him during the day and impairing his level of functioning at work, in society or at home.

MENTAL RETARDATION (INTELLECTUAL DISABILITY)

Personal data Gender: Female = Male Onset age: 0-12 years Current address Place of birth Profession: depending on the level of the disability Civil status: frequently, unmarried Religious confession	**Reasons for admission** • Psychomotor agitation • Self- or hetero-aggression **Emergency**: yes / no Alone/**brought**: brought by the family or the police
Family history: Psychiatric: Other than psychiatric: genetic disorders	**Family of origin**
PPH - genetic disorders, pre-, peri- and postnatal infections, toxic substances exposure, stroke, tumors, physical trauma, severe malnutrition, iodine deficiency **Education and professional cycle** People with mild intellectual disability are schooled (special school – 4 grades)	**Own family** Frequently, the patient is single
Living conditions: frequently inadequate **Work conditions:** **Free time:** **Social support network**: frequently, inadequate	**Premorbid personality**

History of the disorder (previous episodes) Childhood: multiple hospitalizations in child neuropsychiatry services. Adolescent, young adult: admissions in child neuropsychiatry services/adult psychiatry with conduct disorder/ self- or hetero verbal/physical aggression (disharmonic type)		
Current episode	Diagnosis: Borderline intellect/ mild / moderate / severe mental retardation with / without behavioral disorders	
Onset Acute after a minor / major stressful event (interpersonal conflict). **Severity levels:** **Borderline intelligence** (score IQ =70-84) **Mild mental retardation** (IQ=50-69) **Moderate mental retardation** (IQ=35-49) **Severe mental retardation** (IQ=20-34) **Profound mental retardation** (score IQ < 20)	Clinical picture Intellectual-cognitive deficits - deficit in speech, reading, writing, calculating - attention / memory deficit - lack of understanding / judgment - psychomotor restlessness/agitation - verbal or physical hetero-aggression - auto-aggression - irritability - labile affect - depressive - anxious reactions to stress - rarely: psychotic episodes	Treatment 1. drugs for comorbid psychiatric disorders: - depression (antidepressants) - psychomotor agitation and behavioral disturbances (typical or atypical antipsychotics, mood stabilizers) 2. psychotherapy: supportive therapy and/or educational, parental counseling /family, group activities

Case B.T., 19-year-old male, single

He is brought to the psychiatry emergency room by his parents for aggressive behavior that suddenly appeared in the context of family quarrels. The patient is in psychomotor agitation; he threatens his family and the medical staff that it will be very bad if he is not allowed to leave, saying that he was tired to be directed in life by his parents. The vocabulary he uses is poor. Hygiene and clothing are appropriate.

The patient presents cognitive, attention and memory deficits. He has difficulty reporting what causes the repeated quarrels with his family. However, he insists, on the fact that he is directed in life.

The parents say that the patient was born prematurely, by cesarean section, with a birth weight of 1400 g. The child had a delayed psychomotor development (he started walking at the age of 2 years and 8 months and talked at the age of 3 years and 2 months).

He attended a special education school (4 grades) and worked for two weeks in a tailoring shop, but couldn't adjust to the workplace, and had several conflicts with the other employees.

He never had a relationship.

The patient suffered a severe head trauma at the age of 4 years and 6 months (fall). After this event he has become withdrawn, non-communicative and aggressive, both physically and verbally, toward his parents, but also to everyone he came in contact with.

The patient had multiple admissions in the Child and Adolescent Neuropsychiatry Hospital for aggressive outbursts and depressive episodes.

The non-verbal Raven test reveals an IQ score of 62.

PERSONALITY DISORDERS

PERSONALITY = the constant way of feeling, thinking, acting and reacting of an individual

MAIN TYPES	GENERAL FEATURES OF PERSONALITY DISORDERS
	❑ personality traits are globally and excessively accentuated ❑ maladaptive behavior (which affects the functioning of the individual in the family, in society or at work). The behavior is rigid (inflexible in a variety of circumstances) and durable (unevolutive) ❑ egosyntony (the person is satisfied with him/herself) and alloplasticity (the person does not feel the need to change him/herself, but feels others should change) ❑ vulnerability to other psychiatric disorders ❑ pathoplasticity (altering the clinical picture of comorbid pathology) ❑ The onset is in adolescence or early adulthood
SCHIZOID	1. indifference to criticism or praise 2. the need to live a solitary existence 3. emotional coldness (diminished ability to express feelings) 4. disinterest in close or intimate relationships 5. concern for fantasy and introspection 6. preference for solitary and abstract activities 7. eccentricity, nonconformity
PARANOID	1. megalomania, sufficiency 2. hypervigilance and undue concern about the lack of loyalty of friends or colleagues 3. sensitivity to criticism 4. suspiciousness 5. reads hidden demeaning 6. resentment 7. quarrelsome, suing others

ANTISOCIAL	1. disregard for, or violation of the rights and safety of others 2. failure to conform to social norms, laws 3. the use of lies, trickery, complicity to obtain personal profit 4. irresponsibility at work or in honoring financial obligations 5. impulsivity, low tolerance to frustration 6. irritability and aggression 7. the inability to feel guilt or learn from punishments
HISTRIONIC	1. the need to be in the spotlight, selfishness, weak ability of affective transference 2. sociability 3. suggestibility 4. low tolerance to frustration 5. hyperemotivity (exaggeration in expressing emotions), crying easily 6. superficiality, labile affect 7. theatrical behavior, manipulative, seductive, attracting attention to his/her physical appearance (seductive behavior and appearance)
EMOTIONALLY UNSTABLE	Impulsive type: emotional instability and lack of impulse control (explosions of violence to criticism) Borderline type: 1. intense and unstable interpersonal relationships 2. frantic efforts to avoid real or imagined abandonment 3. potentially harming impulsivity (spending, sex, substance abuse, bulimia, driving) 4. instability of self-image 5. affective instability, intense emotional reactions (dysphoria, anxiety, irritability, anger and aggression) 6. harming behavior, threats, recurrent suicidal gestures 7. feeling empty, transient paranoid ideation

ANANKASTIC, PERFECTIONIST, OBSESSIVE-COMPULSIVE	1. inhibited perfectionism (inability to perform a task because of exaggerated self-imposed standards) 2. devotion to work (financially unjustified) at the expense of leisure and relationships 3. concern for order, rules, organization 4. adherence to social conventions, moral rules 5. the inability to dispense of unnecessary objects or objects of no emotional value 6. reluctance to delegate responsibilities 7. rigidity, stubbornness 8. avarice
ANXIOUS AVOIDANT	1. the concern and excessive fear of being rejected or criticized 2. feelings of inferiority, of being socially inadequate 3. restrained in intimate relationships 4. reluctance to get involved in interpersonal relationships, if not sure he/she is liked 5. inhibition in new interpersonal relationships 6. reluctance to take risks or responsibilities 7. avoids activities that involve interpersonal relationships
DEPENDENT	1. difficulty in making everyday decisions without supervision, or initiating their own projects 2. the need for others to take responsibility in his/her place 3. lack of confidence in their own abilities 4. the feeling of helplessness when they need to make a decision on their own 5. inability to express disagreement and accepting unpleasant tasks in order to avoid losing support from others 6. immediate search for a new supportive relationship when the previous one ends 7. fear of being left to care of him/herself

Case C.M., 35-year-old male, unqualified worker, single

He was admitted in hospital at the referral of the forensic medicine, in order to have a psychiatric evaluation. The patient was accused of repeated theft of public and private property. During trial, the defense claimed a "mental illness", and the judge ordered a medical examination. The somatic and mental status examination performed upon the patient's arrival at the hospital show the absence of subjective symptoms and objective signs, both organically and psychologically.

The patient reported that his parents are farmers. He was born and raised in a rural area. His father, a violent and brutal man, was a systematic alcohol drinker, involved in many scandals and convicted several times for various offenses. He is described by the patient as being pleased whenever he managed to upset family members. He once had a short admission and underwent a medical examination in a psychiatric hospital. The mother of the patient is described as having a passive nature, engaging in household duties, which she was running on her own (her husband was mostly absent from home); she had no time to deal with her children's education. He had three siblings, 2 of whom are farm workers; the third, with an alcohol addiction and violent behavior, wanders through the country, without being able to settle down anywhere, without a house and workplace. The family atmosphere during childhood was always tense, because of the scandals with the father. He believes that his parents have expressed indifference towards him and he blames them for this: however, he does not admit that he never loved his family members. He only completed mandatory schooling, and tried, but failed several times, to finish any course of professional qualification. He justifies his mediocre educational performance by the misunderstanding that teachers – like his parents - have manifested towards him, punishing him often and - he believes - wrongly. After finishing school he tried to work in many places, but encountered misunderstanding and injustice everywhere. Because the work is always distributed to his disadvantage, he didn't stay for a long time in any factory. The military service was fully performed in a unit of work on construction sites. He states that he didn't cope at all with the order system that he considers too authoritarian and sometimes protested against and was punished for. Afterward, he resumed work as a laborer, changing many jobs, because he usually either resigns or he is let go for misconduct. He is not married, because, the patient says, "he did not find a suitable companion for life". After the "mistakes of youth" he is bound by judicial sentence to pay child support to a woman. He has very few friends. He states that he only drinks alcohol occasionally. He accuses his friends, who he now disregards, that, after the celebration of a birthday where he had been drinking, they had attracted him in a trap, because he was not fully aware while being

intoxicated. The consequences appeared when he woke up, and found he was indicted on charges of theft, while not being guilty. He states that he did not suffer from any disease in the past, but that as a teenager he suffered a strong blow to the head, after which he fainted, without receiving any medical care. However, he thinks that he must have had a "head illness" due to the blow received, otherwise he cannot explain how alcohol led him to a state of "recklessness", in which he committed acts that were "not in his character" and otherwise he would never commit with a clear mind. After further reports given by a patient's relative and from the social worker's data from his current home and workplace, it was revealed that the patient offered an incomplete version and - in part – a false biographical history of his life. The assertions about his father are true, but the patient, since early childhood, manifested various disorders exhibited at home or at school: he was undisciplined, naughty, often missing from home and school, wandering in a bad company, lying and stealing, starting to drink and smoke at an early age. He liked to torture animals and torment children smaller than him. He could be corrected, neither by word, nor by severe penalties. He cheated many people, seduced girls by making a "claim to fame" among "friends" with these things, without ever manifesting compassion for the suffering of others or remorse for the offenses committed. He always considered that this is the way life should be lived, with unscrupulous advantages at the expense of the gullible. Because of his nature, he was not tolerated in any work team. His neighbors complained about repeated parties, followed by scandal. His professional efficiency was always low, constantly looking to work as little as possible and to take as much, blaming failure on others. He is, in fact, an incorrigible chronic consumer of alcoholic beverages. He had numerous incidents with the police and justice, but he, so far, succeeded to exonerate himself. It is known that, along with his "friends", he committed numerous delinquent acts. He describes himself (in contradiction to his real biography) as a sociable, active, uncompromising, and sometimes easily influenced person. He does not believe that he has an abnormal 'nature'. Present somatic and mental examination did not reveal any significant symptoms of mental or somatic illness. He hasn't received any drug therapy and no indication exists for it. Neurological examination: no changes; EEG: no pathological graphemes; tests (Szondi, Rorschach, Rosenzweig) showed poor tolerance and group conformity, intolerance to frustration, hedonism, self-centeredness, and an absent moral censor. During interview the patient remains cooperative, still looking to "make a good impression." His hospital conduct is flawless. He often requests a pass from his doctor that allows him to go out, under various pretexts.

QUESTIONS:

1. A 22-year-old patient was brought by his family for admission, because he has been barricaded in his room and does not want to communicate with family members for three weeks. He sometimes shows bizarre behavior, such as soliloquy. He says to the psychiatrist, with great difficulty, that his parents are involved in a conspiracy against him, which is why he hates them. The patient does not feel the need to give explanations about this and targeted questions fail to clarify the alleged conspiracy. The most likely diagnosis is:
    a) schizophrenia, simple type
    b) schizophrenia, hebephrenic type (disorganized)
    c) schizophrenia, undifferentiated type
    d) schizophrenia, paranoid type
    e) schizoaffective disorder, schizodepressive type
2. A 60-year-old male, brought by the family for an outpatient consultation, because of a disinhibited impulsive behavior (without compliance with his social behavior). During the interview the man seems euphoric, but his joy does not resonate. He spits on the floor and his pants are stained with urine. The most likely diagnosis is:
    a) Affective bipolar disorder, manic episode
    b) Antisocial personality disorder
    c) Pick's frontal dementia
    d) Histrionic personality disorder
    e) Alzheimer's dementia
3. A patient presents to the hospital complaining of stomachaches, headaches and numbness or tingling in the limbs, whole-body tremor. He demands to be treated for the symptoms that he has, the more so because the psychiatrist is his last hope after many internal medicine and surgical consults. The most likely diagnosis is:
    a) paranoia with poison delusion
    b) generalized anxiety disorder
    c) depression
    d) somatization disorder
    e) hypochondriac disorder

CHAPTER III. CONNECTIONS BETWEEN NEUROLOGICAL, PSYCHIATRIC AND DRUG INDUCED SUFFERING

CONTENT:

- NEUROLOGICAL SYNDROMES THAT CAN BE ASSOCIATED WITH PSYCHOLOGICAL DISORDERS OR MAKE A DIFFERENTIAL DIAGNOSIS WITH PSYCHIATRIC DISORDERS

    1. generalized epilepsy – grand mal seizures
    2. partial complex epileptic seizures – temporal epilepsy
    3. pyramidal syndrome
    4. extrapyramidal syndrome
    5. pseudobulbar syndrome
    6. anterior (ACA), middle (MCA) and posterior (PAC) cerebral artery syndrome

- CONFUSIONAL STATE (DELIRIUM)
- DEMENTIAS
- ALCOHOLISM AND OTHER SUBSTANCE ABUSE DISORDERS

TEACHING OBJECTIVES:

1. THE UNDERSTANDING OF THE CORRELATION BETWEEN THE CENTRAL NERVOUS SYSTEM AND DEMENTIA SYMPTOMS

2. THE ASSIMILATION OF SOME CRITERIA FOR THE DIFFERENTIAL DIAGNOSIS BETWEEN THE ORGANIC NEUROLOGICAL PATHOLOGY AND THE PSYCHOGENIC PSYCHIATRIC ONE

THE DIFFERENTIAL DIAGNOSIS BETWEEN GRAND MAL EPILEPSY SEIZURES AND HYSTERICAL PSEUDO EPILEPTIC SEIZURES

GENERALIZED EPILEPSY – GRAND MAL SEIZURES					
Prodrome (20%)	Onset	Tonic phase	Clonic phase	Resolute phase	Awakening
Migraines Paresthesia Tremor Digestive discomfort Myoclonus	Losing consciousness Falling with injury	Scream Generalized tonic contraction Conjugated deviation of the eyes Cyanosis Urine, fecal emission	Symmetric and rhythmic clonic contractions Biting of the tongue	Profound stertorous sleep Muscular hypotonia Facial hyperemia	Confusion with/without psycho-motor agitation Amnesia of the episode Muscular fatigue
Some days before the seizure	Usually brutal	10 – 20 seconds	1 –2 minutes	1-4 hours	

The differential diagnosis of the grand mal seizure is made with:	
Pseudo epilepsy from hysterical crises (conversion disorder)	• The presence of a third person • Falling, while avoiding injury • Absence of sphincter incontinence • Contractions are not rhythmic and symmetrical • The tongue is not bitten • Amnesia of the episode is absent

THE DIFFERENTIAL DIAGNOSIS BETWEEN PARTIAL COMPLEX SEIZURES AND THE PSYCHIATRIC DISORDERS

PARTIAL COMPLEX SEIZURES – TEMPORAL EPILEPSY		
Aura in 10% of the cases Simple partial seizure: • motor: blinking • sensitive: paresthesias • sensorial: phosphenes, bell noises, the smell of burned sulfur, unpleasant taste • vegetative: palpitations, epigastric discomfort that extends in the chest and neck Specific to each patient	The actual seizure **Unevenness or narrowing of the present state of consciousness** Types: Psycho-sensorial seizures (visual - oneiroid hallucinosis, micropsic or macropsic illusions, auditory hallucinations, olfactory-uncinate seizures) Psycho-motor seizures: automatisms: simple stereotype or complex behavior Cognitive manifestations: déjà or jamais vu, vécu Affective manifestations: anxiety, depression, euphoria 2-3 minutes	Post ictal Sleep / confusion

The differential diagnosis for temporal epilepsy is made with	
Hysterical twilight state	EEG- normal, often a reaction to frustration, failure, conflict
Psychotic episodes	The patient with psychosis does not criticize the hallucinations

THE MAIN NEUROLOGICAL SYNDROMES

PYRAMIDAL SYNDROME Arises from damage to the pyramidal tract (cortical - spinal)	❑ spastic hypertonia with knife blade sign ❑ accentuated tendon reflexes ❑ abdominal skin reflex abolished ❑ Babinski sign present ❑ Clonus	Pyramidal syndrome has to be always excluded in case of vascular dementia that is accompanied by neurological symptoms: - pyramidal syndrome -pseudobulbar syndrome -extrapyramidal syndrome
EXTRAPYRAMIDAL SYNDROME Arises from damage to the extrapyramidal tract	Hypertonic – hypokinetic syndrome (paleostriatum) ❑ hypertonia - plastic type (cogwheel rigidity) ❑ resting tremor ❑ hypokinesia Hypotonic – hyperkinetic syndrome (neostriatum) ❑ muscle hypotonia ❑ hyperkinesia: choreic or athetosic movements	Extrapyramidal syndrome may be due to the effect of neuroleptic (conventional antipsychotic) medication that blocks dopamine receptors in the substantia nigra - basal ganglia circuit
PSEUDO-BULBAR SYNDROME Arises from damage to the cortical - bulbar tract	❑ dysphagia for solids ❑ dysarthria (explosive speech with variable cadence) ❑ labile affect, crying, laughing at minor stimuli	Pseudo bulbar syndrome is frequently associated with Alzheimer's dementia

CEREBRAL ARTERIES SYNDROMES

ANTERIOR CEREBRAL ARTERY
1. contralateral, predominantly crural, hemiplegia, monoplegia 2. contralateral, predominantly crural, hemianesthesia 3. walking apraxia 4. sphincter disorders 5. the emergence of primitive reflexes (grasping reflex) 6. the eyes deviation towards the focus lesion 7. prefrontal syndrome (moria syndrome)

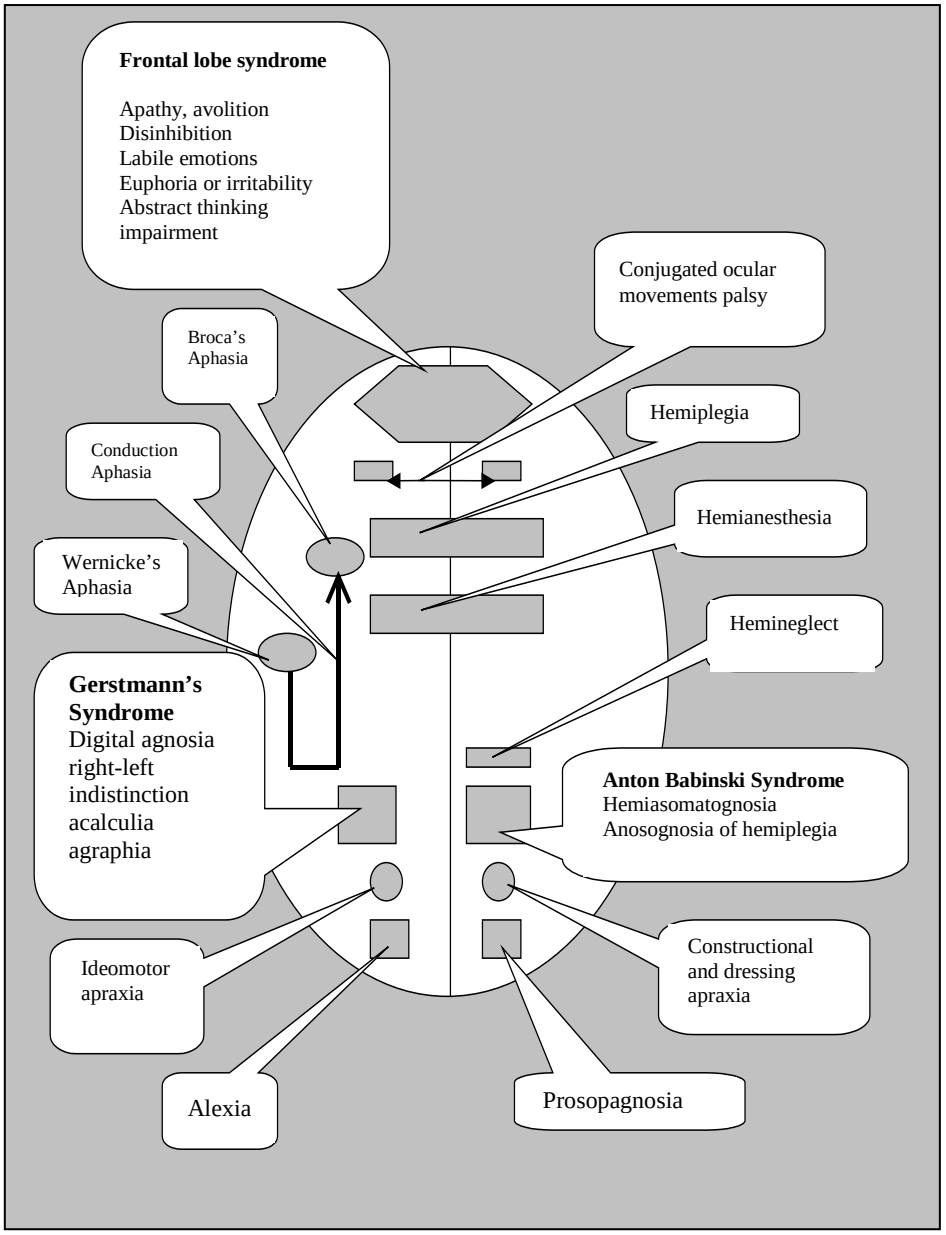
MIDDLE CEREBRAL ARTERY SYNDROME
1. contralateral, predominantly faciobrachial, hemiplegia 2. contralateral, predominantly faciobrachial, hemianesthesia 3. contralateral homonymous hemianopsia 4. paralysis of conjugate lateral deviation of the eyes 5. mixed aphasia: Broca and Wernicke (dominant hemisphere) 6. Gerstmann syndrome (dominant hemisphere) Anton-Babinski syndrome and hemi neglect (non dominant hemisphere) 7. dressing apraxia, constructive apraxia, ideomotor apraxia

POSTERIOR CEREBRAL ARTERY SYNDROME
1. contralateral homonymous hemianopsia with macular vision preservation or quadrantanopia 2. visual amnesia, prosopagnosia 3. posterior disconnection syndrome: alexia without agraphia 4. memory disorder 5. thalamic syndrome (*anesthesia dolorosa*) or hemibalism 6. Weber syndrome, Parinaud syndrome (paralysis of upward vertical movement of the eyes) 7. confusion

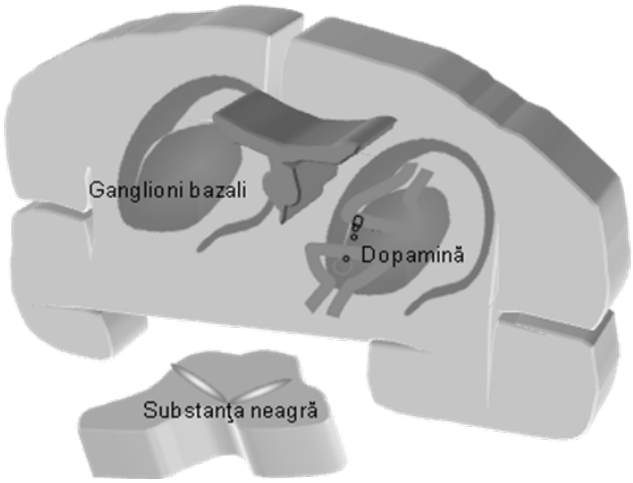
THE MAIN CORTICAL SYNDROMES

FRONTAL LOBE SYNDROME **Prefrontal syndrome**: - personality changes: apathy, avolition, emotional instability, irritability or euphoria that doesn't resonate in the audience, disinhibition (social conduct, eating and sexual level) - impaired executive functions: making a plan, anticipate consequences of actions, feedback - abstract thought disorder - incapacity to organize the learning material - perseverance **the presence of primitive reflexes**: o sucking o palmo-mental o palmar grasp reflex **motor**: - area 4: irritation – jacksonian motor seizures lesion - hemiplegia - supplementary motor area: deviation of the head and eyes to the opposite side of the irritation, toward the injured part - area 44 Broca: motor aphasia **paracentral gyrus**: sphincter disorders	PARIETAL LOBE SYNDROME **areas 3, 1, 2** irritation: paresthesia lesion: anesthesia atopognozia astereognozia the loss of discriminatory sensitivity taste disorders **areas 5, 7** : tactile agnosia **quadrantanopia** **ideomotor apraxia** (dominant hemisphere) **Gerstmann syndrome** (dominant hemisphere) digital agnosia left – right agnosia acalculia agraphia **Anton – Babinski syndrome** (non dominant hemisphere) hemiasomatognozia anosognozia / anosodiaphoria **hemineglect** (non dominant hemisphere) **constructional apraxia** (non dominant hemisphere) **dressing apraxia** (non dominant hemisphere)
TEMPORAL LOBE SYNDROME **primary auditory area:** - irritation: elementary or complex auditory hallucinoses (words – dominant hemisphere, music – non dominant hemisphere) - lesion: cortical deafness **area 22 Wernicke**: sensorial aphasia quadrantanopia **areas 28, 29** irritation: olfactory hallucinoses **anterograde amnesia** déjà vu or jamais vu phenomena **balance disorders** floating, submerging, movement sensations **flight behavior or** attack	OCCIPITAL LOBE SYNDROME **area 17**: irritation: elementary visual hallucinoses lesion: homonymous hemianopsia with preserved macular vision or tunnel vision through bilateral damage, Anton syndrome: cortical blindness + anosognozia **areas 18, 19**: irritation: illusions, complex hallucinoses lesion: visual agnosia: alexia, color agnozia (dominant hemisphere), spatial agnozia, prosopagnosia (non dominant hemisphere) **Balint syndrome**: the inability to properly direct the eyes in space

LOCALIZATION OF THE MAIN NEUROLOGICAL SIGNS OR SYNDROMES



BASAL GANGLIA AND THE EXTRAPYRAMIDAL SYNDROME



The basal ganglia are subcortical gray matter nuclei located in the white matter. This group includes:

- lenticular nucleus: globus pallidus (paleostriatum) and putamen (striatum)
- caudate nucleus (neostriatum)

In the substantia nigra of the midbrain, the dopaminergic neural axons terminate into the basal ganglia. Dopamine has an inhibitory effect on acetylcholine.

Neuroleptics block dopamine receptors in the basal ganglia; therefore, dopamine is not able to attach to its D2 receptor. Acetylcholine free from dopamine inhibition will cause the extrapyramidal syndrome. To counteract this serious side effect of neuroleptic medication, anticholinergic drugs are administered.

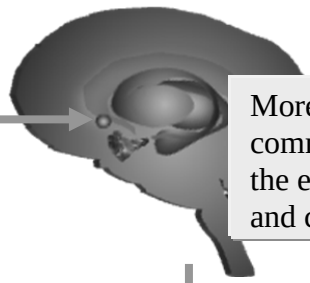
Serotonin acting on its 5HT2A receptors inhibits the secretion of dopamine. New-generation antipsychotics (atypical antipsychotics) have a double antagonism: they block both dopamine receptors and serotonin 5HT2A receptors. Therefore, dopamine will not be inhibited by serotonin and will compete with antipsychotics for dopamine receptors. This explains the reduced risk of atypical antipsychotics to produce an extrapyramidal syndrome.

DELIRIUM (CONFUSIONAL STATE)

ETIOLOGY
1. NEUROLOGICAL (stroke, **infections**, epilepsy, CCT, Wernicke encephalopathy)
2. INTOXICATIONS (alcohol, other drugs, medication)
3. WITHDRAWAL (**alcohol**, other drugs, medication)
4. FAILURE
   - Hepatic
   - Respiratory
   - Renal
5. HYPOGLYCEMIA
6. HYDROELECTROLITIC IMBALANCE

7. FEVER

CHARACTERISTICS
Acute onset
Short evolution (dg. ≠ dementia)
Oscillatory intensity
Sleep rhythm inversion
Attention with secondary amnesia disorder (dg. ≠ dementia)



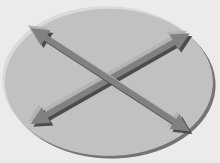
More common in the elderly and children

SOMATIC SYMPTOMS
- AUTONOMIC WITHDRAWAL SIGNS
- INTOXICATION SYMPTOMS
- FOCAL NEUROLOGIC SIGNS
- MENINGEAL SYNDROME.
  OR HEADACHE
- FEVER
- ASTERIXIS

INVESTIGATIONS
Neuroimaging, laboratory

PSYCHOLOGICAL SYMPTOMS
SELF AND ENVIRONMENTAL CONSCIOUSNESS DISORDER + ALERTNESS DISORDER

TIME, SPACE, PERSON DISORIENTATION



SPACE SITUATION DISORIENTATION

Anxiety with motor restlessness +/- visual, tactile hallucinations or

Obnubilation with motor inhibition

Case L.B., 50-year-old male.

The psychiatrist is called to the internal medicine ward to examine a patient who has been hospitalized for four days with bronchopneumonia. It was found that he cannot communicate well and he doesn't respond adequately to questions, talking to himself, sometimes being incomprehensible, other times maintaining the same position for a long time, staring in vain, refusing to eat.

L.B. is a miner. His childhood and life history are not marked by special somatic and psychological events. He is married, has three children and a housewife. He used to be sociable. Typically, every day, after working in the mine, he drinks alcohol with colleagues, but without getting drunk and having a socially appropriate behavior. He smokes a pack cigarettes/day. At age 40 he had a stroke without any significant consequences. He looks older than normal men at the age of 50; his potency also began to decrease.

Due to his working conditions, the patient has developed bronchopneumonia, which poses no particular problem for the medical diagnosis. He has been started on antibiotics. The patient can be fed, but with difficulty. His body temperature is of 40 °C. In this context, his mental status changed. The patient expresses sufferance. His gaze does not "connect" to surrounding objects and people anymore. False recognition of people appears. The patient doesn't always respond to questions appropriately. He confuses the current day, month and year, doesn't remember the information that he is given, and doesn't always realize where he is. Most of the time, he speaks slowly, mumbling something that lacks coherence. He is overly preoccupied with undoing his pyjamas with his fingers. Sometimes he looks around anxiously; he wants to get up and leave, but falls back on the bed. At times he will be standing still, in a bizarre position, opposing any attempts to mobilize him and refusing food.

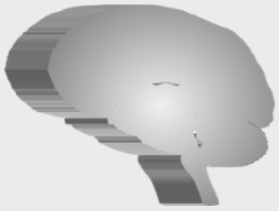
DEMENTIAS

THE DEFINITION OF DEMENTIA

Deterioration:
- global of the psyche (mind)
- acquired
- progressive
- spontaneously irreversible

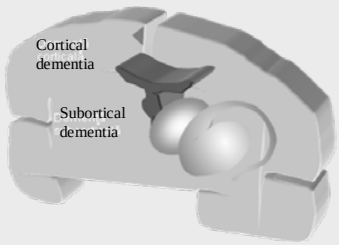
Altering
- intellectual functions
- affective life
- social conduct
- finally, **accompanied** by somatic deterioration: cachexia, sphincter incontinence

TYPES:
Alzheimer dementia
Pick dementia
Vascular dementia



DEMENTIA

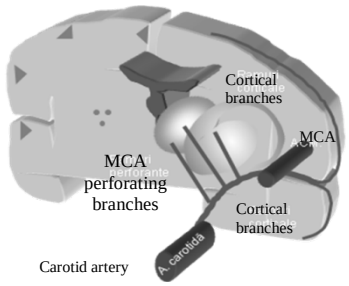
ANTERIOR	POSTERIOR
Pick	Alzheimer
Disturbs social conduct and affective life	Affects cognitive functions with short term amnesia and finally the 3 A syndrome: aphasia, agnosia and apraxia
- abulia/avolition	
- apathy	
- euphoria or irritability	
- labile affect	
- disinhibition	



CORTICAL DEMENTIA	SUBCORTICAL DEMENTIA
Alzheimer	**Parkinson**
	Lacunar stroke
- amnesia	- motor impairment
- aphasia	- dysarthria
- apraxia	- slowness
- agnosia	- depression

VASCULAR DEMENTIA

Type: lacunar stroke	multi infarct
Subcortical lacunae	cortical infarcts
Cause: HBP	atherosclerosis
Paraclinical: FO, CT	blood lipids



MCA = middle cerebral artery, CT = computed tomography

THE ALGORITHM FOR DIAGNOSING THE DEMENTIA SYNDROME

SYMPTOMS	DEMENTIA SYNDROME		
SEVERITY	LOW able to perform simple tasks	MEDIUM has to be helped in simple tasks	SEVERE complete dependence on caregivers
EVOLUTION	PROGRESSIVELY IRREVERSIBLE	TEMPORARY ≠ DEPRESSION ≠ DELIRIUM	
ETIOLOGY	DEGENERATIVE DEMENTIA	VASCULAR DEMENTIA	OTHER DEMENTIAS
	❑ PRIMARY Alzheimer's Pick's	❑ Multi-infarct dementia	❑ expansive process: -tumor -abscess -cyst -hematoma
	❑ SECONDARY Parkinson's Huntington's chorea	❑ Lacunar stroke dementia lacunae = small strokes in the inner capsule, thalamus and basal ganglia	❑ infections -3rd stage syphilis -HIV -Creutzfeldt Jakob
		❑ Strategic strokes	❑ metabolic - B1 deficit - hepatic diseases - uremia - hypoglycemia
		❑ Binswanger disease	❑ endocrine: - myxedema ❑ toxic: alcohol ❑ anoxia: HF, RF ❑ trauma (pugilistic dementia) ❑ normal pressure hydrocephalus

Case P.I., 70-year-old female

Family brought her to the hospital, because lately she began to accuse them of stealing. She goes out on the balcony and shouts after thieves.

The patient is cooperative, calm, not realizing why she is in the hospital and says she feels great. When the doctors ask about a potential injury, she recounts how, not long ago, an old friend of her husband came to visit her and, although he was well received and entertained, he stole things from the house. The patient is convinced of this, which is why she began to reclaim what was stolen by the guest (curtains, cutlery). She becomes argumentative and demanding, and accuses the family that they have stolen some property documents.

When asked to give relations about her husband, the patient only remembers his name. The same happens when she is asked to provide her biographical data. She doesn't even remember her age, place of birth, names of brothers and sisters. She doesn't know what city, county and hospital floor or ward she is located in. She can't recall the words she is asked to memorize. She can't do math calculations or copy a geometrical shape after a model. However, the patient doesn't seem bothered by her deficits. She smiles and remains cooperative.

The physical examination reveals pale skin and mucous membranes, underrepresented subcutaneous tissue, a systolic murmur in the mitral area, hyperreflexia of tendon reflexes in lower limbs, positive Babinski sign on the left lower limb, sphincter incontinence.

The MMSE showed: temporal and spatial disorientation, acalculia, amnesia for recent events, dysgraphia, and inability to copy a drawing after a model. Clock drawing test: hours are not positioned properly or the clock does not show the required time.

Computed tomography shows a diffuse cortical atrophy. There are no expansive processes or strokes.

After three weeks of hospitalization for clarification of diagnosis, the patient's condition remains the same.

ALCOHOLISM

DISORDERS INDUCED BY ALCOHOL

Psychiatric

1. Intoxication (+/- delirium)
2. Withdrawal reaction (+/- delirium tremens)
3. Korsakov amnesic syndrome
4. Dementia
5. Mood disorders (depression)
6. Anxiety disorders
7. Psychotic disorders (alcohol induced hallucinosis or jealousy delusion)
8. Sleep disorder
9. Sexual dysfunctions
10. Suicide

Somatic

11. Esophageal varices, cancer
12. Mallory-Weiss syndrome, gastritis, peptic ulcer
13. Pancreatitis
14. Steatosis, hepatitis, cirrhosis
15. Peripheral polyneuropathy
16. Wernicke's encephalopathy
17. Epilepsy
18. Macrocytic anemia
19. Poor immunity - high risk for pneumonia, TB
20. Dilated cardiomyopathy
21. Dupuytren’s contracture
22. Hypoglycemia, diabetic ketoacidosis, hyperlipidemia, hyperuricemia
23. B1 and B6 vitamin deficiency
24. Physical trauma

ALCOHOL ADDICTION

1. Use of larger amounts of alcohol and for longer periods than the subject would want
2. Continues the use despite harmful side effects
3. Desire and failed attempts to stop drinking
4. Tolerance
5. Withdrawal response when stopping drinking
6. Time spent for obtaining and drinking alcohol
7. Alcohol primacy at the expense of family or career

! Resuming drinking after a period of abstinence causes relapse ("a glass is too much, and a thousand are not enough" - Alcoholics Anonymous)

DELIRIUM TREMENS

appears in an alcohol addicted person with a biological addiction after 3 days since an abrupt withdrawal:

-confusional state with temporal and spatial disorientation + / - visual and tactile zoomorphic, micropsic hallucinations, dreamlike state, anxiety, psychomotor restlessness, defensive reaction, insomnia associated with

- sweating, vomiting and dehydration accompanied by oscillations of blood pressure, tachycardia, tremor, mydriasis, hyperpyrexia + / - seizures

Case C.L., 47-year-old male, hairdresser

He is brought to the psychiatric emergency room by his wife, who relates that he got no sleep over the last few nights, she can't communicate normally with him, he is sometimes incoherent; he seems to see things that do not exist.

At a first glance, the patient looks messy, with telangiectasia, sweating profusely, shaking. He doesn't look the person in the eye; he is carefully looking in one direction, as if seeing something that the physician doesn't see. At times, he moves, as if he throws something off his body. The mental contact is difficultly established. He is temporally and spatially disoriented, presents false recognitions. He has an anxious mimic, expressing revulsion. The patient states that he is concerned with "bugs and snakes that climb on him" from which he would like to escape. The somatic examination reveals that the liver is 3 fingers below the costal margin and painful at palpation.

He grew up in a family with an alcoholic father and a dominant mother, who sought to dictate everyone in the house. His older brother ran away from home at age 15, settling with relatives and failing to keep in touch with family. The patient developed into a man unsure of himself, dependent on others, overly sensitive. After mediocre school results, he got a qualification as a barber. Since the qualification period, he started to drink large amounts of alcohol with coworkers or alone sometimes. Later, alcohol use has become constant, in spite of his wife's criticisms. He tried to quit alcohol, but failed several times. He drinks "so that my hands will no longer shake", says the patient. Five days before admission, he stays in bed for two days because of the flu. During this period and the next, he interrupts alcohol consumption. After the fever passes, the fatigue and loss of appetite remain. He doesn't sleep at night, and so, instead of sleeping, disorientation occurs, with mild anxiety and various "visions". He mostly sees animals attacking him or climbing on him. The day before admission, this "disorientation" and unrest also persist throughout the day. He doesn't recognize his own room; he confuses his wife with a distant relative. He sometimes talks unintelligibly. He doesn't answer any questions. He behaves as if he sees things that others cannot see. He doesn't feed himself. He is sweating profusely with a fever of 40ºC. His alarmed family calls the ambulance to take him to hospital.

OTHER ADDICTIONS (EXCEPT ALCOHOL)

Drug use is one of the challenges that contemporary society is facing, with its direct and indirect effects revealing it as a serious problem.

The drug is a psychoactive substance that is mentally and/or physically addictive.

Classification of drugs, according to their effects on the central nervous system:

- Depressant: opiates, alcohol, cannabis, benzodiazepines, barbiturates and volatile substances
- Stimulant: cocaine, amphetamines, caffeine, nicotine
- Hallucinogenic: MDMA (ecstasy), psychedelic drugs (LSD, mescaline, psilocybin), phencyclidine, cannabis

Types of administration: ingestion (opium, cannabis, amphetamines, psychedelic drugs, benzodiazepines, barbiturates), injection (heroin, cocaine, amphetamines), snorting (cocaine), inhaling (opium, cocaine, tobacco, cannabis, volatile substances).

Types of consumption:

- Experimental consumption - to test the effects of the substance
- Abusive consumption - the subject can control the consumption of drugs in the absence of stimuli that determine the consumption (friends, pipe)
- Addictive consumption - the subject cannot control the use of the substance, after the onset of drug tolerance and dependence.

Clinical manifestations:

They vary widely, depending on the type of drug, the amount used, the individual features:

- Acute intoxication: inhibition (sedative drugs) or psychomotor agitation (stimulant drugs), ecstatic states (hallucinogenic drugs), psychosis-like states (hallucinogenic drugs, amphetamines), somatic manifestations
- Withdrawal: generally, its symptoms are the opposite of intoxication signs.

Premorbid personality: vulnerable personalities are characterized by impulsivity or low self-esteem

The complications are many and varied:

- Related to the lifestyle of the drug addict: sexually transmitted diseases, promiscuity and prostitution related (infection with HIV and hepatic viruses)
- Tuberculosis: characterized in that it is resistant to the specific medication
- Oro-dental injuries that occur due to factors such as deficiency in oro-dental hygiene, malnutrition and drug use

- Related to the injectable administration: the main incriminated germs are: Staphylococcus aureus, streptococci, Gram-negative aerobic bacilli, Gram-negative cocci and bacilli, candida and aspergillus
    - skin infections: boils, skin abscesses, cellulitis, lymphangitis, phlebitis, septic thrombophlebitis, pyomyositis, necrosis, gangrene and gas embolism.
    - septic metastatic with skin starting point: bone, heart (endocarditis), pulmonary, cerebral, general (sepsis).
- Depressive episodes, which present some particular features, such as a greater frequency of irritability and aggressive behavior, violence caused by decreased tolerance to frustration.
- Confusional state characterized by: temporal-spatial disorientation, low level of the current state of consciousness with anterograde amnesia, sometimes accompanied by uncontrollable aggression, auditory, visual and tactile hallucinations, or even delusions of persecution.
- Psychotic episodes with hallucinations, delusions, passivity phenomena

The treatment of addictions is complex and difficult:

- Emergency pharmacological treatments: acute intoxication can be managed with antagonists of the ingested substances; complicated withdrawal states with tranquilizers and sometimes neuroleptics.

- Pharmacological treatment of substitution (methadone substitution programs for heroin)

- Psychotherapeutic treatment: cognitive-behavioral psychotherapy, family psychotherapy, logotherapy, group therapy.

QUESTIONS:

A 54-year-old diabetic patient is brought to the emergency department in a hyperglycemic coma. After awakening from the coma, the patient has serious memory disturbances. The CT scan shows a slight cortical atrophy and a hypodense formation in the occipital lobe. In addition, an abnormal visual field is found. Once out of the coma and metabolically rebalanced, the patient is transferred to the department of neurology. You are called to examine her, but you find that evoking memory disorders are still present, the patient saying that she got dizzy before losing consciousness. The patient can write, but can't read anything, no matter how big the letters are. One daughter visits her and you find out that the patient can't give correct information about her own family. Within a few days the patient gradually regains her memory. The most likely diagnosis is:

a) Vascular dementia
b) A stroke in the posterior cerebral artery territory
c) Occipital cerebral tumor
d) Metabolic encephalopaty
e) Cranio–cerebral trauma with occipital hematoma

Positive diagnosis is established by considering:

a) The evolution of memory impairment
b) CT scan result
c) The patient's underlying disease (insulin-dependent diabetes)
d) Writing and reading test
e) Signs of intracranial hypertension

A 65-year-old hypertensive patient was admitted into the psychiatric clinic and got a score of 24 points at the Mini Mental State Examination. After a few days, the score increased to 26 (the normal score for his age and level of training is 28). How do you explain this increase in score?

CHAPTER IV. AUTO- AND HETEROAGGRESIVITY

CONTENT:

- AUTOAGGRESIVITY: SUICIDE AND PARASUICIDE
- HETEROAGGRESIVITY AND PSYCHOMOTOR AGITATION

TEACHING OBJECTIVES:

1. ASSIMILATION OF THE AUTO AND HETEROAGGRESIVITY CONCEPTS
2. THE ASSIMILATION OF ANAMNESIS TECHNIQUES IN CASE OF PATIENTS WITH SUICIDE IDEATION OR ATTEMPTS
3. THE ASSIMILATION OF THE CONDUCT TO ADOPT IN CASE OF AN AGGRESSIVE PATIENT

SELF AGGRESSION: SUICIDE AND PARASUICIDE

Suicide is characterized by the following features:

- a real intent to die
- it is planned, and measures are taken to ensure success
- efficient and violent methods are chosen: hanging, jumping from a height, throwing oneself in front of a vehicle, or in rivers, fountains, shooting oneself, ingestion of toxic substances or of potentially lethal medication.

Suicidal ideation may occur both in the context of psychiatric disorders and in their absence (conditioned by despair, cultural norms, a desire to protest or by altruism). In psychiatry suicide occurs more frequently in:

- Mood disorders
- Schizophrenia
- Chronic alcoholism and other addictions
- Personality disorders

The risk factors for suicide are:

- Male gender,
- Age (young and old people)
- Impulsiveness
- Heredity,
- Organic illness (terminal illness, disability)
- Environment (urban)
- Season (spring)
- Religion (in case of permissive religious groups)
- Unemployment, social isolation
- Previous attempts

Suicidal ideation or attempted suicide is a psychiatric emergency and requires hospitalization. Addressing this issue during anamnesis should not be avoided, because it does not make the suicidal behavior more probable. Questions may be vague and general (“Have you ever felt that life is meaningless, or that it’s no longer worth living?)”, or more specific (“Did it cross your mind to take your life?” “Do you have a plan in this regard?” “Have you ever/recently tried to commit suicide?”). Protective factors such as: family, friends, and religion should be identified. Sometimes the patient is not honest and denies suicidal ideation at the beginning or during treatment.

Parasuicide is characterized by a demonstrative mimic of a suicidal act, without any real intention of dying. It is used mainly as a method of attracting attention or as an emotional blackmail. It is often reactive, impulsive, carried out in a specific context, and the chosen methods are less efficient or violent (harmless drugs). It may be accompanied by letters, throwing all responsibility on the entourage. It is more common in women. In certain situations parasuicide may end up by mistake in suicide.

HETERO-AGGRESIVITY AND PSYCHOMOTOR AGITATION

Aggression can occur in people with mental disorders in certain situations, but it is not a feature of mental disorders. Aggression can be structured and targeted on a/some specific person or it can be unstructured, untargeted. It can have various degrees of severity, from verbal aggression (irony, threats, swearing) to more or less violent physical acts.

Aggression can be:

- Deliberate: in individuals with antisocial/dissocial personality disorder, or in addicted people when they need money to purchase the drug.
- Reactive-impulsive: in case of psychomotor agitation in schizophrenia (generated by the anxiety of self-defense), in bipolar disorder ("furor maniacalis"), in states of intoxication or withdrawal from alcohol and other drugs.

Psychomotor agitation is the maximum degree of psychomotor restlessness accompanied by aggression. It is a psychiatric emergency. When a person, through his/her behavior, becomes a danger to himself or others, it is required by law to have a non-voluntary admission. This is based on documents provided by caregivers, neighbors, police, ambulance staff (written and signed), plus one provided by the examining psychiatrist.

Aggression risk is higher in people with a history of violence, with a personality disorder, with brain damage (epilepsy, frontal lobe pathology), or addiction.

The conduct in case of agitated and aggressive patients should be:

- The examination must take place in a room where escape is easier for the physicians and medical staff.
- The examination must take place in the presence of several persons.
- The examiner should have an easy access to a door or an alarm.
- The examiner should always sit facing the aggressive person and keep a comfortable distance from him. Hands should be kept visible.
- The examiner should adopt a calm attitude and avoid the escalation of violence through inappropriate language or behavior.
- Restraining an aggressive person requires five people (one at the head and four at the limbs).
- The immobilization of the aggressive person must be made by the medical staff, not by the doctor.
- The physician checks regularly the status of the immobilized person.

CHAPTER V. MANAGEMENT OF PATIENTS WITH MENTAL DISORDERS

CONTENT:

- DRUG AND NON - DRUG THERAPEUTIC STRATEGIES: DRUG TREATMENT IN PSYCHIATRY
- PSYCHOSOCIAL REHABILITATION

TEACHING OBJECTIVES:

1. LEARNING THE THERAPEUTIC AND SIDE EFFECTS OF PSYCHOTROPIC MEDICATION IN CLOSE CORRELATION WITH THE MECHANISM OF ACTION

2. THE ASSIMILATION OF BASIC NOTIONS ABOUT THE MAIN TYPES OF PSYCHOTHERAPY

3. LEARNING THE PRINCIPLES OF PSYCHO–SOCIAL REHABILITATION FOR THE MENTAL HEALTH BENEFICIARIES

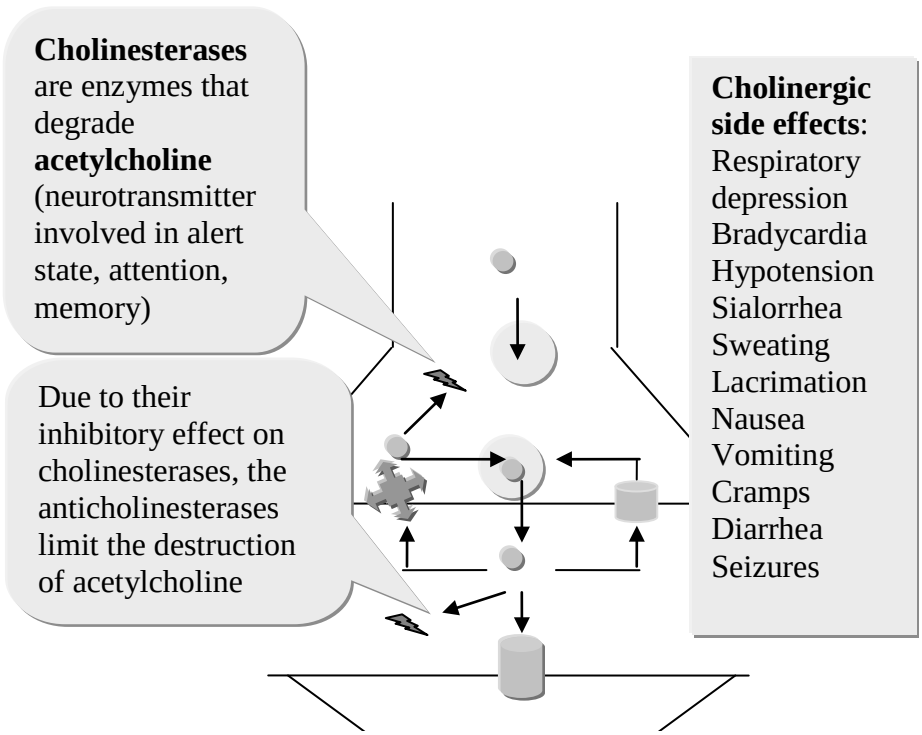
V.1.DRUG TREATMENT IN PSYCHIATRY: PSYCHOTROPIC MEDICATION:

ANTIPSYCHOTICS
ANTIDEPRESSANTS
ANXIOLYTICS AND HYPNOTICS
MOOD STABILIZERS
ANTICHOLINESTERASE AGENTS (ANTICHOLINESTERASES)

1. The etiology of mental disorders it not known; therefore the treatment with psychotropic medication remains **symptomatic**. In responsive patients it results in full or partial remission. Recurrences are possible when maintenance doses are to low or medication is administered discontinuously. The differential diagnosis of a mental disorder from an organic disorder must be made. It is important not to treat symptoms and delay the diagnosis of organic illnesses manifested through severe psychiatric symptoms (e.g. brain tumor)
2. Antipsychotics, antidepressants and mood stabilizers do not cause addiction. Neuroleptic or antidepressant medication discontinuation may be accompanied by relapse (the same episode) or recurrence (a new episode of the disorder). Most anxiolytics and hypnotics can be **biologically addictive,** if taken in high doses for a long time.
3. **Side effects and drug interactions** are multiple. Therefore they have to be known and prevented or controlled. Administration of psychotropic medication should be made only after a thorough medical history and physical examination. Side effects can be observed clinically or highlighted by laboratory results.
4. Due to the potential side effects, psychotropic medication will be administered in **gradually increasing doses**. These doses will be increased until reaching the efficient dose and then maintained for a certain period, to avoid relapse. **Dose reduction** should be gradual, in order to prevent the *rebound* reaction (relapse disorder symptoms after abruptly stopping the drug) or *withdrawal* reaction in case of anxiolytics (symptoms opposite to those treated by the medication).
5. Mood stabilizers (thymoregulators) are represented by lithium salts and some antipsychotics and some antiepileptics (valproate, carbamazepine, lamotrigine. Except for lamotrigine, all have major teratogenic risk.
6. Anticholinesterases are used to prevent degradation of acetylcholine, a neurotransmitter with an important role in attention, memory and motivation. They are useful mainly in the early stages of dementia.

ANTICHOLINESTERASES

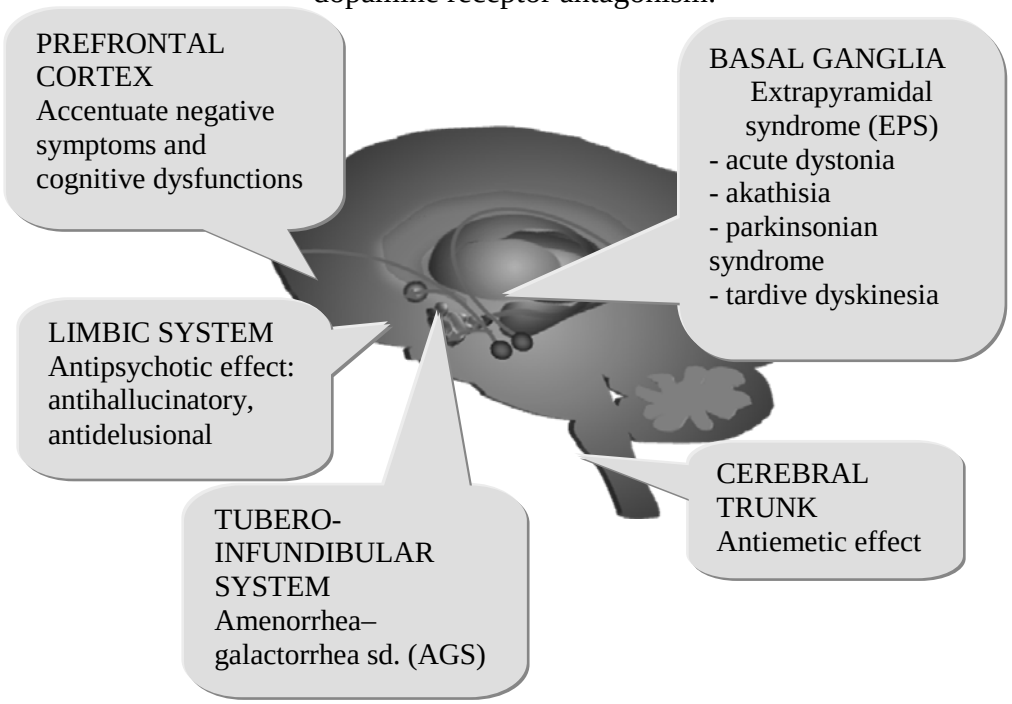
CLASSIFICATION		
RIVASTIGMINE	DONEPEZIL	GALANTAMINE
Nonselective inhibitor for acetylcholinesterase and butyrylcholinesterase	Selective inhibitor for acetylcholinesterase	Selective inhibitor for acetylcholinesterase and modulator for nicotinic receptors
Systemic cholinergic side effects	Rare systemic cholinergic side effects	Rare systemic cholinergic side effects
Intermediary action 2 doses daily	Long action 1 dose daily	Intermediary action 2 doses daily
Drug interactions: no	Drug interactions: yes	Drug interactions: yes
Efficiency: in EARLY phases of Alzheimer's dementia, as long as cholinergic neurons still exist in the basal nucleus of Meynert.		



The mechanism of action of anticholinesterase agents on cholinergic neurons

NEUROLEPTICS (CONVENTIONAL ANTIPSYCHOTICS)

The effects of neuroleptics on CNS through dopamine receptor antagonism:

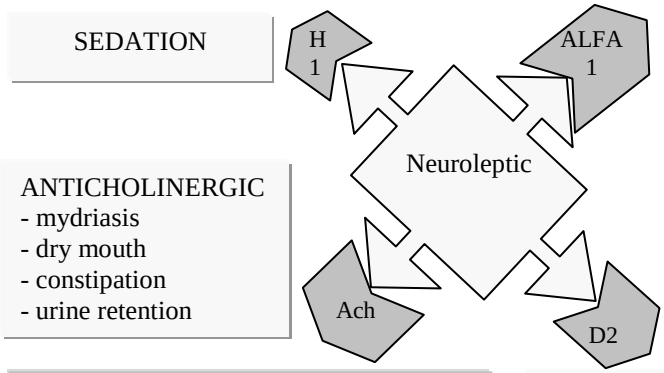


Discovery of first-generation antipsychotics (conventional antipsychotics or neuroleptics - NL) in the mid-twentieth century was of particular importance, because it amended violent treatments previously applied to people with mental disorders (showers, insulin coma, electroshocks, and straitjackets). Electroshocks (electroconvulsive therapy - ECT) are now used only as a last resort when the pharmacologic treatment, correctly administered, is not effective.

Antipsychotics are used in adult psychiatry for the following effects:

- Antipsychotic (antihallucinatory, antidelusional) – incisive NL, atypical antipsychotics, bimodal antipsychotics in high doses
- Sedation (in case of psychomotor agitation and psychotic anxiety - sedative NL, sedative atypical antipsychotics, anxiolytics
- Antidepressant / activating - bimodal NL
- Amelioration of cognitive dysfunctions - atypical antipsychotics

THE MAIN SIDE EFFECTS OF CONVENTIONAL ANTIPSYCHOTICS (NEUROLEPTICS) THROUGH RECEPTOR ANTAGONISM



CLASSIFICATION:

CONVENTIONAL (neuroleptics)	ATYPICAL
	Clozapine
	Olanzapine
SEDATIVE	Quetiapine
Chlorpromazine	Risperidone
Levomepromazine	Ziprasidone
	Aripiprazole
POTENT	
Haloperidol	ACTIVATING
Flupentixol	Sulpiride
Fluphenazine	Amisulpride

PSYCHOMOTOR AGITATION:
haloperidol im, chlorpromazine im
olanzapine im, aripiprazole im

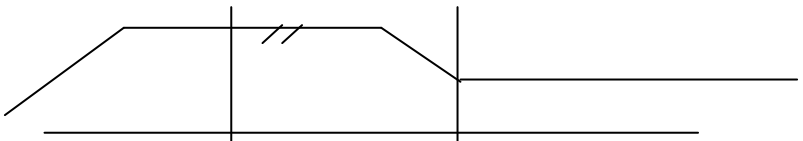
POSITIVE SYMPTOMS:

I. conventional or atypical antipsychotic
Failure or EPS, then
II. CLOZAPINE
Failure
III. ECT

NEGATIVE SYMPTOMS:
ACTIVATING OR ATYPICAL

Antipsychotic treatment strategy

4-6 weeks 6 months 1 year / 5 years / life long

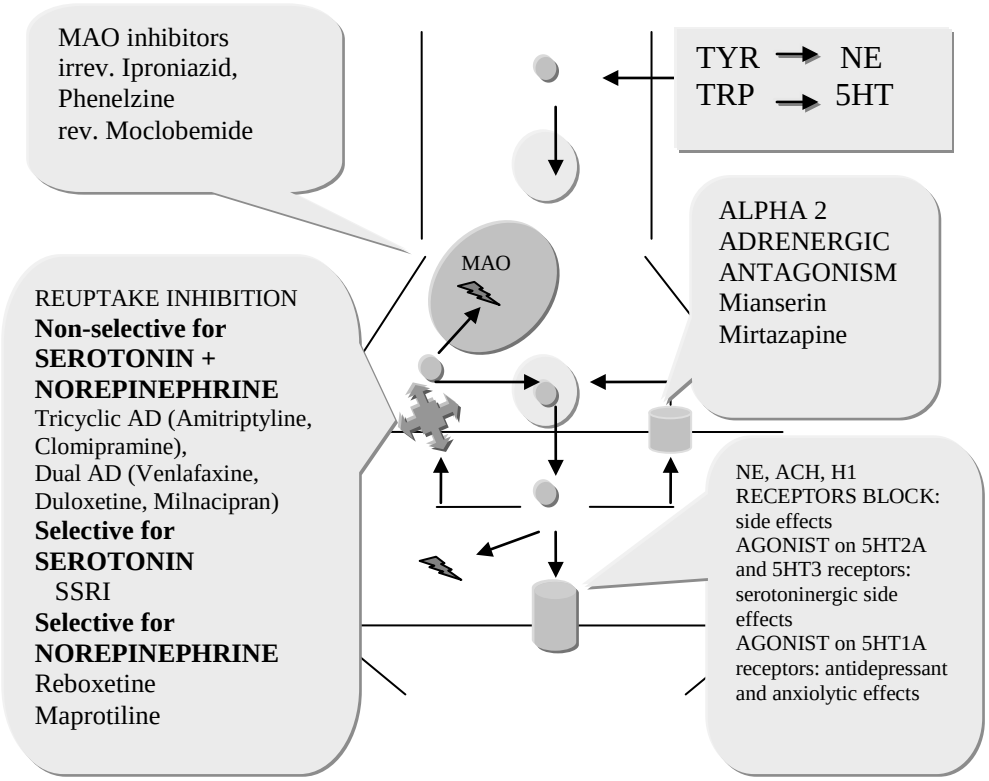


acute phase	consolidation	maintenance
symptom resolution	relapse prevention	recurrence prevention
antipsychotic		
+ /-	the same	depot preparation
anticholinergic		administered im
(in case of EPS)		1/month, 2/month

Depot or long acting antipsychotic injection:
haloperidol decanoate
flupentixol decanoate
olanzapine long acting
risperidone long acting

Oral or injectable treatment (in case of a lack of adherence to treatment

ANTIDEPRESSANTS



In depression there is a deficit of norepinephrine and serotonin in the brain synapses. Antidepressants correct these deficits by:

a) Inhibiting the neurotransmitter reuptake pumps (transporters)

b) Antagonizing the presynaptic alpha-2 inhibitors

c) Inhibition of MAO enzymes in the mitochondria

d) Agonist effect on postsynaptic receptors (5HT1A)

Depending on their mechanism of action, antidepressants are classified in:

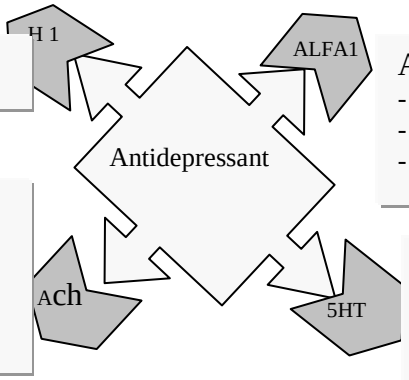
- Stimulating antidepressants (used for depression with psychomotor inhibition)
- Sedative antidepressants (used in depression associated with anxiety)

Increasing the amount of neurotransmitter in the synaptic cleft determines, within two weeks, a compensatory reduction in the number of post-synaptic neurotransmitter receptors (*down-regulation*) that correlates with the onset of the antidepressant effect.

Blocking post-synaptic receptors can lead to side effects or it may protect against certain serotoninergic side effects (nausea, vomiting, headaches, insomnia, anxiety, tremor, sexual dysfunction – common in treatment with SSRI antidepressants).

SIDE EFFECTS OF ANTIDEPRESSANTS

SEDATION

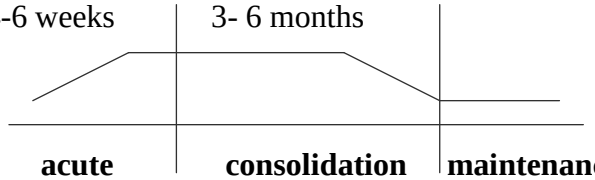


ANTIADRENERGIC
- Orthostatic hypotension
- Nasal congestion
- Ejaculatory dysfunction

ANTICHOLINERGIC
- Mydriasis
- Dry mouth
- Constipation
- Urinary retention

$5HT_2$ and $5HT_3$ BLOCKADE:
Avoiding insomnia and dyspeptic conditions

Antidepressant treatment strategy



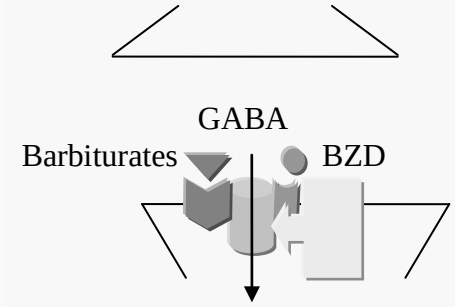
acute	**consolidation**	**maintenance**
resolution of symptoms	relapse prevention	recurrences prevention
AD +/- neuroleptic	AD +/- mood stabilizers (Li, carbamazepine, valproate)	

ATTENTION
! antidepressant effects after 2 weeks
! acting out (suicide)
! Possible switch towards mania
! decrease of seizure threshold
! cardiotoxic effect (quinidine syndrome)

CLINICAL CLASSIFICATION OF
STIMULATING AD
I MAO
Tricyclic antidepressants: desipramine, nortriptiline

INTERMEDIARY AD
Tricyclic AD: imipramine, clomipramine
Maprotiline
SSRI (escitalopram, citalopram, sertraline, fluvoxamine, fluoxetine, paroxetine)
Venlafaxine, duloxetine
SEDATIVEAD
Tricyclic AD: amitriptyline trimipramine, doxepin
mianserin
mirtazapine
trazodone

ANXIOLYTICS (TRANQUILIZERS) AND HYPNOTICS



Chlorine
Hyperpolarization of the cell

EFFECT

ANXIOLYTIC
= antianxiety
TRANQUILIZERS
= calm, ataraxia
SEDATIVE
= decrease alertness
= sleepiness
HYPNOTIC
= induce sleep

GABA is the major inhibitory neurotransmitter of the CNS. Acting on its receptors, GABA opens chloride channels. The negatively charged chloride ions penetration in the cell will cause the cell's hyperpolarization, making it unresponsive to stimulation. Benzodiazepines potentiate the GABA's binding to its receptors and barbiturates act directly on chloride channels.

CLASSIFICATION

ANXIOLYTICS

BZD	non BZD
Alprazolam	Buspirone
Diazepam	Meprobamate
Bromazepam	Hydroxyzine
Oxazepam	

HYPNOTICS

BZD	non BZD
Nitrazepam	Zopiclone
Flunitrazepam	Zolpidem
Temazepam	Barbiturates
Triazolam	Glutethimide

EFFECTS AND INDICATIONS OF BZD

ANXIOLYSIS
(paroxysmal / panic and generalized anxiety)

MUSCLE RELAXATION
(generalized anxiety)

HYPNOTIC
(insomnia)

ANTICONVULSIVE
(status epilepticus)
(myoclonus)

SIDE EFFECTS OF BENZODIAZEPINES

PSYCHOLOGICAL AND BIOLOGICAL DEPENDENCE
when administered in high doses for months

SEDATION OR PARADOXICAL REACTION with delirium or agitation in the elderly
Contraindicated in association with ALCOHOL

BENZO DIA ZEPINE

MUSCULAR HYPOTONIA
with decreased reaction time - traffic accident risk
Contraindicated in myasthenia gravis

DECREASED RESPONSE TO CO_2
Contraindications in respiratory failure and sleep apnea

ANTEROGRADE AMNESIA
Indicated in preanesthesia

Contraindicated in CLOSED ANGLE GLAUCOMA

$T_{1/2}$ under 5h
Midazolam
Triazolam

$T_{1/2}$ 5-24h
Alprazolam
Lorazepam
Temazepam

$T_{1/2}$ over 24h
Diazepam
Clonazepam
Nitrazepam
Flunitrazepam

Higher risk of addiction
Faster withdrawal
Severe withdrawal

BZD WITHDRAWAL
Delirium (confusional state)
Tremors, convulsions
Anxiety
Psychomotor restlessness
Insomnia

BENZODIAZEPINE (BZD) TREATMENT RULES

1. short-term treatment (3 weeks, maximum 3 months)
2. discontinuous treatment
3. the higher dose is given in the evening
4. avoid the association with alcohol
5. gradual dose increase (sedation) or reduction (withdrawal risk)

PSYCHOTHERAPEUTIC TREATMENT IN PSYCHIATRY
(PSYCHOTHERAPIES)

TYPE	DESCRIPTION	INDICATIONS
Crisis intervention (crisis: death, divorce, natural hazard, etc.)	Using the techniques to solve the problems in order to determine an effective adjustment at present and in the future. The crisis may cause a change in the patient or may reveal appropriate ways to react to later stress.	Treatment is short and intensive • Psycho-pathological reactions
Supportive therapy	Initiated along with psychotropic medication. Consists in: empathic listening, advice, encouraging. The patient will always be the one who takes decisions concerning him/her!	Does not require special training
Psychoanalysis **! is contraindicated in psychosis (schizophrenia or periodical affective disorders)**	The analyst helps the patient to acknowledge his unconscious conflicts which generate symptoms, by interpreting: -free associations (patient lying on a couch, without seeing the analyst, speaks freely and unreservedly about whatever comes to his mind), -dreams -fantasies -transference (emotions related to significant people and transferred to the analyst) or the conduct of the patient during and outside sessions	The treatment is long and expensive (several weekly meetings for several years). The patient must be motivated and willing to talk • Neurosis
Cognitive therapy	It is based on the idea that maladaptive behaviors are the result of distorted thinking, hence the need to recognize and correct the latter. Illogical, stereotypical and often unconscious thoughts are acknowledged and examined (patients write down what they think in certain situations). Alternatives are provided	Duration is short (15 to 20 sessions in 3 months) • Non-psychotic depression (Beck triad) • Anxiety • Addiction

Behavioral therapy	The therapist enters into a therapeutic contract with the patient, in order to change certain learned behavior patterns that are maladaptive (generating psychopathological symptoms). This is used to analyze the patient's behavior by means of patient written diaries. The techniques are based on - Classical conditioning: gradual (systematic desensitization) or abrupt (flooding) exposure, while using relaxation techniques (autogenic training) or use of anxiolytic drugs - Operant conditioning	Limited duration (months up to a year) • Phobias • Bulimia • Sexual dysfunction • Stress induced illnesses: hypertension asthma, pain
Systemic Family Therapy	The family is seen as an ever-changing system (formation, birth of children, their departure) and in a permanent interaction with the environment. The intervention is not focused on family members who present symptoms, but on the dysfunctional relationships that are established between family members (coalition, double bind) in their attempt to adapt and maintain the family system in balance. The analysis and explanation of the interactions between members of the family is designed to: - Reestablish a clear hierarchy in the family - Determine the dysfunctional relationship patterns between members of the family system - Improve communication between family members - Balance abnormal cohesion trends or excessive individualization	Meetings of approx. 2 hours once a week, limited duration • In children and adolescents: conduct disorder, school refusal, enuresis, anorexia • Family crisis (bereavement, divorce) • Adjunctive therapy in schizophrenia, addictions

Group therapy	It is based on the idea that the most important therapeutic factor is the group itself (through cohesion and interaction between participants). Other therapeutic factors: - Inspiring hope in the rest of the group by those who received successful therapy - Learning from interaction with other group members - The possibility of free expression of emotions and observing feedback from the group - Exchange of information between members of the group – psychoeducation or awareness that the one's experience is not unique, but also found in other members (universality of the problems) Alcohol groups (Alcoholics Anonymous) Multifamily groups (families of psychotic patients) Groups of psychotic patients Groups of patients with cancer, myocardial infarction, diabetes, etc. Psychodrama	Group sessions for 1 1/2 hours two times per week Purposes are psycho education (offering patients or their families information about the disease or the treatment) or about self-help. Often these therapies are used by people without medical training and therefore are sometimes viewed with some reserve by psychiatrists.

ATTENTION!

STARTING A PSYCHOTHERAPEUTIC TREATMENT MAY ONLY BE DONE BY REFERRAL FROM THE PSYCHIATRIST AFTER ANY ORGANIC CAUSE TO EXPLAIN THE PSYCHIATRIC SYMPTOMS IS EXCLUDED.

V.2. PSYCHOSOCIAL REHABILITATION (PSR)

Psychosocial rehabilitation includes all care measures addressed to people with long-term mental health problems, in order to reintegrate them into society. It is based on the idea of socio-professional reintegration, which means going back to the previous functioning level, before the onset of the disorder. Psychosocial rehabilitation requires an individualized approach, involvement and empowerment of the subject in his/her social context.

The PSR principles are:

1. Considering the social aspect to be a priority in the detriment of the medical one.
2. Supporting the potential for change, even in persons with disabilities.
3. The focus is on the person.
4. Guidance on practical and everyday needs.
5. The recognizing that people with mental health difficulties have rights and abilities to take decisions
6. Reducing the distance between doctor and patient.
7. Structured interventions on behaviors, not on symptoms.
8. Avoiding unnecessary hospitalization.
9. The development of appropriate coping skills and a social support network.
10. Indefinite duration

The goal of psychosocial rehabilitation is:

1) The direct reduction of disability;

2) Developing new skills to counteract or compensate for the damage that caused the disability;

3) Targeted manipulation of the environment, so that the support grows and sustains a better functioning of the person.

PSR programs include:

- Assessing the needs of people with mental health problems
- Psychotherapy (individual or group, with family involvement)
- Vocational therapy programs
- Psycho-educational programs
- Rehabilitation programs through protected housing services

PSR programs are designed to strengthen the abilities and skills of individuals, so as to meet the needs of their vocational, social and personal development. Psychosocial rehabilitation, by all the measures that it provides, aims to increase social functioning of the person with mental health problems and, thus, increase the quality of life, which represents an issue of great interest in contemporary psychiatry.

QUESTIONS:

1. A patient with Alzheimer's dementia presented psychomotor restlessness throughout the day. He wakes up at night, goes out of the room and into the corridor. Unable to find his way back to the room, he enters other wards and awakens other patients by making a lot of noise. This patient had received an anxiolytic treatment previously. What sort?
    a) meprobamate
    b) alprazolam
    c) diazepam
    d) midazolam (Dormicum)
    e) bromazepam
2. A physician is self-managing his paroxysmal anxiety crises of tremor, palpitations and dyspnea with alprazolam. Over the last week he increased his doses, reaching 3mg/day. He believes that he took too much, but is also afraid to quit taking the alprazolam because the crises might reappear. Therefore, he decides to consult a psychiatrist, because he has become addicted to alprazolam. The psychiatrist must clarify that this is not a case of addiction, because:
    a) He ought to have taken 3mg/day alprazolam for months.
    b) Panic attacks do not resemble the withdrawal reaction.
    c) Alprazolam does not cause biological addiction.
    d) Withdrawal implies the presence of a confusional state (delirium).
    e) Panic attacks are not related to the withdrawal reaction, but to panic disorder.
3. A patient with paranoid schizophrenia is brought to the medical emergency department presenting a vertical conjugate deviation of the eyes accompanied by sustained muscle contracture. The following should be administered:
    a) haloperidol
    b) anticholinergic agent
    c) diazepam
    d) chlorpromazine im
    e) flupentixol im

V. REFERENCES:

1. *** ,*Diagnostic and Statistical Manual of Mental Disorders,* 4th Edition,. Text revision(DSM IV – TR), American Psychiatric Association, Washington D.C., 2000
2. *** ,*I.C.D.-10, Classification of Mental and behavioral disorders - Symptoms and clinical diagnosis*, WHO Geneva 1992, Ed. ALL, Bucureşti, 1998.
3. Cummings J.L., Trimble M.R., *Concise Guide to Neuropsychiatry and Behavioral Neurology,* 2nd edition, American Psychiatric Publishing Inc. Washington DC, London, England.
4. Dehelean L., Sturz O., Marin A., *Practical Notebook for Adult Psychiatry*, Lito U.M.F.T, Timişoara, 2003.
5. Dehelean M., Dehelean P., Ienciu M., Lăzărescu M., Marin A., Romoşan F., *General course of adult and elderly psychiatry*, Lito U.M.F.T. Timişoara, 1998
6. Gelder M., Gath D., Mayou R., *Oxford Textbook of Psychiatry*, Ed. A.P.L.R., 1994
7. Gelder M., Mayou R., Cowen P., *Shorter Oxford Textbook of Psychiatry*, 4th edition, Oxford University Press, Oxford, 2001
8. Goldberg D. *Psychiatry Practical Guide*, 3rd edition, Bucureşti, Ed. Fundației PRO, Bucureşti, 1997.
9. Howland R.D., Mycek M.J., *Pharmacology* 3rd edition, in *Lippincott's Illustrated Reviews*, R.A. Harvey and P.C. Champe editors, Lippincott Williams & Wilkins, 2006.
10. Lăzărescu M. *Psychiatry, sociology, anthropology*, Brumar Publishing, Timişoara, 2002
11. Leff J.P, Isaacs A.D. *Psychiatric examination in clinical practice*, Blackwell Scientific Publication, 1979
12. Sadock BJ, Sadock V.A. *Kaplan and Sadock's Synopsis of Psychiatry, Behavioral Sciences/Clinical Psychiatry*, Lippincott Williams & Wilkins, 9th edition, 2003.
13. Semple D., Smyth R., *Oxford Handbook of Psychiatry*, 2nd edition, Oxford University Press, 2009.
14. Stahl S.M., *Stahl's Essential Psychopharmacology - Neuroscientific Basis and Practical Applications,* 2nd edition, Cambridge University Press, Cambridge, 2008
15. Winokur G., Clayton Paula J., *The Medical Basis of Psychiatry,* 2nd edition, W.B. Saunders Company, 1994
16. Zaman R., Makhdum A., *Churchill's Pocketbook of Psychiatry*, Churchill-Livingstone, 2000.

VI. ABBREVIATIONS

5HT = serotonin
ACA = anterior cerebral artery
ACH = acetylcholine
AD = antidepressant
AIDS = acquired immunodeficiency syndrome
AGS = amenorrhea-galactorrhea syndrome
BD = Bipolar disorder
BZD = benzodiazepine
CCT = cranio-cerebral traumatism
CT = computed tomography
CVA = cerebrovascular attack
D = dopamine
ECT = electroconvulsive treatment
EPS = extrapyramidal syndrome
FO = fundoscopic exam
GABA = gamma-amino-butyric acid
GAD = generalized anxiety disorder
GAMMA GTP = gamma-glutamyl transpeptidase
H = histamine
HIV = human immunodeficiency virus
HF = heart failure
IM = intramuscular
IMAO = monoamino-oxidase inhibitors
LSD = di-ethyl-amide of lysergic acid
MCA = middle cerebral artery
MDMA = 3,4-methylene-dioxi-N-methyl-amphetamine
NA/NE = noradrenaline (norepinephrine)
NL = neuroleptic
OCD = obsessive – compulsive disorder
P/A/B = pregnancies, abortions, births
PCA = posterior cerebral artery
PD = panic disorder
PET = Positron Emission Computed Tomography
PSR = psychosocial rehabilitation
RDD = recurrent depressive disorder
RF = respiratory failure
SSRI = selective serotonin reuptake inhibitor
SPECT = computed tomography with single photon emission
TYR = tyrosine
TRP = tryptophan

VII. EXERCISES

1. A patient presents to the doctor with the following symptoms: falling asleep insomnia, restlessness, and nervous tension. He complains that during the last month he suffered from irritability and memory loss. He had a fronto-temporal evening headache. The clinical symptoms would orient us towards the following diagnosis:
    a. Depressive episode
    b. Manic episode
    c. Generalized anxiety disorder
    d. Panic disorder
    e. Alzheimer's dementia
2. A 20-year-old patient presented to the Emergency Unit with the following symptoms: shortness of breath, palpitations, hypertension, chest pains, tremor, and fear of imminent death. The ECG shows sinus tachycardia. The laboratory test results excluded any organic pathology or a pathology induced by a psychoactive substance. The patient is sent for a psychiatric consult with the following diagnosis:
    1. Spasmophilia
    2. Panic attack
    3. Convulsive disorder
    4. Manic episode
    5. Hypochondriac disorder
3. A 30-year-old woman is brought to the psychiatrist for behavior disorders that started a year ago, but have increased gradually. The patient checks for an excessive number of times if she has turned off the light, closed the windows or the front door. She also has an intense fear of dirt and microbes, which is why she excessively washes her hands, and using gloves whenever she goes out on the street. The clinical examination reveals skin lesions on the hands. What is the most likely psychiatric diagnosis:
    1. Obsessive-compulsive disorder
    2. Hypochondriac disorder
    3. Specific phobic disorder
    4. Convulsive disorder
    5. Generalized anxiety disorder

4. A 19-year-old patient is brought by the ambulance to the psychiatric emergency room with his family, because ever since last month he has developed a bizarre behavior: he isolates himself in his room, unplugs the TV and the computer, and looks if the phones are bugged. He says that he is followed on the street by secret services. The symptoms started eight months ago when he became withdrawn and suspicious, even avoiding contact with former friends. Toxicology screening did not indicate the presence of drugs in his body. The most likely diagnosis is:
    1. Manic episode
    2. Depressive episode
    3. Paranoid schizophrenia episode
    4. Generalized anxiety episode
    5. Obsessive-compulsive episode
5. A 30-year-old woman is brought to the psychiatric emergency room by her family because she presented lately with serious behavioral disturbances: spending a lot of money, wearing excessive makeup, sleeping only two hours a night, listening to loud music and disturbing the neighbors the rest of the time. The patient considers her a very smart person and refuses admission on the grounds that she is perfectly healthy, has a lot to do and does not want to spend time in the hospital. The psychiatric differential diagnosis is between:
    1. Paranoid schizophrenia
    2. Manic episode
    3. Amphetamine intoxication
    4. Opiates intoxication
    5. Conversion-dissociative disorder
6. A 50-year-old man is suing for malpractice the surgeon and the hospital where he was admitted and operated. He is convinced that the doctors forgot a clamp in his abdomen, so he is now experiencing abdominal cramps, feels bloated and has diarrhea. He made numerous complaints to the Head of the Medical College and to the hospital, but with no benefit because he thinks that doctors are in complicity and defend themselves. He was always a suspicious man by nature, self-confident and a tireless fighter for his rights. The most likely psychiatric diagnosis is:

a. Persistent delusional disorder (paranoia) doubled by paranoid personality disorder
b. Paranoid schizophrenia doubled by schizoid personality disorder
c. Hypochondriac disorder
d. Somatization disorder
e. Conversion disorder

7. A 30-year-old woman presents to the psychiatrist extremely worried because, for some months, she had palpitations, generalized tremor, abdominal pain, headache and sexual problems. Her husband does not understand her and does not offer any emotional support, which is why many quarrels disturb the couple. A month ago, after an argument, the patient attempted suicide with drugs (10 tablets of diazepam which she found at home), accusing her husband of being cold and indifferent. She was taken to hospital and was referred for a psychiatric consultation. The most likely psychiatric diagnosis is:
    a. Severe depressive episode with suicide risk
    b. Hypochondriac disorder
    c. Somatization disorder
    d. Generalized anxiety disorder
    e. Obsessive-compulsive disorder
8. A 40-year-old woman presents herself to the family doctor for sleep disorders that started last month. She falls asleep easily, but wakes up during the night without being able to fall back asleep. Her appetite is reduced, resulting in weight loss. She accuses difficulty in fulfilling her household duties and complains that her work efficiency decreased. Nothing arouses her interest and she sometimes wonders if she will ever return to her previous state. The general practitioner initiates a series of tests and consults, including a psychiatric one, with the following potential diagnosis:
    a. Anxious episode
    b. Depressive episode
    c. Hypochondriac episode
    d. Neurasthenic episode
    e. Conversion episode
9. A 30-year-old man is on trial for destruction of goods and serious and bodily harm after an altercation in a bar. At his trial he argues that he

did not want to cause any harm to anybody, but was provoked by the victim. In addition, he was drunk and under the influence of alcohol he lost his mind clarity for a moment, demanding special circumstances because of diminished discernment. The patient has no stable job and had problems with the police in the past for violation of public order. His intelligence quotient is 110. The most likely psychiatric diagnoses are:

a. Emotionally-unstable personality disorder
b. Dissocial (antisocial) personality disorder
c. Histrionic personality disorder
d. Dependent personality disorder
e. Paranoid personality disorder

10. A 70-year-old woman was brought by her family to the hospital for nocturnal restlessness and the urge to leave home to visit her mother. The patient has had an impaired memory for years, which the family considered age-related. Psychiatric examination highlighted computing and writing deficiencies, impaired short-term memory, temporal and spatial disorientation. Computed tomography shows cortical atrophy. The most likely diagnosis is:
    a. Confusional state
    b. Alzheimer dementia
    c. Vascular dementia
    d. Mixed Alzheimer and vascular dementia
    e. Depression in elderly
11. A 40-year-old woman suffered a car accident, which resulted in fatalities and injuries. She survived the accident with serious medical complications. After a few months from the accident, the patient has difficulties falling asleep at night, experiences nightmares about the accident scene; she feels anxious and uneasy. Since the accident she refuses to get into a car. The most likely psychiatric diagnosis is:
    a. Phobic disorder
    b. Adjustment disorder
    c. Acute stress disorder
    d. Posttraumatic stress disorder
    e. Depressive reaction
12. A 55-year-old man is brought to the psychiatric department from gastroenterology, where he was hospitalized for gastritis and ethanol

induced toxic hepatitis. The reasons for referral are bizarre behavior (seeing rats in the ward), and nocturnal restlessness. The medical examination revealed inadequate answers to questions, temporal and spatial disorientation, sweating, vomiting, tremor of the extremities, tachycardia with hypertension. The most likely diagnosis is:

a. Paranoid schizophrenia
b. Temporal epilepsy seizure
c. Hallucinogenic drug intoxication
d. Confusional state secondary to alcohol withdrawal
e. Stroke

13. A 65-year-old man is brought to the psychiatric ward for memory loss, dysphasia, and moments of mind clarity loss. A month ago he had a stroke resulting in predominantly brachiofacial hemiplegia. Computed tomography reveals multiple ischemic areas located cortically. The man is suffering from ischemic heart disease and type II diabetes. The most likely diagnosis is:

a. A stroke in the posterior cerebral artery
b. Vascular dementia, multi infarct type
c. Alzheimer's dementia
d. Mixed Alzheimer's and vascular dementia
e. Vascular dementia, lacunar type

14. A 35-year-old woman presents to a psychiatrist for a moderate depressive episode. This episode is not induced by an organic disease or a substance. The patient has a history of three depressive and manic episodes and a thyroidectomy. During the depressive episodes the patient admits that she uses alcohol to help fall asleep. The most likely psychiatric diagnosis is:

a. Recurrent depressive disorder, depressive episode
b. Bipolar disorder, depressive episode
c. Adjustment disorder, depressive episode
d. Depressive episode induced by alcohol
e. Depressive episode because of the hypothyroid disease