**KAZAN FEDERAL UNIVERSITY**

**A. S. GRANITSA, P.G. KALIMULLIN, Y.V. KARINA**

# CLINICAL CASES IN PSYCHIATRY

Handbook

Kazan

2022

*UDC 616.89*

*G75*

Recommended for publication
Educational and Methodological Commission
Institute of Fundamental Medicine and Biology of KFU
(Protocol No. 6 of 18.05.2022)
Reviewer:
Associate Professor of the Department of Psychiatry and Medical Psychology,
Kazan State Medical University,
Ph.D., Makaricheva A. V.

Granitsa A.S., Kalimullin P.G., Karina Y.V.

G75 Clinical cases in psychiatry. Handbook/ Granitsa A.S., Kalimullin, P.G.Karina Y.V. / - Kazan: Kazan. un-ty, 2022. - Educational and methodical manual. - 63 p.

This handbook examines the process of diagnosis in psychiatry by the example of solving clinical problems. Readers will be familiarized with the basic approaches of diagnosis in various mental pathologies, with the principles of justification and differentiation of diagnosis. It is intended for students and residents of medical, psychological and pedagogical areas of training.

*UDC 616.89*

# TABLE OF CONTENTS

# INTRODUCTION

Understanding the basics of psychiatry is necessary for doctors of various specialties, since the overwhelming number of patients initially visit not psychiatrists, but, for example, physicians or other narrowly focused specialists. At the same time, the prevalence of mental disorders, according to various estimates, puts them in the top five most common diseases and in the first place for causes of disability of patients. In addition, many symptoms of mental illness may be similar to those diseases that occur in general somatic practice. There is a wide variety of pathologies that future general practitioners will encounter most often: borderline, or minor, psychiatry (neuroses, personality disorders and transitional states), somatogenic mental disorders, mental disorders with general and brain infections, alcohol disorders of various levels, drug addiction, substance abuse, oligophrenia. A number of diseases relate to interdisciplinary problems with neurology, medical genetics, infectious diseases and others. And finally, patients with mental disorders may also suffer from concomitant somatic diseases, when providing this medical assistance, it will be necessary to take into account features of this group of comorbid patients. Thus, despite the specifics of psychiatry as a clinical discipline, a broad understanding of mental disorders, their clinical manifestations and principles of therapy is important for the general education of a student of a higher educational institution of a medical profile [7].This manual is designed to help students, residents and postgraduates to prepare in "psychiatry" and "medical psychology" disciplines.

In this handbook we will focus on the diagnostic process in psychiatry, considered on the example of real clinical cases and arranged in the form of clinical tasks.

# CHAPTER 1. GENERAL APPROACHES TO DIAGNOSIS IN PSYCHIATRY

The leading diagnostic methods in psychiatry are: clinical-anamnestic (anamnesis - study of family and social history), clinical-psychopathological (study of the mental status of the patient), experimental-psychological (application of methods of psychodiagnostics) [2, 4-7]. Additional examination methods habitual for somatic medicine are used: laboratory (blood tests and tests of other physiological fluids), instrumental (electroencephalography, X-ray diagnostics, magnetic resonance imaging, etc.). A description of additional examination methods and the possibilities of their application in psychiatry can be obtained from the relevant literature.

**The structure of academic medical history in psychiatry**

**1. Anamnesis of life**.

**2. Allergic history and previous diseases** (infections, TBI, ONMC), chronic diseases (GB, DM, etc.), operations, blood transfusions.

**3. Bad habits**. Smoking experience, number of cigarettes per day. Alcohol experience, characteristics of drinks, volume at a time, the presence of a gag reflex, the presence of binge drinking, the presence of abstinence. Drug experience, characteristics of the drug, volume at a time, the presence of cravings and binge drinking, the presence of abstinence.

**4. Anamnesis of the disease**. Predisposing factors (peculiarities of upbringing, heredity, somatic diseases, character (personality traits). The onset of the disease (year, causality). The course of the disease (leading syndrome, frequency of exacerbations). Adherence to therapy (observation by a psychiatrist, taking medications). Current exacerbation (onset, clinical picture, circumstances of hospitalization). Clinical picture from the moment of hospitalization.

**5. Mental status at the time of examination.**

**6. Data from other methods of examination** (conclusion of the clinical psychologist, neurologist, therapist, functional diagnostician, if available).

**7. Preliminary diagnosis** (ICD-10 cipher, ICD-10 disease formulation, leading syndrome/syndromes at the time of examination or prevailing since hospitalization) and its confirmation (conclusions from anamnesis, from data from other examination methods, symptoms and syndromes).

**8. Differential diagnosis** (with which diseases (at least 3), based on the clinical picture of a particular patient, indication of similarities and differences). For example, a patient shows signs of apathetic-abusive syndrome within the framework of schizophrenia. This syndrome can occur with depression, epilepsy and psychoorganic syndrome, respectively, it is worth comparing with them. It would be wrong to compare schizophrenia with bipolar disorder, autism spectrum disorder or dementia just because schizophrenia itself may have similar symptoms. You should compare the symptoms of a particular patient with the symptoms of diseases and thereby confirm why it is worth choosing your diagnosis.

**9. Offer for additional examination** (if appropriate).

**10. The proposal of treatment tactics** (medication (indication of the drug group, justification of the choice, example), non-drug) and rehabilitation.

**Anamnesis is a set of information obtained during a medical examination by questioning the patient and/or persons who know him [2, 7].** It may be objective (collected on the basis of the words of other people, medical and other documentation) and subjective (collected from the words of the patient) anamnesis.

**Anamnesis structure in psychiatry:**

1. Anamnesis of life (life history). This section lists the main stages of the patient's life, starting with the peculiarities of pregnancy. Following sections of the life history are important for psychiatric diagnosis:

* Features of pregnancy.

* Features of the course of childbirth.

* Early and preschool development: the timing and features of the stages of early development (when patient started talking, walking, showed social interest,

visiting preschool institutions, etc.). Qualitative features of reactions and behavior in this period may also be important: openness, characteristics of play activity, the presence of children's fears and fantasies, features of speech, etc.

* School period: the timing of admission to school, the nature of academic performance, social contact with peers, physiological changes.

* Features of the mature period: education, hobbies, social contact, work, military service, menopause, pregnancy, driving, criminal record.

* Character of the patient from his own or his relatives' words – in order to trace the dynamics and its connection with a mental disorder.

2. Allergic history and the presence of side effects of drugs.

3. Heredity.

4. Transferred and concomitant diseases. This section is not only of general medical and organizational importance, but in some cases it can help in diagnosis and partially goes to the section anamnesis of the disease.

5. Bad habits. This section may also overlap with the history of the disease (in the case of addiction syndrome or the consequences of abuse in the form of organic brain damage).

6. Anamnesis of the disease. One of the most important sections demonstrating several aspects of diagnosis: the type of disorder (for example, personality disorder), the cause (for example, the consequences of head injury), the duration of the disease, the type of course (continuous or paroxysmal), characteristic and predominant symptoms, adherence to therapy. This section separately specifies the circumstances of hospitalization or psychiatric examination: self-referral, court decision, referral from another specialist. It reflects the patient's critical attitude towards the disease. The type of disorder should be indicated in this section in cases of previous hospitalizations or visits to a psychiatrist.

**Structure of mental status** [2, 4-6]:

1. The state before the interview. This section indicates the available information about the patient's behavior before the direct meeting with the doctor.

If this is an outpatient appointment, then how he behaved in the corridor, whether he wanted to go to a meeting, and so on. If inpatient, then you can find out their records or reports of medical staff about how the patient spent time in the department: violated or did not violate the department's regime, whether there is aggressiveness of behavior, conflicts, how he sleeps, eats, takes medications. Knowing patient's behavior can indicate the severity of the condition and guide the dialogue.

2. Circumstances of the interview: where the interview takes place (in the office, in the ward, etc.), the patient's motivation for the conversation (he turns to the conversation himself, comes accompanied by the staff, refuses to talk in the office, etc.). If the conversation takes place in the office, then this may indicate compliance between the patient and the doctor, his adherence to treatment or compliance with the rules of medical care. If the conversation does not take place in the office, then this may be due to the severe somatic or mental state of the patient, his negative reaction to the regime of the department or the doctor. If the patient turns to the conversation himself, this may indicate compliance, his criticism, or the anxiety and discomfort that he is experiencing, and which he is ready to share with the doctor. Refusal to talk may be due to a lack of criticism of disease or lack of trusting relationship with the doctor.

3. Definition of clear or clouded consciousness (if necessary to differentiate of these states). If there is no doubt about the presence of a clear (not clouded) consciousness, this section can be omitted. A sign of clarity of consciousness is presence of orientation in the place (knows where he is), time (knows the current date), his own personality (knows his name, age). Another sign is contact with the surrounding reality - answers or seeks to answer the questions asked, correctly perceives the environment, can correctly name objects and surrounding people, etc. Disorientation may be associated with loss of contact with the outside world and immersion in hallucinatory and delusional experiences, which is observed in the syndromes of clouded consciousness (delirium, amentia, oneiroid, twilight clouding). Another reason may be memory disorders (amnestic disorientation). In

this case, the patient retains contact with others, but cannot determine the current place, time and parts of his personality due to amnesia.

4. The presence or absence of complaints and their content. This section describes complaints that patient makes, with a primary focus on complaints of mental, behavioral or social content: mood, relationships with other people, relationships with society, etc.

5. Appearance. This section describes appearance of a patient and its compliance with age, culture, social norms, situation: the peculiarities of his clothes (cleanliness, integrity, season), hair (cleanliness, hairstyle features), makeup, etc. The appearance may be neat, well-groomed, careless, pretentious, or the patient may show complete indifference to appearance.

6. Behavior. It describes the behavioral acts of the patient: his motor activity, gestures, completed actions. The behavior can be calm, fussy, excited, ridiculous, pretentious, demonic, aggressive, auto-aggressive, mannered. Also here you can describe the features of gait, posture (free, natural, unnatural, pretentious, forced, ridiculous, monotonous, open or close), gestures (active, poor gestures).

7. Contact features. It specifies the features of interaction with the patient, his ability and desire to maintain a conversation with the doctor. Contact can be active (the patient himself addresses questions and requests, shares experiences, fully answers the doctor's questions), passive (the patient only answers the doctor's questions), formal (the patient answers yes or no); productive (conversation leads to a result), unproductive (conversation does not lead to a result). The unproductiveness of the conversation may be due to the patient's unwillingness and his hostile, oppositional or negative attitude towards the doctor. Similarly, unproductiveness may be due to the mental state of the patient: deep disorganization of thinking, a deep decrease in intelligence and memory, confusion, psychomotor agitation, attention disorders, dominance of hallucinatory experiences during a conversation, stupor. In this regard, it is worth to specify in detail both the reason for the productiveness of the contact and its unproductiveness.

8. Speech**.** Speech allows you to evaluate several features of patients at once: the general level of intelligence and erudition, the structure and pace of thinking, the presence of neurological symptoms, the emotional state of the patient. In some cases, patients may not answer questions asked in a normal voice, but may respond to whispered or written speech. Speech can be described by the following parameters: vocabulary and literacy (literate, agrammatic, primitive, rich, poor, with jargon and neologisms); by logical harmony (harmonious, illogical and paralogical), by internal coordination of words, phrases and syllables (coherent, incoherent); by sequence (sequential, inconsistent, with slipping, torn, schizophasia); by detail (thorough, usual), by tempo (slow, accelerated); by the number of words (voluble, talkative, brief, "speech pressure"); by dynamics (sudden stops of speech, silencing, acceleration, slowing down, repetition – verbigerations, getting stuck). It's possible to give here the most striking examples of speech (quotes).

9. Emotional processes are evaluated through a whole group of phenomena. Emotional background (a certain dominant level of emotions during a conversation): lability (mobility), rigidity, excitability (speed and strength of occurrence), inhibition (speed and depth of extinction). Background quality: reduced, elevated, smooth (without pronounced fluctuations). Mood: good, bad, elated, satisfactory. The dominant emotion is: anger (irritation, rage, resentment), joy (gaiety, euphoria, ecstasy), sadness (longing, grief), fear (fright, horror, excitement, anxiety), interest, surprise, shame, disgust, guilt, contempt.

10. Patient's reaction to his experiences, clarifying questions from the doctor, comments, attempts at correction, humor, emotionally significant life events (talking about loved ones, traumatic situations). A decrease in emotional response can be a symptom of many mental disorders and manifest itself as sensitivity (hypersensitivity), explosiveness (explosive with a predominance of anger), coldness (a decrease in the level of emotional reactions), ambivalence (the coexistence of opposite emotional reactions), paradoxicity (the discrepancy between the emotional reaction and the stimulus).

11. Facial expressions (facial reactions) reflect the dominant emotion during the conversation. Facial expressions can be lively, rich, poor, monotonous, expressive, "frozen", pretentious (mannered), grimacing, masked, hypomimia, amimia, etc.

12. Voice. It can also reflect an emotional background and be closely related to the emotion being experienced. The voice can be described as quiet, loud, monotonous (without changing the pitch), modulated (the ability to change the pitch is preserved), expressive, hoarse, trembling.

13. Somatic manifestations of emotions: hyperemia, pallor, increased breathing, pulse, hyperhidrosis, tremor.

14. Presence of suicidal thoughts and tendencies (whether patient denies or not, necessary to describe in detail). Since there are no reliable ways to read the patient's thoughts, the presence or absence of suicidal thoughts can only be detected through the patient's own statements. In addition, behavior observation and anamnesis can predict risk of suicidal tendencies.

15. Presence of aggressive tendencies (whether patient denies or not, necessary to describe in detail). Aggression is a behavioral act aimed at causing physical, psychological or social harm to another person. Aggression can be accompanied by emotional experiences, but it can also be isolated. An intention to cause harm may be indicated by patient’s own statements or/and observation of his behavior and his anamnesis.

16. Attention is a mental process associated with the ability to be focused on object or activity. It is characterized by: stability (duration of concentration on the same object or activity), selectivity (ability to select significant stimuli and ignore secondary ones), switchability (purposeful change of the object of concentration of attention), distribution (ability of attention to simultaneously concentrate on several objects of different nature), exhaustion (reduced ability to focus on a certain phenomenon or activity for a long time due to increased fatigue), absent-mindedness (a violation of the ability to concentrate for a long time with constant

transitions from one object to another, without lingering on anything), arbitrariness (the ability to deliberately, consciously concentrate one's attention on an object).

17. Memory characterizes the ability of the patient to remember, save and reproduce the received information. In this section, it is appropriate to ask the patient about the events of the recent and distant past. According to Ribot's law, with an increasing decrease in memory, first of all, the closest memories are lost, and distant, children's, are preserved for a long time. During the conversation you can ask the patient to remember a number or a word / words and ask him to remind him after a few minutes. Here we describe the amount of memory, signs of memory loss, paramnesia, amnesia (describe the type of disorders), or corresponds to age and level of education.

18. Intelligence is characterized by the development of abilities for successful activity. Intelligence is based on the processes of thinking and memory. For a preliminary assessment, you can ask to perform simple mental operations – to count, to  a logical problem, etc. It is studied in more detail by special psychological tests. When describing intelligence, it is necessary to indicate signs of decline (describe the type of violations), or safety, and accordance to age and level of education.

19. Thinking is the process of reflecting the essential properties of objects, as well as the connections between them, which leads to the appearance of ideas about objective reality. It is characterized by: pace (moderate, slow, accelerated), consistency, mobility, that is, the ability to switch from one mental task to another (or violations in the form of inertia, rigidity, stiffness, stability), harmony (purposefulness, logic), violations of harmony (slipping, discontinuity, diversity, incoherence, paralogicity, illogicality), productivity (the ability to come to a result), the ability to abstract or concreteness.

20. Presence or absence of volitional disorders and drive disorders (describe the type and nature of violations). Willpower characterizes the ability to regulate one's own behavior and mental processes and is closely related to the concepts of purpose and motive. Drives characterize activities aimed at satisfying needs. It is

worth to describe if the patient is able to control his actions (activity, consistency, orderliness), or vice versa, his impulsivity or passivity; as far as he can manage his behavior to meet his needs and to what extent these needs are socially acceptable.

21. Active psychopathological products: the presence and nature of delusional symptoms, supervaluable ideas and obsessions, the presence and nature of sensation and perception disorders, or active psychopathological products are not detected. Examples of the patient's statements can be given here to characterize sensory disorders (paresthesia, senestopathy, etc.), perceptions (illusions, hallucinations, psychosensory disorders), meaningful thinking disorders (delusional, over-valued, obsessive ideas). It is worth to describe here in as much detail as possible these disorders and concomitant behavior and changes in the dynamics of other mental processes. For example, when experiencing true hallucinations, the patient has congruent behavior (he interacts as with a real object: looking for the source of sound, looking around, trying to catch), attention is redistributed (he pays more attention to hallucinatory images and sounds), there may be an emotional reaction (vivid emotions: surprise, interest, fear, anger, joy). In the presence of meaningful thinking disorders changes in the emotional sphere may be detected, according to the context of ideas (increased fear in case of ideas of a threat to the patient), a redistribution of accents during a conversation (focus on the topic), or a tendency to avoid the conversation (in case of distrust of the doctor).

22. The dynamics of the mental state during the conversation may reflect the patient's compliance, the degree of his trust in the doctor and treatment, the presence of signs of organic brain damage (with increasing fatigue): improved contact (deterioration), increased suspicion, detachment, confusion, the appearance of delayed, slow, monosyllabic responses, malice, aggressiveness, or, conversely, greater interest, confidence, goodwill, friendliness.

23. Criticism of the disease is the patient's ability to realize the fact that he has a mental disorder, signs of its manifestation (symptoms), the influence of the disease on his life, behavior and mental processes, as well as the need for

treatment. *Criticism can be active or passive, complete (incomplete, partial), formal.* Criticism of individual manifestations of the disease (symptoms) in the absence of criticism of the disease as a whole. Criticism of the disease in the absence of criticism of "personality changes".

24. Range of interests (breadth or limitation). Assessed: the degree of satisfaction from these activities, any changes in them, the accordance of interests to the age and education, the degree of immersion in them.

25. Plans for the future (their realism, structuring).

26. Sleep: sufficient (an objective number of hours, subjective feeling of being rested and energized after sleep), the dynamics of the number of hours of sleep, intermittent, difficulty falling asleep, early awakening, altered sleep and wakefulness, lack of sleep.

27. Appetite: sufficient (with a sense of satisfaction of hunger), objective amount of eaten food, dynamics in the amount of eaten food, reduced, increased.

28. Brief somatic state.

The sequence of the diagnosis

- Study of anamnesis
- Study of mental status
- Study of additional surveys
- Isolating of symptoms
- Isolating of the leading syndrome
- Identifying of mental disorder
- Differentiation with other disorders
- Determination of treatment tactics

## CHAPTER 2. AN EXAMPLE OF STUDYING A CLINICAL CASE

Psychiatric case history [2, 3]

Patient Sh., male, 20 years old.

**Life anamnesis (according to parents):**

Patient's paternal grandfather was treated in a psychiatric hospital in his old age.

Patient was born in Baltasy-town, from the first pregnancy, on time, by caesarean section due to mother's risk of threat of retinal detachment. (Baby) screamed immediately. Developed up to a year in accordance with age norms. Up to 3 years old, he often cried at night, after 3 started to sleep well, calmly. From the age of 1.5, he attended a nursery, adapted easily, was a favorite of educators. He was a moderately active child, willingly read poetry, took part in matinees (performances). He went to school at the age of 6 (almost 7). At the same time, he entered a music school in the kurai class (tatar national musical instrument). He always studied well, was an activist. Tried to play sports, basketball, football, karate, but not for a long time. He graduated from school with a gold medal, immediately entered the KAI. Where he studied only perfectly and passed the first session for all A's.

**Character traits**. He has always been an owner. As a child he did not let anyone play with his toys. When guests came home, he had hidden his toys. Especially he loves soft toys, sometimes he sleeps with his beloved toy dog even now. He has not been very sociable, has loved peace and quiet.

Since he started studying at the institute, he suddenly began to ask parents about meaning of their life, about their purpose, whether they achieved it or not. He asked his mother: "Are these garden beds the meaning of your life?" He reflected about the purpose of his life and whether he had chosen the right specialty.

**Anamnesis of the disease according to the parents**. We noticed oddness in his statements for the first time on May 23, when he, calling his mother, asked her in a pleading voice how she found out that he had stolen an extension cord. Then

he told that he was cleaning the utility room in the hostel, and for some reason put the extension cord in the trash and put it out the door. He asked out of place who of his grandfathers had a scar on his head and when his nephew's birthday was. On May 24, unexpectedly, without informing, he came home to Baltasy. He was tensed, "as zombified, his eyes were running," blamed himself for theft, wanted to surrender himself to the police, and said that he was guilty in front of everyone. He said that he was being watched, that his account had been hacked, that he needed to be isolated. He asked himself when it all started for him. The parents turned to Prof. M., who sent Sh. to the hospital.

**Subjective anamnesis of life.** Patient remembers himself from the age of 4-5, "was an ordinary average child." He attended kindergarten, but he does not remember the details, "probably read poetry and played." He went to school at the age of 6 (turned 7) in November. There were some friends, usually 3-4 people, but he was not too sociable. He tried to play sports, football, basketball, but he decided that he had no talent for it and left. The coaches never said that there were no prospects, but he realized that others were better than him. He went to judo for two weeks, but he couldn't continue, because he couldn't bring himself to wrestle and fight.

He always studied well, but became an excellent student from the 8th grade, "everyone has their own priorities." There was no time and desire to communicate with friends. He was doing lessons diligently. After graduating from the 11th grade, he was admitted to KAI-university on budget. But recently he realized that he was a humanitarian, that he had to choose a different specialty.

At the age of 10, he began to analyze himself, probably there were periods of bad mood. He tried to figure out whether he lived right way, whether he did everything correctly, whether he developed physically correctly, compared himself with other children, "it was the beginning of puberty."

At the end of the 10th grade, he began to self-reflect on his destiny, on the meaning of life.

**Subjective anamnesis of the disease**. Over the last few days before admission, he felt that he was being watched, "to find out my emotions, what I am, will lead me to what." "They made me think that I needed to steal something to find out what I would do in such a situation, steal or not." He claims that he stole from Pyaterochka, put everything in a backpack, but no one noticed. He showed a large list of products that he allegedly stole. He is sure that "there is a full proceeding of the state now." He understood it from the judgmental looks of the people around, in which it was read that it's forbidden to steal. He believes that he should be in court now, that the judge should sentence him, and he is ready to be punished. He would like to read the Penal, Civil and other Codes in order to get to the point.

Allergic anamnesis is not burdened. He categorically denies the use of alcohol, tobacco, and drugs. The transferred diseases – colds.

**THEREFORE**

- No external factors and causes have been identified.
- There were character traits before the disease: against the background of good inclinations, he could develop them, but when he faced with difficulties, he tried to look for other easier ways, some aloofness and isolation, diligence.
- He has been inclined to philosophize in the last few years.
- The disease started recently.
- The ideas of persecution and self-blaming prevailed in the clinical picture (presentation).

**Mental status and psychodiagnostic examination.** During the examination, the patient is motorically calm, even mood, low emotional, hypomimic, constrained, cautious, formal. "Withdrawal into himself" is periodically noted. Criticism is reduced, the reason for being in the hospital he named as "they say psychosis against the background of studies; there was insomnia, confusion of reality, memory lapses." The contact is available, answers the questions on the merits, in terms of the asked, the pace is unstable.

**In the process of attention research** instability with a tendency to exhaustion is noted. **Direct memorization** is productive in positive dynamics. **Mediated memorization** has an average level of productivity (65%). The drawings have formal, symbolic, attributive and specific-situational nature. The patient occasionally uses letter designations ("victory - the V sign", "deception – the letter L – a lie", "doubt – hmmm ..."). A poorly differentiated fragmentary image is noted (for the word "feat"(heroic dead) patient drew a "semicircle" with the explanation "this is a muscle that is connected with strength and strength with a hero - that's why the feat is such a logical connection"). **In the method of "exclusion of excess"** instability, diversity of processes of generalization and exclusion processes, equalization of essential and secondary features, actualization of latent ones ("the book should be excessed, and the rest can create unpleasant, prick") are noted. When designating a generalizing concept, patient operates with functional values (“key is superfluous, and the rest is for storing liquids, the cart is superfluous, and the rest is for moving a person").

**When comparing concepts** - with a sufficient level of comparison operations, he actualizes latent signs with a tendency to compare distant concepts ("fraud and false - common begin with F, difference – at will – by chance", "alarm and rooster – both can sing – inanimate and alive"). The figurative meaning of proverbs is inaccessible, patient interprets only familiar simple proverbs, sayings.

**In the associative experiment** a formality is noted, a combination of both higher and primitive associations.

Thus, in the process of **experimental psychological research**, against the background of a tendency to exhaustion, there is a violation of the purposefulness of thinking with a slip to latent signs in a person with an accentuation of the "sensitive schizoid" type, a conflicting combination of multidirectional tendencies.

**So from the mental status we can distinguish**:

• Signs of disorganization of thinking: diversity, slippage, reliance on latent signs.

• Low emotional expressiveness.

• Isolation.

• The ideas of persecution and self–accusation expressed are nonsense of persecution and self-accusation.

• Partial criticism of the condition.

The ideas of self-accusation and persecution can be interpreted as delusional ideas. Delusional ideas are false, erroneous judgments (conclusions) that have arisen on a painful basis and are inaccessible to criticism and correction.

They belong to the category of primary delirium. The primary delirium, or delirium of interpretation, interpretation follows directly from disorders of thinking and is reduced to the establishment of wrong connections, a wrong understanding of the relationship between real objects.

Delusional ideas form the basis of paranoid delusions. Paranoid syndrome is a systematic delusion of attitude, jealousy, invention. The judgments and conclusions of patients outwardly give the impression of being quite logical, but they proceed from wrong premises and lead to wrong conclusions.

Thus, the leading syndrome in the patient:

Paranoid syndrome, combined with ideas of self-accusation.

Let's compare the detected symptoms with the criteria for ICD-10 [1]:

Criteria for the diagnosis of "schizophrenia":

thought echo;

thought insertion or withdrawal;

thought broadcasting;

delusional perception and delusions of control; ***delirium***

influence or passivity; (*catatonic devices: arousal, waxy flexibility, negativism, mutism and stupor;* ***behavior change: loss of interest, lack of direction, inactivity, self-absorption and autism; smoothness or inadequacy of emotional reactions****)*

hallucinatory voices commenting or discussing the patient in the third person; *hallucinatory experiences*

thought disorders and negative symptoms. *apathy, abulia, poverty of speech;* ***loosening of associations: schizophasia, reasonableness***

Thus, a comparison of the detected symptoms and syndromes with the ICD-10 criteria suggests "paranoid schizophrenia".

To differentiate with other mental disorders, it is necessary to answer the question: "In what diseases can this syndrome occur?"

It can occur in the following diseases:

• Schizophrenia

• Organic schizophrenic disorder

• Epilepsy

• Depression

• Bipolar affective disorder

• Reactive psychoses

• Psychoses caused by the use of psychoactive substances.

Let's go back to the anamnesis:

• No external factors and causes have been identified.

• There were character traits before the disease: against the background of good inclinations, he could develop them, but when faced with difficulties, he tried to look for other easier ways, some aloofness and isolation, diligence.

• Has been inclined to philosophize in the last few years.

• The disease started recently.

• The ideas of persecution and self-accusation prevailed in the clinical picture.

Consequently, it is possible to exclude Organic schizophrenic disorder, reactive psychoses, psychoses caused by the use of psychoactive substances. In addition, there are no indications of seizures, what help us to exclude epilepsy. There is no indication of fluctuations in the emotional background towards depression or mania, which excludes bipolar affective disorder. Thus, the diagnosis of schizophrenia remains.

So, the final diagnosis will look like this:

Schizophrenia, paranoid form, paranoid syndrome, the period of observation is less than a year.

**Choice of management and treatment tactics.** At the present moment, the patient is in an acute psychotic state. Failure to provide psychiatric care can be fraught with aggravation of symptoms, progression of the disease, possible danger to himself and others during the transformation of symptoms and the addition of new ones (for example, pseudohallucinations during the transition to the Kandinsky-Clerambault syndrome). All of the above indicates the need for treatment in a psychiatric hospital.

The choice of treatment is largely determined by the detected symptoms, syndromes, concomitant pathology, allergic history. The current leading syndrome is paranoid. Neuroleptics with a global antipsychotic effect (for example, haloperidol, olanzapine) or selective anti-delusional (for example, triftazine) are used to relieve delusional symptoms. Concomitant emotional decline, autism, and the self-accusing nature of statements may also justify the use of an antidepressant (for example, from the SSRI group).

## CHAPTER 3. EXAMPLES OF CLINICAL CASES

**Case 1. Male patient, 32 years old.**

**Anamnesis of life.** Heredity for mental disorders is not burdened. Patient was born on time of the second pregnancy. Early development without disabilities. He went to school at the age of 7. Studied satisfactorily. Has secondary professional education. He served in the army. He worked in various working professions, with a total experience of 7 years. Divorced, does not maintain relationships with his ex-wife, doesn't have children. He hasn't been judged. He's living with his parents. Smokes 1 pack/day. He denies the use of alcohol and drugs. There were no traumatic brain injuries, infectious diseases of the brain, chronic diseases from the words.

**Anamnesis of the disease.** The disease began acutely, claimed that he was being persecuted, "heard voices of a threatening nature". He is observed by a psychiatrist for 5 years. He was repeatedly hospitalized in a psychiatric clinic. The last discharged from the hospital was a year ago. After discharge, he took medications irregularly. According to the patient's words, 2 weeks before the current hospitalization, "the voices started again". The patient started taking haloperidol in drops. He describes "voices" as multiple, imperative, the meaning of which is difficult to convey. The day before hospitalization, under the influence of "voices", the patient wanted to cause self-harm, to cut his forearm in order to "drown out the voices". He was discovered by relatives who called an ambulance and the patient was taken to a psychiatric hospital.

**Mental status.** He is oriented correctly in place, time and its own personality. Motor restless, shifting from one foot to the other. Facial expressions are inexpressive. The mood at the time of the examination is assessed as "reduced". Attention is attracted by a question, but it is not held enough, it is easily distracted, it cannot be concentrated on the conversation for a long time. He often looks away, as if listening to something. Intelligence and memory without gross violations. Thinking is moderate in pace, amorphous, not always consistent. He does not express suicidal thoughts at the time of the examination. During the

conversation, he said that he heard "voices" inside his head, periodically throughout the day, including now, but "after the injection it got better." The "voices" were male, different, unfamiliar, mostly of a threatening or commenting nature. They called the patient names (insulted), threatened him with death. Criticism of his condition is not complete, admits that he "needs to get rid of the voices," but doubts that he is ill. Sleep (from his words) is intermittent, there are difficulties with falling asleep.

**Questions:**

1. What anamnesis data helps in diagnosis?
2. What mental status data helps in diagnosis?
3. Name the symptoms of psychopathology.
4. Name the leading syndrome(s) of psychopathology.

**Case 2. Male patient, 63 years old.**

**Anamnesis of life.** There is no data on heredity. Was born on time, grew and developed without peculiarities. He graduated from the 10th grade of secondary school. Then he studied at professional college. He served in the missile forces, then worked in the navy. He is married and has two children. Lives with his wife in a separate apartment. Disabled person of the 2nd group for mental illness since 2012. Capable. He denies syphilis, HIV, hepatitis, diabetes mellitus, tuberculosis. Denies hemotransfusion. The allergological anamnesis is not burdened from his words. Categorically denies use of drugs, smoking, alcohol. In 2004, he suffered a TBI (traumatic brain injury) with damage to the bone plate of the right parietal region.

**Anamnesis of the disease.** Since the autumn of 2010, there has been a progressive decline in cognitive functions, with the addition of affective disorders. He has been observed by a district psychiatrist since 2011. Was hospitalized once. Disabled person of group 2. His mental and emotional condition changed 5 months ago, he became more conflicted, irritable. He left the house, shouted incoherent

accusations from the window of the house to passers-by. Relatives turned to district psychiatrist where a referral for hospitalization was given.

**Mental status**. Conscious. He is not motorically excited. The gait is slow, shaky. Movements are impetuous. Productive contact is difficult, confuses events of distant and near time. He called his name correctly. Attention is attracted for a short time, exhausted. The current year is not called, the age is 6 years. Can't tell where he is. In a conversation, he answers questions after a long pause for reflection. He does not answer many questions. When answering, he often starts talking about one thing, but then moves on to another topic. A pronounced intellectual-mnestic decrease is revealed. Hallucinatory products are not detected. The emotional background is unstable, prone to irritation and affective outbursts. He tried to bite the nurse who brought him lunch. According to observation, sleep is intermittent, uneven, does not fall asleep for a long time.

**Questions:**

1. Name the symptoms of psychopathology.
2. Name the leading syndrome(s).
3. Name the preliminary diagnosis
4. Prescribe medication and target therapy

**Possible answers:**

1. Symptoms:

• delusional ideas of persecution,
• delusional ideas of damage,
• emotional lability,
• bradyfrenia,
• delusional ideas of reformism,
• dissomnia,
• reducing the arbitrariness of attention,
• anxiety,
• reduced intelligence,
• dysmnesia,

• amnesic disorientation.

2. Syndromes:

• hallucinatory delusional syndrome,

• emerging paranoid syndrome,

• psycho-organic syndrome,

• manic syndrome,

• delirious syndrome.

3. Diagnosis:

• Bipolar affective disorder type 1,

• Schizophrenia, observation period less than a year,

• Organic personality disorder, pronounced psycho-organic syndrome, explosive variant,

• Dementia,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Normotimic to relieve emotional stress, for example carbamazepine,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve anxiety and dissomnia,

• Tricyclic antidepressant with sedative effect to relieve anxiety and dissomnia (for example, amitriptyll),

• Neuroleptic with a sedative effect, for example, chlorprotixen.

**Case 3. Male patient, 28 years old.**

Complaints: low mood, anxiety, difficulty falling asleep.

**Anamnesis of life.** Heredity is not burdened from his words. He was born on time. The only child in his family. He grew and developed without any peculiarities. He graduated from the 11th grade of secondary school. Then the university majored in engineering. Currently works as a salesman in a grocery store. Has no disability. Capable. He denies syphilis, HIV, hepatitis, diabetes

mellitus, tuberculosis. Denies hemotransfusion. The allergological anamnesis is not burdened from his words. Categorically denies use of drugs, smoking, alcohol.

**Anamnesis of the disease**. From his words since childhood, he was anxious, suspicious. From the age of 15, there were obsessive thoughts that he forgot to turn off the gas and he had to go back to the kitchen 5-6 times to make sure. Although he understood the absurdity of these thoughts, he could not cope with them, because the thought automatically appeared: "if I don't, the house will explode." One day he saw a stain on the floor and there was an irresistible desire to step on it, as the thought arose: "if I don't step on it, my parents will die." Since then, every time he passed by, he had to step on a spot, the number of times increased to 7 ("seven is a lucky number"). When trying to interrupt thoughts or not to perform actions, strong anxiety increased. He felt his thoughts as something alien, stupid, irrational, but he couldn't resist them. He was afraid that he was going crazy. Thoughts arose, as well as other thoughts, were no difference from his own thoughts. The presence of such conditions was exhausting, he persuaded his parents to hospitalize him in a psychiatric clinic. After discharge, olanzapine and clomipramine were prescribed. The patient accepted them, but the effect was weakly expressed. One day, by an effort of will, he did not succumb to thoughts and noticed that the anxiety gradually disappeared. Since then, he has tried not to perform rituals and not to pay attention to these thoughts. After that, rituals and thoughts became less frequent. About six months ago, there was a fear that these states would return. The mood decreased, anxiety increased. In addition, obsessive thoughts related to jealousy often arose in relationships with girls. He did not take medications. He decided to visit a psychiatrist.

**Mental status**. Correctly oriented in all kinds (time, space, self). Facial expressions are closer to anxious. Tells willingly, pays great attention to the answers and questions of the doctor. Restless. The emotional background is unstable, notes of anxiety prevail. The mood from his words is reduced. Intellectually-mnestically without a pronounced decrease. Thinking is moderate in pace, consistent. He denies deceptions of perception at the time of examination.

Denies suicidal intentions. Sleep (from this words) is intermittent, appetite is reduced.

**Questions:**

1. Name the symptoms of psychopathology.
2. Name the leading syndrome(s).
3. Name the preliminary diagnosis
4. Prescribe medication and target therapy

**Possible answers:**

1. Symptoms:

• delusional ideas of persecution,
• tachyphrenia,
• delusional ideas of jealousy,
• anxiety,
• true hallucinations,
• dissomnia,
• reduced attention stability,
• obsessions,
• impulsiveness,
• overestimation of one's own personality.

2. Syndromes:

• hallucinatory delusional syndrome,
• depressive syndrome,
• paraphrenic syndrome,
• obsessive-compulsive syndrome,
• delirious syndrome,
• apathetic-abusive syndrome.

3. Preliminary diagnosis:

• Bipolar affective disorder type 1,
• Schizo-affective disorder,
• Anacastic personality disorder,

• Schizotypal personality disorder, a neurosis-like variant,

• Obsessive-compulsive disorder,

• Narcissistic personality disorder,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Normotimic to relieve manic syndrome, for example, lithium salts,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve anxiety and dissomnia,

• Selective serotonin reuptake inhibitor, e.g. sertraline.

**Case 4. Male patient, 79 years old.**

**Anamnesis of life**. Heredity is not burdened. Education - vocational school. He didn't serve in the army. He worked at the Tochmash factory as an adjuster. Retired by age. Lives with his wife in a separated apartment. Does not drink alcohol, does not smoke. In 1995-1997 he suffered two acute myocardial infarctions. He is observed by the therapist in connection with hypertension.

**Anamnesis of the disease**. Over the past 6 years, he has changed in character, began to constantly write complaints, to go to various authorities. He refuses to pay "non-urgent" rent (the debt for the apartment is about 86 thousand rubles). In August 2010, together with his wife, they were fasting (Ramadan or uraza). He insisted, although his wife's health did not allow. He believed that she needed to be cleansed. He expressed delusional ideas of jealousy in her address, sought recognition. He was treated inpatient in a psychiatric hospital. After discharge, he visited the psychiatrist irregularly, did not take medications. In the last month, the condition has worsened. He started contacting various authorities again. He wrote ridiculous complaints, made ridiculous accusations. He claimed that "the wife's brother was killed", "that the wife's brother's killer owns the apartment", "that the housing and communal services are engaged in fraud", that he is being monitored by wiretapping the apartment. He reacted to refusals to initiate

criminal cases with affectation. He again appealed to the city prosecutor's office, was angry and aggressive, did not let employees inside the building. An ambulance was called.

**Mental status**. The patient is conscious. Sharply negative. Maliciously looks at others from under his brows. Most often he does not answer questions. Does not fulfill requests. Resists inspection. Refuses to obey the schedule and the regime of the department. He does not agree to undergo examination and take treatment, claiming that "they want to kill him." Threatens "problems that will arise from the staff." He does not listen to persuasions and explanations. Oriented in all kinds to a sufficient extent. Intelligence and memory with signs of some decline. Thinking is rigid, concrete, at a moderate pace. The emotional background is embittered, prone to aggressive reactions, both in the form of verbal aggression and physical. He does not express suicidal thoughts. There is no criticism of the condition.

**Questions:**

1. Name the symptoms of psychopathology.
2. Name the leading syndrome(s).
3. Name the preliminary diagnosis
4. Prescribe medication and target therapy

**Possible answers:**

1. Symptoms:

• delusional ideas of persecution,
• delusional ideas of damage,
• delusional ideas of reformism,
• emotional lability,
• dysmnesia,
• reduced intelligence,
• delusional ideas of metamorphosis and staging,
• true verbal hallucinations,
• ideatory automatism,

• dissomnia,

• reducing the arbitrariness of attention,

• anxiety.

2. Syndromes:

• delusional syndrome,

• paraphrenic syndrome,

• manic syndrome,

• delirious syndrome,

• psycho-organic syndrome,

• apathetic-abusive syndrome.

3. Diagnosis:

• Bipolar affective disorder type 1,

• Schizophrenia, observation period less than a year,

• Organic delusional disorder,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Normotimic to relieve emotional stress, for example carbamazepine,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve anxiety and dissomnia,

• Tricyclic antidepressant with sedative effect to relieve anxiety and dissomnia (for example, amitriptyll).

**Case 5. Female patient, 89 years old.**

**Anamnesis of life.** She was born the 2nd out of 5 children. Early development without peculiarities. Grew and developed in accordance to age. Now she lives with his daughter in a separate apartment. She was not convicted. Alcohol has not been consumed for more than 30 years.

**Anamnesis of the disease**. She suffered from hypertension for many years. She suffered acute insufficiency of cerebral circulation with mild hemiparesis 15

years ago. Since then, memory has decreased, has become more sluggish, weakened. In the last 2 years does not leave the apartment. They called a psychiatrist to the house, because she stopped sleeping at night, also she saw water pouring out of the wall. She put basins under the "water", was extremely excited and preoccupied with these visions.

**Mental status.** She looks somewhat untidy. At the time of the examination, she is motor restless. Facial expressions are inexpressive. She is oriented in her own personality, in place and in time she is not oriented. She speaks in a low voice. She enters into the conversation willingly, she does not always speak according to the essence of the task. Attention is exhausted, it is difficult to switch from one activity to another, at the end of the conversation she became distracted. The emotional background is unstable, closer to anxious. Intellectual and mnestic capabilities are grossly reduced. She denies suicidal thoughts at the time of examination. Thinking is slow in pace, not always consistent. She tells that she sees how the water pours from the wall: "probably the pipe broke". Criticism of her condition is formal.

**Questions:**

1. Name the symptoms of psychopathology.
2. Name the leading syndrome(s).
3. Name the preliminary diagnosis
4. Prescribe medication and target therapy

**Possible answers:**

1. Symptoms:

• True visual hallucinations,
• delusional ideas of damage,
• delusional ideas of reformism,
• emotional lability,
• dysmnesia,
• reduced intelligence,
• delusional ideas of metamorphosis and staging,

• true verbal hallucinations,

• ideatory automatism,

• dissomnia,

• reducing the arbitrariness of attention,

• anxiety.

2. Syndromes:

• hallucinatory syndrome,

• paraphrenic syndrome,

• manic syndrome,

• delirious syndrome,

• psycho-organic syndrome,

• apathetic-abusive syndrome.

3. Diagnosis:

• Organic hallucinosis,

• Schizophrenia, observation period less than a year,

• Vascular dementia with hallucinatory syndrome,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

- Normotimic to relieve emotional stress, for example carbamazepine,.
- Antipsychotic to relieve hallucination for example haloperidole
- Antidepressants to relive anxiety for example sertralinum
- Antipsychotic to relieve dissomnia and anxiety, for example chlroprotixene

**Case 6. Female patient, 32 years old.**

**Anamnesis of life.** Heredity is not burdened. Born on time, the youngest of 2 children. Early development without features. She grew and developed according to her age. She went to school at the age of 7. Graduated from 11th grade. Then she graduated from the medical university. Married, son is 4 years old. Currently works as a general practitioner. Has no disability. Syphilis, HIV, tuberculosis

denies. Blood transfusion, surgery denies. She denies smoking, using drugs and alcohol.

**Anamnesis of the disease.** Previously, she turned to a psychologist a year ago. Her husband works in the police. Due to the peculiarities of his work, he often does not spend the night at home (sometimes on special operations), communicates with criminal elements. 2 years ago, her husband was kidnapped, they (kidnappers) called the patient, demanded a ransom. She described an episode when she was driving a car, she was chased and forced to drive into a distant urban area and give the car to save her husband's life. She was very scared, worried. The situation was resolved safely - the husband was able to escape and the criminals were arrested. However, since then, the patient has had a constant fear that the situation could be repeated. It became difficult for her to watch detective stories, watch criminal TV shows. However, the husband has not stopped his occupation, continues to work in the same field. Sometimes he (husband) took her with him at night to preserve the "legend". In the last 2 months, the patient has often experienced states of severe anxiety and anxiety. Especially if her husband did not answer her calls or SMS. During those periods her heart rate increased, it took her breath away, she could not sit still, sometimes she could burst into tears, even in front of patients. In this regard she turned to a psychiatrist.

**Mental status.** Oriented correctly. Facial expressions are anxious. The physique is normosthenic. Tensed, often changes position. Attention is attracted and retained enough. Describes her bodily symptoms in detail. However, she hardly talks about what happened. The emotional background is unstable, she cried during the conversation. Intelligence and memory correspond to age and level of education. Thinking is moderate in pace, consistent. Hallucinatory and delusional symptoms cannot be detected at the time of examination. She denies suicidal thoughts at the time of the conversation. Sleep (from her words) is intermittent, sensitive, nightmares are often with the plot of the murder of her or her husband.

**Questions:**

1. Name the symptoms of psychopathology.

2. Name the preliminary diagnosis.

3. Prescribe medication and target therapy.

**Possible answers:**

1. Symptoms:

• delusional ideas of persecution,

• delusional ideas of damage,

• emotional lability,

• bradyfrenia,

• dissomnia,

• reducing the arbitrariness of attention,

• anxiety,

• reduced intelligence,

• dysmnesia,

• nightmarish dreams.

2. Diagnosis:

• Bipolar affective disorder type 1,

• Schizophrenia, observation period less than a year,

• Organic personality disorder,

• Post-traumatic stress disorder,

• Psychotic disorder caused by the use of unknown surfactants.

3. Medical treatment:

• Normotimic to relieve emotional stress, for example carbamazepine,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve anxiety and dissomnia

• SSRI (Selective serotonin reuptake inhibitor) effect to relieve anxiety and dissomnia (for example, sertraline),

• Neuroleptic with mild sedative effect, for example alimemazine.

**Case 7. Female patient, 48 years old.**

**Anamnesis of life.** Heredity is not burdened. Born on time. Early development without features. She grew and developed according to her age. She went to school at the age of 7. Graduated from 11th grade. Then she graduated from the university with a degree in architecture. She is married and has two children. Currently, she is raising a younger child (4 years old) and works at home in the field of architecture, while studying at a medical college for a nurse. By nature, she always describes herself as a persistent, strong-willed person who always took responsibility for herself. Has no disability. Capable. She denies syphilis, HIV, tuberculosis. Denies hemotransfusion and surgery. The allergological anamnesis is not burdened from her words. She denies use of drugs, smoking, alcohol.

**Anamnesis of the disease.** Previously, she did not visit a psychiatrist or a psychologist. About a year ago, there were difficulties and tensions in the relationship with her husband. Conflicts became more frequent (the husband began to drink often), the frequency of sexual acts with her husband decreased. During the same period, the onset of menopause occurred. She felt constant internal tension. Two months ago, when she was in a college class, she felt bad. The lesson was held in a stuffy and cramped room, the lesson was associated with emotional stress: it was zachet. The patient describes her symptoms that moment: dizzy, felt a lack of air, palpitations increased. She began to be afraid that she would faint, asked to leave. After leaving the room, her condition did not improve, she began to worry that she was having a heart attack. She left zachet, turned to the therapist on the same day, but no data for acute cardiac pathology was revealed. Since then, similar episodes lasting from 20 to 60 minutes happened several times a week and were associated with a variety of situations. The patient was very worried about them, underwent examination in several clinics, but internists ruled out chronic somatic diseases. They recommended contacting a neurologist. The neurologist diagnosed vegetative-vascular dystonia, recommended treatment with atarax, a course of therapeutic massage and MRI of cerebral vessels. No vascular pathology was detected on MRI. The treatment brought relief for a few days, but then the

attacks returned, became more intense and happened several times a day. Then the patient decided to go to a psychiatrist.

**Mental status**. Oriented correctly. Facial expressions are anxious. The physique is normosthenic. She is restless, tense, and often changes her posture. Attention is attracted and retained enough. She enters into the conversation willingly, answers in detail, in essence, what was asked. Describes her complaints in detail. The emotional background is anxious. Intelligence and memory correspond to age and level of education. Thinking is moderate in pace, consistent. Hallucinatory and delusional symptoms cannot be detected at the time of examination. She denies suicidal thoughts at the time of the conversation. Sleep (with her words) is intermittent, sometimes wakes up from an attack.

**Questions:**

1. Name the symptoms of psychopathology.
2. Name the preliminary diagnosis.
3. Prescribe medication and target therapy.

**Possible answers:**

1. Symptoms:

• delusional ideas of persecution,
• delusional ideas of damage,
• emotional lability,
• bradyfrenia,
• dissomnia,
• reducing the arbitrariness of attention,
• anxiety,
• reduced intelligence,
• dysmnesia,
• nightmarish dreams,
• vegetative symptoms: shortness of breath, tachycardia, dizziness,
• derealization.

2. Diagnosis:

• Bipolar affective disorder type 1,

• Schizophrenia, observation period less than a year,

• Organic personality disorder,

• Post-traumatic stress disorder,

• Panic disorder,

• Psychotic disorder caused by the use of unknown surfactants.

3. Medical treatment:

• Normotimic to relieve emotional stress, for example carbamazepine,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve anxiety and dissomnia

• SSRI (Selective serotonin reuptake inhibitor) effect to relieve anxiety and dissomnia (for example, sertraline),

• Neuroleptic with mild sedative effect, for example alimemazine.

**Case 8. Male patient, 61 years old.**

**Anamnesis of life**. Born on time, the youngest of two children. He grew and developed without any peculiarities. He received a secondary special education. He worked in the police until retirement. He served in the SA. Married twice. Has 1 child from the first marriage (does not communicate), an adopted daughter from the second. Currently lives with his wife, caring for her. There is no disability. Retired by age. Capable. He denies syphilis, HIV, hepatitis, diabetes mellitus, tuberculosis. Denies hemotransfusion, surgery and TBI. The allergological anamnesis is not burdened from his words. Categorically denies using of drugs, smoking, alcohol.

**Anamnesis of the disease**. Heredity is not burdened. According to his wife, patient and daughter, he abused alcoholic beverages for many years, binge drinking was observed. He was "coded" three times. The last binge for about a week, stopped on his own. The next day, according to his wife and daughter, sleep was disturbed, he became sharply restless, withdrawn, fussy, talked without an

interlocutor, incoherently shouted threats, manifested aggression against the background of which he inflicted self-cuts. The emergency care was called, after providing surgical assistance, the patient was taken to a psychiatric hospital.

**Mental status.** The patient is conscious. It is difficult to contact, but accessible. He gave his name correctly, the current year and month, the place is a hospital. Motorically slow. Speech in slow motion, in a quiet voice is not always legible. Answers questions willingly, not always in the essence of what is asked. Attention is draining. He does not always consistently tell his story. In a conversation often he gets distracted, starts looking away, listening to something. He pointed to a spot on the ceiling and began to reason: "where did this drawing come from, who painted it?" Periodically repeats that "Mikhalych" should come to him soon. In the department he slept for about an hour at night.

**Questions:**

1. Name the symptoms of psychopathology.
2. Name the preliminary diagnosis.
3. Prescribe medication and target therapy.

**Possible answers:**

1. Symptoms:

• delusional ideas of persecution,
• hallucinations,
• emotional lability,
• bradyfrenia,
• dissomnia,
• reducing the arbitrariness of attention,
• anxiety,
• reduced intelligence,
• dysmnesia,
• detachment from the environment.

2. Diagnosis:

• Bipolar affective disorder type 1,

• Schizophrenia, observation period less than a year,

• Organic personality disorder,

• Alcoholic delirium,

• Psychotic disorder caused by the use of unknown surfactants.

3. Medical treatment:

• Normotimic to relieve emotional stress, for example carbamazepine,

• Typical neuroleptic with a global antipsychotic effect (for example, haloperidol) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve anxiety and dissomnia,

• SSRI (Selective serotonin reuptake inhibitor) effect to relieve anxiety and dissomnia (for example, sertraline),

• Neuroleptic with mild sedative effect, for example alimemazine.

**Case 9. Female patient, 32 years old.**

**Anamnesis of life.** Heredity for mental illness is not burdened. Was born on time from the first pregnancy. Early development without features. She went to school at the age of 7. Studied satisfactorily. Higher professional education. She worked as an accountant before maternity leave, then a housewife. She is married and has two children. The youngest child is 4 years old, the eldest is 7 years old. Hasn't been judged. Capable. She denies syphilis, HIV, hepatitis, tuberculosis. Denies hemotransfusion and surgeries. Does not smoke. She denies use of drugs and alcohol.

**Anamnesis of the disease.** About six months ago, oddities in behavior began. She began to suspect that her husband lived in two families, insisted that he started to sleep in another room. She became suspicious. She often looked around on the street. Conflicts became more frequent in the last month. She became distracted. In the last 2 weeks, sleep was disturbed, it became more superficial, short. She was lying in bed for a long time without falling asleep. She often hugged the child to her, muttered something over him. For the last 4 days, her husband was

afraid to leave her alone at home, she refused to go to the hospital. An ambulance team was called.

**Mental status.** The husband is present during the conversation.

Patient correctly named the name, age, date of birth, place of residence, current date. She enters the conversation reluctantly, looks with disbelief. Facial expressions are inexpressive. Motorically ordered. Speech at a moderate pace, not always consistent. The emotional background is closer to the anxious. She reported that she was afraid for herself and the child. She said that six months ago she began to suspect her husband of a double life, as he was often late at work. She began to notice that the people around her looked at her strangely, as if they were "reproaching me for my sins." She noticed that a camera appeared in the courtyard of the house, "I don't know why, it wasn't there before." One day a child found a phone on the street while walking and brought it home. She was sure that she was being tapped through the phone. She said that she heard music and male voices from the ventilation hole at night. Upon examination, the presence of deceptions of perception denies. She expresses doubts that she is "she", that someone changed her name and "shoved her into this family." She is not critical to the condition.

**Questions:**

1. Name the symptoms of psychopathology.
2. Name the leading syndrome(s).
3. Name the preliminary diagnosis.
4. Prescribe medication and target therapy.

**Possible answers:**

1. Symptoms:

• delusional ideas of persecution,

• delusional ideas of damage,

• delusional ideas of reformism,

• delusional ideas of metamorphosis and staging,

• true verbal hallucinations,

• ideatory automatism,

• dissomnia,

• reducing the arbitrariness of attention,

• anxiety.

2. Syndromes:

• hallucinatory delusional syndrome,

• emerging paranoid syndrome,

• paraphrenic syndrome,

• manic syndrome,

• delirious syndrome,

• apathetic-abusive syndrome.

3. Diagnosis:

• Bipolar affective disorder type 1,

• Schizophrenia, observation period less than a year,

• Schizoid personality disorder,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Normotimic to relieve emotional stress, for example lamotrigine,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve dissomnia,

• Tricyclic antidepressant with sedative effect to relieve anxiety and dissomnia (for example, amitriptyll).

**Case 10. Male patient, 52 years old.**

**Anamnesis of life**. Born on time, the youngest of three children. He grew and developed without any peculiarities. He has a secondary special education. He worked in shifts in the North as an adjuster. Married. Has two children. Currently, he lives more often with his mother, caring for her. Disabled person of the 2nd group for mental illness. Capable. He denies syphilis, HIV, hepatitis, tuberculosis. Suffers from the 2nd type of diabetes mellitus. Denies hemotransfusion. The

allergological anamnesis is not burdened from his words. Categorically denies use of drugs, smoking, alcohol.

**Anamnesis of the disease**. Heredity is burdened with bipolar affective disorder in the son. He has been mentally ill since 1987. In the clinical picture affective and delusional disorders with alternating phases of manic and depressive. After discharge he visited psychiatrist irregularly. The last visit (from his words) was six months ago. He takes medications, but not always systematically. From his words, the last 3 weeks he took 6-8pills of sedalite. During the same period, he noted an increase in mood, appetite, strength, slept for 3 hours a day. He notes a recent episode when he "picked up a 22-year-old boy, his stepfather beats him, I brought him home, he lived with me for three days, then I rented him an apartment and gave him all the money for his pension." He does not deny that he made several loans. At the insistence of his wife, an ambulance team was called and the patient was sent to a psychiatric hospital.

**Mental status.** The patient is conscious. The contact is available. Oriented correctly in all kinds. Movingly somewhat fussy, restless, impetuous. Smiles during conversation. Speech at an accelerated pace, in a cheerful voice. Talkative. Attention does not linger on one subject for a long time. He looks around the office. He does not always consistently tell his story. He says about himself with a overestimation: "I could put everyone in the department, I'm a boxer, I have a lot of talents: I play the accordion superbly, I play chess, I write very good songs." He treats his condition lightly. Hallucinatory symptoms are not detected. He has a negative attitude towards his wife. Recognizes the presence of a mental illness, but denies the possibility of its influence on his decisions, actions and thoughts. He didn't sleep in the department all night.

**Questions:**

1. Name the symptoms of psychopathology.
2. Name the leading syndrome(s).
3. Name the preliminary diagnosis.
4. Prescribe medication and target therapy.

**Possible answers:**

1. Symptoms:

• delusional ideas of persecution,

• tachyphrenia,

• delusional ideas of greatness,

• delusional ideas of reformism,

• true hallucinations,

• dissomnia,

• reduced attention span,

• hyperthymia,

• impulsiveness,

• overestimation of one's own personality.

2. Syndromes:

• hallucinatory delusional syndrome,

• depressive syndrome,

• paraphrenic syndrome,

• manic syndrome,

• delirious syndrome,

• apathetic-abusive syndrome.

3. Diagnosis:

• Bipolar affective disorder type 1, current episode of mania,

• Schizo-affective disorder,

• Schizophrenia, paraphrenic syndrome,

• Narcissistic personality disorder,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Normotimic to relieve manic syndrome, for example, lithium salts,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve dissomnia,

• Tricyclic antidepressant with sedative effect to relieve dissomnia (for example, amitriptyll).

**Case 11. Male patient, 34 years old.**

**Anamnesis of life.** Heredity is not burdened from his words. He was born on time, the youngest of two children, the birth was protracted with the entanglement of the umbilical cord. Then he grew and developed without any peculiarities. He graduated from the 11th grade of secondary school. Then studied in KSEI (energetic institute). He often changed his place of work. Disabled person of the 2nd group for mental illness. Capable. He denies syphilis, HIV, hepatitis, diabetes mellitus, tuberculosis. Denies hemotransfusion. The allergological anamnesis is not burdened from his words. Patient's brother categorically denies use of drugs and smoking. According to his brother's words, he has not been drinking alcohol for the last 10 years.

**Anamnesis of the disease.** At the age of 13, seizures with loss of consciousness began. He was repeatedly treated by a neurologist with a diagnosis of epilepsy. Registered with a psychiatrist since 1991. Affective and hallucinatory disorders were observed in the clinical picture. The last discharge from the hospital was 3 years ago. At home, according to relatives, he did not take medications regularly. The patient called his brother with a request for help, suddenly broke off the conversation and was found unconscious. After returning to consciousness, he refused food and water for several days. Epiprimes have become more frequent. The ambulance was called and the patient was taken to the hospital.

**Mental status.** Patient is examined within the bed. Conscious. Productive contact is not easily accessible, the patient cannot fully express himself verbally: he utters only a few words, unintelligible. He executes commands sluggishly, reacts slowly to the addressed questions. He cannot serve himself. In the department he is periodically restless and impulsive. The rest of the time freezes in monotonous poses. Thinking is sluggish, slow in pace. Hallucinatory-delusional

products are not detected at the time of examination. The emotional background is inexpressive.

**Questions:**

1. Name the symptoms of psychopathology.
2. Name the leading syndrome(s).
3. Name the preliminary diagnosis.
4. Prescribe medication and target therapy.

**Possible answers:**

1. Symptoms:

• delusional ideas of persecution,
• bradyfrenia,
• delusional ideas of reformism,
• delusional ideas of metamorphosis and staging,
• psychomotor agitation,
• ideatory automatism,
• dissomnia,
• reducing the arbitrariness of attention,
• stupor.

2. Syndromes:

• hallucinatory delusional syndrome,
• emerging paranoid syndrome,
• catatonic syndrome,
• manic syndrome,
• delirious syndrome,
• apathetic-abusive syndrome.

3. Diagnosis:

• Bipolar affective disorder type 1,
• Epilepsy, catatonic syndrome,
• Schizoid personality disorder,
• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Anticonvulsant to relieve epileptic activity, for example valproate,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, diazepam) to relieve tension,

• Tricyclic antidepressant with sedative effect to relieve anxiety and dissomnia (for example, amitriptyll).

**Case 12. Male patient, 31 years old.**

**Anamnesis of life.** He was born on time, the youngest of two brothers in a family of workers. Early development without features. Heredity is not psychopathologically burdened. Attended kindergarten. He went to school at the age of 7, studied mediocre, did not show much interest in studying. At school he was fond of weightlifting and skiing, participated in competitions. He graduated from the 9th grade of secondary school, and did not study anymore. After graduation, he worked as a carpenter with his father. He served in the Armed Forces in the Navy. He served for 8 months. Upon his return he opened a private business – engaged in the retail trade of carpets, worked for 3 years, then for 2 years worked in shifts in the North. In 2011 he got married (has a son of 2.5), worked for some time as a window installer (about 5 months).

**Anamnesis of the disease.** In 2012 he received a TBI, a moderate brain injury. He was treated in the Department of Neurology. Six months later, epileptic seizures began. He was treated in the Department of Neurology. Discharged in October 2015. He took antiepileptic drugs at home. The condition changed about a month before admission, when seizures became more frequent, headaches appeared. He was hospitalized in the Department of neurology, then redirected to a psychiatric clinic.

**Mental status.** Posture and facial expressions are tensed. Oriented in time, place and self. Attention is draining. He talks through a survey, tries to answer questions in detail. He is competent, answers simple questions with 10 sentences.

Speech is in slow motion, somewhat jerky, the voice is loud, moderately modulated. In communication with the doctor, he is polite, observes the distance. The emotional sphere with elements of some instability and lability, anxious shade prevails. The mood is lowered. The patient shares that he is "afraid of seizures." Thinking at the usual pace is rigid, thorough. Deceptions of perception are not detected during the examination. Memory and intelligence with signs of moderate decline. Interested in the timing of hospitalization. Punctual in performing medical appointments. Sleep is intermittent, difficulties with falling asleep.

**Questions:**

1. Name the symptoms of psychopathology.
2. Name the leading syndrome(s).
3. Name the preliminary diagnosis.
4. Prescribe medication and target therapy.

**Possible answers:**

1. Symptoms:

• delusional ideas of persecution,
• bradyfrenia,
• delusional ideas of reformism,
• delusional ideas of metamorphosis and staging,
• psychomotor agitation,
• ideatory automatism,
• dissomnia,
• reducing the arbitrariness of intelligence,
• thoroughness,
• convulsive paroxysms.

2. Syndromes:

• hallucinatory delusional syndrome,
• psycho-organic syndrome,
• catatonic syndrome,
• manic syndrome,

• delirious syndrome,

• apathetic-abusive syndrome.

3. Diagnosis:

• Bipolar affective disorder type 1,

• Organic personality disorder due to mixed diseases,

• Symptomatic epilepsy with frequent polymorphic paroxysms,

• Schizoid personality disorder,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Anticonvulsant to relieve epileptic activity, for example valproate,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, diazepam) to relieve tension,

• Tricyclic antidepressant with sedative effect to relieve anxiety and dissomnia (for example, amitriptyll).

## CHAPTER 4. STANDARDS OF THE CORRECT ANSWERS

**Case analysis No. 1.**

1. **In the anamnesis**, it is noteworthy that the patient was socialized before the disease. The disease began acutely, without external or traumatic causes, which indicates rather endogenous causes of the disorder. By the time of hospitalization, the patient had already been repeatedly treated in a psychiatric hospital, which indicates a chronic, recurrent process. The irregularity of taking medications may indicate an incompleteness of critical attitude to the disease, incomplete compliance. The current aggravation manifested itself in the appearance of "voices" in the patient, which caused the patient severe discomfort, which was reflected in the desire to stop their effects through the use of haloperidol and the intention to self-cut.

2. **In the mental status**, motor anxiety attracts our attention, the fact that the patient often looks away, listens to something. This behavior is consistent with his indication that he "hears voices." Distraction of patient's attention is also consistent with this, as if it is difficult for him to maintain contact with others because of stronger competing sensations. Low mood and intermittent sleep are consistent with the content of "voices" described by the patient as threatening, calling the patient names, unpleasant to him. There are also signs of negative symptoms – lack of expressiveness of facial expressions, amorphous thinking, violation of its sequence. It is important that intelligence and memory are generally sufficiently preserved, which is not found in mental disorders due to brain damage.

3. Verbal pseudo-hallucinations. In favor of them it says that the patient describes their localization inside the head, is able to distinguish them from natural sounds, is aware of their unnaturalness.

4. **The leading syndrome** is hallucinatory because it is characterized mainly by hallucinatory symptoms, without direct indication of delusional or emotional disorders. Behavioral disorders (autoaggression) have a causal relationship with the content of hallucinations and the patient's attitude to them.

**Case 2. Possible answers:**

1. Symptoms:

• delusional ideas of persecution,

• delusional ideas of damage,

• emotional lability,

• bradyfrenia,

• delusional ideas of reformism,

• dissomnia,

• reducing the arbitrariness of attention,

• anxiety,

• reduced intelligence,

• dysmnesia,

• amnesic disorientation.

2. Syndromes:

• hallucinatory delusional syndrome,

• emerging paranoid syndrome,

• psycho-organic syndrome,

• manic syndrome,

• delirious syndrome.

3. Diagnosis:

• Bipolar affective disorder type 1,

• Schizophrenia, observation period less than a year,

• Organic personality disorder, pronounced psycho-organic syndrome, explosive variant,

• Dementia,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Normotimic to relieve emotional stress, for example carbamazepine,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve anxiety and dissomnia,

• Tricyclic antidepressant with sedative effect to relieve anxiety and dissomnia (for example, amitriptyll),

• Neuroleptic with a sedative effect, for example, chlorprotixen.

**Case 3. Possible answers:**

1. Symptoms:

• delusional ideas of persecution,

• tachyphrenia,

• delusional ideas of jealousy,

• anxiety,

• true hallucinations,

• dissomnia,

• reduced attention stability,

• obsessions,

• impulsiveness,

• overestimation of one's own personality.

2. Syndromes:

• hallucinatory delusional syndrome,

• depressive syndrome,

• paraphrenic syndrome,

• obsessive-compulsive syndrome,

• delirious syndrome,

• apathetic-abusive syndrome.

3. Preliminary diagnosis:

• Bipolar affective disorder type 1,

• Schizo-affective disorder,

• Anacastic personality disorder,

• Schizotypal personality disorder, a neurosis-like variant,

• Obsessive-compulsive disorder,

• Narcissistic personality disorder,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Normotimic to relieve manic syndrome, for example, lithium salts,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve anxiety and dissomnia,

• Selective serotonin reuptake inhibitor, e.g. sertraline.

**Case 4. Possible answers:**

1. Symptoms:

• delusional ideas of persecution,

• delusional ideas of damage,

• delusional ideas of reformism,

• emotional lability,

• dysmnesia,

• reduced intelligence,

• delusional ideas of metamorphosis and staging,

• true verbal hallucinations,

• ideatory automatism,

• dissomnia,

• reducing the arbitrariness of attention,

• anxiety.

2. Syndromes:

• delusional syndrome,

• paraphrenic syndrome,

• manic syndrome,

• delirious syndrome,

• psycho-organic syndrome,

• apathetic-abusive syndrome.

3. Diagnosis:

• Bipolar affective disorder type 1,

• Schizophrenia, observation period less than a year,

• Organic delusional disorder,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Normotimic to relieve emotional stress, for example carbamazepine,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve anxiety and dissomnia,

• Tricyclic antidepressant with sedative effect to relieve anxiety and dissomnia (for example, amitriptyll).

**Possible answers:**

1. Symptoms:

• True visual hallucinations,

• delusional ideas of damage,

• delusional ideas of reformism,

• emotional lability,

• dysmnesia,

• reduced intelligence,

• delusional ideas of metamorphosis and staging,

• true verbal hallucinations,

• ideatory automatism,

• dissomnia,

• reducing the arbitrariness of attention,

• anxiety.

2. Syndromes:

• hallucinatory syndrome,

• paraphrenic syndrome,

• manic syndrome,

• delirious syndrome,

• psycho-organic syndrome,

• apathetic-abusive syndrome.

3. Diagnosis:

• Organic hallucinosis,

• Schizophrenia, observation period less than a year,

• Vascular dementia with hallucinatory syndrome,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

- Normotimic to relieve emotional stress, for example carbamazepine,.
- Antipsychotic to relieve hallucination for example haloperidole
- Antidepressants to relive anxiety for example sertralinum
- Antipsychotic to relieve dissomnia and anxiety, for example chlroprotixene

**Case 6. Possible answers:**

1. Symptoms:

• True visual hallucinations,

• delusional ideas of damage,

• delusional ideas of reformism,

• emotional lability,

• dysmnesia,

• reduced intelligence,

• delusional ideas of metamorphosis and staging,

• true verbal hallucinations,

• ideatory automatism ,

• dissomnia,

• reducing the arbitrariness of attention,

• anxiety.

2. Syndromes:

• hallucinatory syndrome,

• paraphrenic syndrome,

• manic syndrome,

• delirious syndrome,

• psycho-organic syndrome,

• apathetic-abusive syndrome.

3. Diagnosis:

• Organic hallucinosis,

• Schizophrenia, observation period less than a year,

• Vascular dementia with hallucinatory syndrome,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Normotimic to relieve emotional stress, for example carbamazepine,

• Typical neuroleptic with a global antipsychotic effect (for example, haloperidol) to relieve of active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve anxiety and dissomnia,

• Tricyclic antidepressant with sedative effect to relieve anxiety and dissomnia (for example, amitriptyll).

**Case 7. Possible answers:**

1. Symptoms:

• delusional ideas of persecution,

• delusional ideas of damage,

• emotional lability,

• bradyfrenia,

• dissomnia,

• reducing the arbitrariness of attention,

• anxiety,

• reduced intelligence,

• dysmnesia,

• nightmarish dreams,

• vegetative symptoms: shortness of breath, tachycardia, dizziness,

• derealization.

2. Diagnosis:

• Bipolar affective disorder type 1,

• Schizophrenia, observation period less than a year,

• Organic personality disorder,

• Post-traumatic stress disorder,

• Panic disorder,

• Psychotic disorder caused by the use of unknown surfactants.

3. Medical treatment:

• Normotimic to relieve emotional stress, for example carbamazepine,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve anxiety and dissomnia

• SSRI (Selective serotonin reuptake inhibitor) effect to relieve anxiety and dissomnia (for example, sertraline),

• Neuroleptic with mild sedative effect, for example alimemazine.

**Case 8. Possible answers:**

1. Symptoms:

• delusional ideas of persecution,

• hallucinations,

• emotional lability,

• bradyfrenia,

• dissomnia,

• reducing the arbitrariness of attention,

• anxiety,

• reduced intelligence,

• dysmnesia,

• detachment from the environment.

2. Diagnosis:

• Bipolar affective disorder type 1,

• Schizophrenia, observation period less than a year,

• Organic personality disorder,

• Alcoholic delirium,

• Psychotic disorder caused by the use of unknown surfactants.

3. Medical treatment:

• Normotimic to relieve emotional stress, for example carbamazepine,

• Typical neuroleptic with a global antipsychotic effect (for example, haloperidol) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve anxiety and dissomnia,

• SSRI (Selective serotonin reuptake inhibitor) effect to relieve anxiety and dissomnia (for example, sertraline),

• Neuroleptic with mild sedative effect, for example alimemazine.

**Case 9. Possible answers:**

1. Symptoms:

• delusional ideas of persecution,

• delusional ideas of damage,

• delusional ideas of reformism,

• delusional ideas of metamorphosis and staging,

• true verbal hallucinations,

• ideatory automatism,

• dissomnia,

• reducing the arbitrariness of attention,

• anxiety.

2. Syndromes:

• hallucinatory delusional syndrome,

• emerging paranoid syndrome,

• paraphrenic syndrome,

• manic syndrome,

• delirious syndrome,

• apathetic-abusive syndrome.

3. Diagnosis:

• Bipolar affective disorder type 1,

• Schizophrenia, observation period less than a year,

• Schizoid personality disorder,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Normotimic to relieve emotional stress, for example lamotrigine,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve dissomnia,

• Tricyclic antidepressant with sedative effect to relieve anxiety and dissomnia (for example, amitriptyll).

**Case 10. Possible answers:**

1. Symptoms:

• delusional ideas of persecution,

• tachyphrenia,

• delusional ideas of greatness,

• delusional ideas of reformism,

• true hallucinations,

• dissomnia,

• reduced attention span,

• hyperthymia,

• impulsiveness,

• overestimation of one's own personality.

2. Syndromes:

• hallucinatory delusional syndrome,

• depressive syndrome,

• paraphrenic syndrome,

• manic syndrome,

• delirious syndrome,

• apathetic-abusive syndrome.

3. Diagnosis:

• Bipolar affective disorder type 1, current episode of mania,

• Schizo-affective disorder,

• Schizophrenia, paraphrenic syndrome,

• Narcissistic personality disorder,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Normotimic to relieve manic syndrome, for example, lithium salts,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidoneto relieve active psychoproduction,

• Tranquilizer (for example, phenazepam) to relieve dissomnia,

• Tricyclic antidepressant with sedative effect to relieve dissomnia (for example, amitriptyll).

**Case 11. Possible answers:**

1. Symptoms:

• delusional ideas of persecution,

• bradyfrenia,

• delusional ideas of reformism,

• delusional ideas of metamorphosis and staging,

• psychomotor agitation,

• ideatory automatism,

• dissomnia,

• reducing the arbitrariness of attention,

• stupor.

2. Syndromes:

• hallucinatory delusional syndrome,

• emerging paranoid syndrome,

• catatonic syndrome,

• manic syndrome,

• delirious syndrome,

• apathetic-abusive syndrome.

3. Diagnosis:

• Bipolar affective disorder type 1,

• Epilepsy, catatonic syndrome,

• Schizoid personality disorder,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Anticonvulsant to relieve epileptic activity, for example valproate,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, diazepam) to relieve tension,

• Tricyclic antidepressant with sedative effect to relieve anxiety and dissomnia (for example, amitriptyll).

**Case 12. Possible answers:**

1. Symptoms:

• delusional ideas of persecution,

• bradyfrenia,

• delusional ideas of reformism,

• delusional ideas of metamorphosis and staging,

• psychomotor agitation,

• ideatory automatism,

• dissomnia,

• reducing the arbitrariness of intelligence,

• thoroughness,

• convulsive paroxysms.

2. Syndromes:

• hallucinatory delusional syndrome,

• psycho-organic syndrome,

• catatonic syndrome,

• manic syndrome,

• delirious syndrome,

• apathetic-abusive syndrome.

3. Diagnosis:

• Bipolar affective disorder type 1,

• Organic personality disorder due to mixed diseases,

• Symptomatic epilepsy with frequent polymorphic paroxysms,

• Schizoid personality disorder,

• Psychotic disorder caused by the use of unknown surfactants.

4. Medical treatment:

• Anticonvulsant to relieve epileptic activity, for example valproate,

• Atypical neuroleptic with a global antipsychotic effect (e.g. risperidone or paliperidone) to relieve active psychoproduction,

• Tranquilizer (for example, diazepam) to relieve tension,

• Tricyclic antidepressant with sedative effect to relieve anxiety and dissomnia (for example, amitriptyll).

## REFERENCES

1. Medical psychology in the healthcare system of the region: materials of the First regional scientific and practical conference of medical (clinical) psychologists of health institutions of St. Petersburg. October 8-9– 2015 / edited by A.N. Alyokhin. – St. Petersburg: publishing house "Traktat", 2015. – 257 p.

2. Mendelevich, V.D. Psychiatric propaedeutics / V.D.Mendelevich. – 4th ed. – Moscow: MEDpress–inform, 2008. – 528 p.

3. Methods of diagnostics of the emotional sphere: psychological practicum / comp. O.V. Barkanova [series: Library of Current Psychology]. – Vol.2. – Krasnoyarsk: Litera-print, 2009. – 237 p.

4. Psychiatry: textbook / B. D. Tsygankov, S. A. Ovsyannikov. — M.: GEOTAR-Media, 2012. — 496 p.

5. Psychiatry: Textbook for medical students / M.V. Korkina, N.D. Lakosina, A.E. Lichko, I.I. Sergeev. — 3rd ed. — Moscow: MEDpress-inform, 2006. — 576 p.

6. Psychodiagnostics: Textbook for universities. — St. Petersburg: Peter, 2006 — 351 p.: ill. — (Series "Textbook of the new century").

7. Samokhvalov, V. P. Psychiatry. Textbook for students of medical universities / V. P. Samokhvalov. – Rostov-on-Don: "Phoenix", 2002. – 324 p.

Educational publication

**Granitsa Alexander Stanislavovich**

**Karina Yana Vladimirovna**

**Kalimullin Philip Gasinurovich**

# CLINICAL CASES IN PSYCHIATRY

**Handbook**