Lecture No. 1

Psychiatry subject, its relation with other sciences and value in medicine

Definition of a subject of psychiatry. Common and various in psychiatry and somatic medicine. Mental as ideal; the material fundamentals of mentality and its pathology. Morphological bases of mental activity. Physiological laws of reflex activity of a brain. A dialectic method in psychiatry. Psychological and clinical bases of a systematics of symptoms. A symptom, a syndrome, nosological unit in psychiatry.

The psychiatry is a medical science, science about mental disorders, about mental diseases, their origin and about ways of their prevention and treatment. As well as all other clinical disciplines, psychiatry has an anatomico-physiological basis. For a long time it is established that mental diseases a brain illness essence. Data on a structure and functions of a brain are essential for the psychiatrist also pathologies are normal. Therefore we need to concern some specification on a substratum of mental activity and processes, in it flowing past.

Most the composite psychological function of the person is provided with body – a brain – with the highest organization. Each of those 11-14 billion neurons which are available as a part of a brain is carried out various also by enough composite functions. At mental processes the brain functions as whole, it is impossible to date these or those types of mental activity for any isolated brain sites. Therefore the clarification of localization of brain changes very important for the diagnosis and treatment of mental diseases, presents a great difficulty. I.P. Pavlov declared dynamic localization of brain functions and showed that at destruction of cortical part of this or that analyzer of a cage of other departments of bark can partially adopt, at least, on themselves its activity. He said that cortical departments of analyzers block each other: analyzers are presented not only "cores", "centers", but also dispelled elements scattered on all cortex. On the basis of neurophysiological data it is possible to as-

sume that these dispelled elements fall into with that to diffuse projective system which connects cortex to a reticular formation of a brain trunk.

Even rather prime acts, such as motion, have not one nervous function, but the functional structure, a complex, a combination of different types of nervous activity in the basis. To it there corresponds also the complex anatomical structure placed at the different levels and in different places of a brain. If constituents of structure can be established quite precisely now, then the functional structure of intellectual operation or sensual experience, remains still very acritical.

Owing to this fact, speaking about localization of brain disorders at mental disorders, we mean only that circumstance that there are areas of cortex which defeat obligate (always) leads to deterioration of particular mental functions. But the local diagnosis is exposed always by comparison of all clinical data: psychopathological, neurologic, radiological, etc. In some cases psychopathological symptoms specify a right direction for searches of localization of the morbid center in a brain. So happens, in particular, at localization of tumors of a brain.

Now psychiatrists saved up many data on communications between separate mental functions and activity of particular departments of a brain, between mental diseases and disorders in these departments. These data are got, first of all, in the morphological and pathomorphologic way. For a long time the cytoarchitectonic card of cortex of larger hemispheres is created, in it there are more than 50 fields which differ from each other on structure and an arrangement of cells. Having established anatomic (cytoarchitectonic) differences between fields of a brain, we can find also their functional differences, and also develop pathological architectonic of a brain, with a particular degree of accuracy to reveal character and the place of morphological changes in nervous cells and fibers. In some cases we use "anatomic methods on alive", a pneumoencephalography, an angiography, computer and magnetic and resonance tomographies.

Clinico-anatomical comparisons remain the main, but now not the single path of clarification of localization of defeat at mental disorders. One of other paths are experiments on animals who have some mental functions, the close to human. These experiments are not limited to removal or rough diffuse irritation of a brain now. The

modern electrophysiological receptions with use of stereotactical operational technique allow to cause irritation and to observe reactions to it nearly within one neuron. In such a way in experiments on animals essential data on a role of a reticular formation and nervous mechanisms of emotions and inclinations were received. Neurophysiological data can be obtained also during brain operations at people by causing electric irritation of various sites of a brain and overseeing by these or those mental manifestations at patients who are in clear consciousness (operations are performed without general anesthesia, under local anesthesia). Larger service in search of localization of mental functions is rendered by record of bioelectric currents from different places of a brain – an electroencephalography.

Let's shortly light concrete data on those brain structures which have the most defined value for mental activity. For you will not be new that the most important substratum of mental activity is the cerebral cortex. This most difficult, most perfect, most differentiated formation in all an organism. But both clinical supervision, and experiment show that for mental activity along with cortex very great value have also subcortex of a brain trunk: hypothalamic area, reticular formation, thalamus. In these areas there are those instances which connect the highest mental functions with vegetative nervous system, with endocrine organs, with somatic processes. There are a reticular formation which carries out cortex activation, providing a tone of cortical processes. In diencephalic areas, a hypothalamus, in optic thalamus such formations which are related to emotions of the person, to his experiences, to his motives, memory.

From the experiments conducted during neurosurgical operations it is known that the irritation of an betweenbrain electrical shock can cause change of mood, the person becomes very cheerful and talkative. Experiments on animals and clinical observations found out that except diencephalic formations, the cortical areas, nearest to a subcortex, have close relation to emotional life. These cortical areas more ancient in origin. They include a cingulate gyrus, corpus amygdaloideum, part of orbital cortex and together with a hypothalamus enter into so-called limbic system. The same areas are bound also to the main biological inclinations, such as food and sexual. Neurophysiological experiments of Hess showed that the direct irritation through the elec-

trodes implanted to the hypothalamic area at cats is caused in them by emotions of anger, rage, fear. Olds's experiences in which the rat with the implanted electrodes in a brain, pressing on a pedal, causes to himself irritation of a brain are even more interesting. When finding electrodes in the particular place, responsible for a condition of pleasure, the rat does up to 2 thousand inclusions of electric current. It is possible to find such place in a brain which irritation causes, on the contrary, the negative reaction, and the rat after the first irritation avoids an inclusion pedal. Of course, inclinations and emotions at cats and other animals are far from mental experiences of the person, qualitatively others and more composite. Nevertheless these experiences testify to value of a hypothalamus and all limbic system (operating at the person together with the highest cortical areas and under their monitoring) in mental human life.

Value of **stem, subcrust zone**s appears also from the modern experience with psychopharmacological tools, in particular aminazine and Imizinum (Tofranilum). One of them is able to cause melancholy, another, on the contrary, cheerful mood. As show pharmacological experiments and observational of patients these drugs affect, mainly, systems of the intermediate brain and a reticular formation.

From those rich data which collected about localization of mental functions in cortex now we will sort only the significant. Before everything in cortex the areas providing so-called "instrumental" functions of the speech were allocated: creation of actions – a praxis and recognitions of objects – a gnosis. These functions also, as well as the centers which are carrying out them, are considered it is aware of a neurology. Though they cannot be attributed to mental functions in narrow sense, they are the most important prerequisite of cognitive activity. It should be reminded that all these functions are bound to a dominant hemisphere.

As for more composite mental function of reflection of world around – function of thinking, all cortex in general participates in it and it is impossible to allocate any center or the centers of thinking. Most of all frontal, inferior parietal gyrus and temporal lobe areas have relation to it. Frontal areas of a brain have essential value for directional activity of thinking and scheduling of all mental activity in general. Frontal cell fields, the most differentiated and after all developing, carry out the braking role regulating, in particular, in relation to other systems of a brain. At defeat of a

convex surface of anterior areas of a frontal lobe there is a psychopathological syndrome (apatite-adynamic) which is characterized by a flaccidity, indifference, lack of activity, an initiative, weakening of the volitional attention. At defeat of the basis of a frontal lobe, its orbital surface, there is, on the contrary, an increased mobility owing to a disinhibition, with complacent or euphoric mood, lack of criticism to the actions, to circumstances surrounding. If pathological process affects a back third of the lower frontal crinkle, then violation of motor function of the speech (Brock's center) – a motor aphasia develops.

At defeat of temporal shares auditory and olfactory hallucinations are sometimes observed. Patients hear nonexistent sounds – usually human speech or perceive nonexistent smells. There is a frustration of one of the main instruments of thinking – the speech, but its already touch component – phonemic hearing, i.e. misunderstanding or absence of the exact perception of speech sounds, words (their distortion) – a touch aphasia (Wernicke's center). For memory function the diencephalon is responsible (a hypothalamus, quadrigemina, a hippocampus, medial surfaces a temporal and frontal lobe).

It is necessary to emphasize that use of a "local" psychopathological symptomatology for establishment of the place of defeat is possible only taking into account all other symptoms, the course of a disease, constitutional features of the patient. Especially important both for defeat localization, and for comprehension of an entity of an illness, are a combination of anatomic approach with physiological.

The brain of the human providing reception and processing of information, creation of programs of characteristic actions and control of their successful realization always works as a unit. Nevertheless on preferred functioning of these or those structural systems in a brain of the person allocate three blocks.

The first block – the cortical tone block, or the power block of a brain – provides the common tone (wakefulness) of cortex and an opportunity the long time to keep exaltation traces. The hypothalamus, a visual hillock and a reticular formation are a part of this block.

The second block is directly bound to work on the analysis and synthesis of the signals brought by sense organs from the outside world i.e. to reception, processing

and storage of information obtained by the person. It consists of the devices located in cortex departments of a brain (parietal, temporal and occipital area) and, unlike the first block, has modal and specific character. This block is system of the central devices which perceive visual, acoustical and tactile information, overwork or "code" it and keep traces of the got experience in memory.

The third block of a brain of the person carries out programming, regulation and monitoring of the vigorous human activity. It is realized by the nervous systems located in forward departments of larger hemispheres, the leading place in it is taken by frontal departments of a brain. Frontal lobes support the cortical tone necessary for realization of an objective, play a crucial role in creation of intentions and formation of the action program which carry out these intentions.

You have to know from a course of normal physiology that the philosophy of functioning of higher nervous activity – the conditioned reflex. It arises on the basis of an instinctive reflex as a result of action of environmental irritants and serves for adaptation of the person to changes of a surrounding medium. In the well-known work "Brain Reflexes" I.M. Sechenov extended the reflex principle to all activity of a brain and, thereby, to all mental functions of the person. He showed that all acts of adult and unconscious life on a way of the origin, in fact, reflexes. Explicitly analyzing reflexes of a brain of the person, I.M. Sechenov allocates in them three main links: an initial link – external irritation and transformation by their sense organs in process of the nervous exaltation transferred to a brain; an average link – processes of exaltation and braking in a brain and emergence on this basis of mental states (feelings, thoughts, feelings, etc.); a terminating link – the external movements. At the same time I.M. Sechenov emphasized that the average link of a reflex with its mental element cannot be isolated from two other links (external irritation and reciprocal action) which are its natural beginning and the end. Therefore all mental phenomena are an inseparable part of all reflex process. The reflex principle of mental activity allowed I.M. Sechenov to draw the conclusion, major for scientific psychology, on determinancy, a causal condition of all actions and acts of the person external influences. Here matters not only external influences, but also all set of the previous influences experienced by the person, all his last experience.

I.P. Pavlov experimentally proved a regularity of comprehension I.M. Sechenov to mental activity as reflex activity of a brain, opened its fundamental physiological laws, created the new field of science – physiology of higher nervous activity, the doctrine about the conditioned reflexes that was the base of materialistic comprehension of the mental phenomena. All mental activity of animals is carried out at the level of the first signaling system. At the person signals of the first signaling system play an important role too, regulating and directing behavior, but unlike animals, along with it the person has the second signaling system which signals are words, i.e. "the second signals". By means of words signals of the first signaling system can be replaced. The word can cause the same actions, as signals of the first signaling system, i.e. the word is a "signal of signals».

By I.P. Pavlov the major regularities in the area are open not only for normal physiology of higher nervous activity, but also its pathology; when the brain is affected by the pathogenic agent, in it the condition of protective braking is developed. This braking not always happens the complete, as at an anesthesia or a deep sleep. Usually inexact braking, as develops at hypnosis which is characterized by phase states. Studying work of a brain, in particular the phenomena of poured braking at a hypnotic and natural dream, processes of transition of exaltation to braking I.P. Pavlov opened sequentially the parabiotic stages (a transition stage) replacing each other: a leveling stage when impulses of different force cause reaction of identical force; a paradoxical stage when impulses of different force cause reaction, counter on force; an ultra-paradoxical stage when the positive irritant causes braking, and the negative, i.e. brake, the irritant causes positive reaction – exaltation. The ultra-paradoxical phase is specific only to the central nervous system.

But along with the original positions of theory of higher nervous activity developed in due time by I.P. Pavlov the neurophysiological representations which developed recently are of great importance for psychiatry. Now neurophysiologists, in particular, one of the most visible representatives of this specialty Soviet physiologist P. K. Anokhin, speak not about a reflex arch, and about "system of functions of nervous activity" (SFNA) with a number of blocks stages of information processing and formation of response which gives more systematized idea of the composite diverse

mental behavior of the person. The structure of FSND is presented by the following blocks:

1. The block of processing of information for satisfaction of the specific arisen need where enters: the dominating motivation and requirement, an situational afferentation (situation), the background of experience (memory).
2. The block of decision-making of a particular way of behavior for satisfaction of this requirement.
3. Block of the program of action (behavior) and acceptor of result of action: the program of action provides the detailed plan of behavior for receiving the result satisfying requirement; the acceptor of action controls implementation of the program and introduces in it amendments for achievement of necessary result.
4. Action with particular result and its parameters: if the result does not satisfy requirement, parameters do not correspond to satisfaction of requirement, the reafference signals about it and the action acceptor which changes the program – resolve it or changes for new.

According to this concept, already in the beginning the reflex act there are centrifugal influences providing the known choice of irritations. In turn the executive, effector part of a reflex works with participation of axipetal, afferent functional structures. In other words, from effector part there is inverse information as P. K. Anokhin speaks, the reafferece which is carried out by means of action acceptors. The role of an acceptor of action is reduced to comparison of the received result and requirement. In the absence of satisfaction of requirement amendments are introduced in the program and respectively in activity realization.

One of the most visible Soviet psychiatrists academician M. O. Gurevich still in the forties as one of the main mechanisms of nervous activity put forward the **fugalno-petalny principle**. He said that the perception of a real is not the photographic act, it is made not only centripetally, but also centrifugally, i.e. a path of the fissile assimilation of the perceived phenomenon, put forward anatomic-physiological substantiation of the **fugalno-petalny principle** and pointed, in particular, that in system of the visual analyzer are available not only the paths going centripetally from an eye retina to an external elbowed body and further to visual cortex, but also ways back –

fugalny – from cortex to a retina thanks to which an opportunity actively is had to influence perception. Thus, the retina is as if lit not only outside, but also from within. Still I.M. Sechenov, characterizing the fissile role of perception, spoke: we listen, but we do not hear, we look, but we do not see. Therefore, the person not passively resists to incentives from out of; using a feedback mechanism, he actively directs the feelings and perceptions.

So, the mentality is property of a brain. The feeling, thought, consciousness is the highest product in a special way of organized matter. Mental activity of an organism is carried out by means of a set of express solid devices. One of them perceive interaction, others will transform them to signals, make plans of behavior and control it, the third – put muscles in action. All this most difficult work provides the fissile orientation in the environment.

Thanks to achievements of neurophysiology, in particular, in research of biological potentials of a brain, and also to achievements in area of mathematical expression of biological processes, new ideas of an entity of the fissile action ripened. In these representations the concept of model operation of action according to which in nervous structures at first the model is created in the beginning held a firm place, then on this model action is carried out. Model operation of future action has close relation to concept of anticipation. This anticipation not "the divine afflatus ". It is created on the basis of multiple repetition of similar situations in last experience. On the basis of integration of last experience the possibility of the installation directed to adaptation of the most possible situation in the future to that situation which statistically is more probable is created. At the person prediction of the future can be carried out at the highest level and makes one of the major properties of conscious and unconscious (intuition) activity, specific to it.

Anatomy and physiology of a brain, doctrine I.M. Sechenov and I.P. Pavlov about higher nervous activity are normal and pathologies represent one of fundamentals of psychiatry. Other its basis – psychology. If the physiology of higher nervous activity studies the material fundamentals of mentality, the concrete dynamic phenomena in a brain to which thoughts, feelings, acts of people are bound, then the psychology studies mental properties and mental processes in their qualitative originality.

And about its methods you learned about the maintenance of psychology on the first and second courses, having taken a course of lectures on the common and medical psychology.

The doctor has to be familiar with psychology of the patient at least in order that it is correct to estimate symptoms, signs of a mental deviation which he faces. He has to know surely what has to be normal mentality what processes and as in it proceed. For example, you need to establish that those phenomena which you observed at the patient cannot be explained with normal properties, in particular, those expenses of memory which arise also at healthy elderly (aged) people. In this way, having received these or those clinical facts at survey of the patient with a physical illness, you can estimate completely their pathological value, being only guided by data of normal anatomy and physiology. Not only a diagnostic assessment, comprehension of an entity of mental deviations it is impossible without knowledge of psychology.

At a conscientious attitude to the business any expert interferes with with need of substantial acquaintance to mentality of people and its deviations. Whether the doctor teeth treats whether delivers, whether he subjects the patient of operation for stomach ulcer, carries out treatment of frustration of cardiovascular system, its success substantially depends on the exact assessment of mentality of the patient, on the exact to it approach.

Such approach is caused, first of all, by a humanistic orientation of activity of the doctor. The doctor has to be extremely humane, own a reasonable individual approach to mentality of the patient. Teach such approach you when passing all clinical disciplines. But only the medical psychology and psychiatry give you that systematized scientific knowledge of mentality of people and of its deviations which is so necessary to carry out the humane principle in the work. To be a doctor, it is necessary to be the expert on people. The acquaintance already the concept of a nervism shows you how the role of a psychological condition of the patient in development and the course of pathological process is big. Data on psychology and psychiatry are necessary to the doctor in order that it is correct to estimate subjective data which are reported by the patient, dependence of their statement on mentality of the patient does not demand proofs.

Allow to stop in more detail on value of psychiatry in the common medical practice. Patients with mental disorders, if we include the milder, pretty much. The mental condition of the patient plays very important role at treatment of any disease. Approval, maintaining of confidence in happy end, goodwill – obligatory satellites of correctly put medical influence. The increasing attention is paid to deontology – science about how to behave with the patient not to do much harm him by the own words and actions. For the doctor of the common profile meetings with such patients are inevitable; the doctor has to be guided in their state and take these or those tentative measures. It has to direct such patients to the psychiatrist in time, carry out their treatment on the advice of the psychiatrist, and in some cases and to treat self-contained.

But not only the possibility of the address to any doctor of the patient with psychosis defines need of acquaintance of this doctor to psychiatry. In the manifestations any illness does not limit itself only to one body, the person, but not body is ill. Therefore the illness discernment, as well as its treatment, demands complete, integrative approach. We already said that somatic signs quite often affect, first of all, in the psychological sphere. Without owning psychological and psychiatric data, it is impossible to treat with success patients because from all remedies the most required and constant is the psychotherapy. It is under construction also on the scientific psychological and psychiatric base, to carry out a psychotherapy at the vulgar "spontaneous" level as it quite often becomes, it is impossible. The psychiatry most closer costs to the questions which are especially interesting and concerning most of people. As soon as the person begins to do comparisons and the conclusions, begins to think about environmental, he first of all tries to understand experiences, acts, character of people and himself. In your occupations by psychiatry you will constantly interfere with with these questions and to solve them. As told Goethe: "For the person the most interesting is a person».

It is even more, than other medical objects, psychiatry demands from all who go in for it, the known methodological armament which is cultivated as a result of materialistic philosophical views. Materialistic views of mentality go back to ancient philosophy. Ancient Greek scientific nature philosophers representatives Anaksiman-

dr and Anaksimen possess a merit in selection of mentality or "soul" from the material phenomena. They put forward situation that all variety of the world including soul, are various conditions of the uniform material beginning, a fundamental principle or a primal. Contemporaries of the Ancient Greek doctor Hippocrates among whom Democritus is most known created the atomistic doctrine according to which all existing including the soul, consists of atoms. Aristotle united materialistic and idealistic views of the nature and an origin of soul. He considered that a form of alive matter is the soul – the fissile, active beginning in the material body, i.e. the soul is a function of a body, but not some phenomenon, external in relation to it.

Supporters of an idealistic view of mentality are antique philosophers Socrates, Platon. One of the most important provisions of Socrates is that there is an absolute knowledge or absolute truth which the person can open in himself, learn only in the reflection. He for the first time connected thought process with the word, created the well-known *Socratic method of conversation* which cornerstone the way of the so-called directing reflections which gradually lead the interlocutor to self-contained discovery of truth that was the first attempt of development of technology of problem tutoring, development of heuristic thinking is. The method of socratic conversation is also widely applied also in the modern psychotherapeutic practice.

Ideas of soul as the directing, moral beginning of human life long time were not accepted by "the experimental psychology". Only in the last decades spiritual aspects of human life began to be discussed intensively by psychologists in connection with such concepts as the person's maturity, health of the person, personal body height, and also many other of what now is found and has something in common with ethical corollaries of the doctrine about douche of antique philosophers.

Dualistic views of mentality (views about independence and independence of existence in the world of two fundamental beginnings – matter and spirit) also originating in prehistoric times and antiquity, were most actively developed by the French philosopher, the psychologist and mathematician of the 17th century Descartes. He considered that the person consists of non-material soul and the material body, i.e. the soul and a body have the different nature. In his opinion not only the soul influences a body, but also the body is capable to influence essentially a state of mind, i.e. it put

forward a psychophysical problem. Any knowledge, according to Descartes, has to be output by method of a logical reasoning and if "I think, therefore I am" ("cogito ergo sum"). "To think" on Descartes, means not only to understand, but also to wish, to imagine, feel. Psychology of the end of the 19th century, having apprehended spirit of ideas of Descartes, made the subject studying of consciousness.

Ability to use method of dialectics is of fundamental importance for any expert. But it is especially necessary for the psychiatrist. The dialectic method represents a particular set of rules, methods of research of reality. These receptions an essence no other than the same common dialectic principles only formulated in an imperative form. In other words, if we undertook research of any phenomenon, then have to observe the following requirements:

• to approach an object of research historically, i.e. to take it obligatory in development — from the moment of emergence to today's state;
• to look for a way of its self-driving, i.e. an internal contradiction, duality, conflict of opposites in evolution of our subject;
• to be able to define a subject measure, i.e. unity of its quantitative and qualitative characteristics, and also their interaction;
• in the ratio serial stages of development of object to see not only negativity, negativity, but also unity, continuity;
• to try to qualify various characteristics of object as common or simple, necessary or casual, the formal or substantial, etc., and also to see their mutually transitions and interconversions, i.e. relativity etc.

The psychiatrist constantly resolves the main philosophical issues – the relations mental and physical, reflections of the world in consciousness of the person, the relation of matter and consciousness. The most visible domestic psychiatrist of the past S. S. Korsakov wrote: "Psychiatry from all medical sciences the most close to questions philosophical. The knowledge of itself, knowledge of any properties of the person was always one of the most deep aspirations of people, and the psychiatry gives more than other branches of medicine of material for this purpose».

The illness includes idea of some group of pathological frustration, and without them it does not exist. Any illness including mental, is shown not in the form of sepa-

rate separate signs — symptoms, and in the form of syndromes, i.e. typical set internally of the bound symptoms (a syndrome — collateral run of symptoms). The syndrome represents system of the interdependent standard frustration — symptoms (elements) united by a uniform pathogenesis. The symptom out of this system does not make sense.

The syndrome from the point of view of this moment is static (status praesens), from the point of view of an interval of time — is dynamic. Any process including pathological, is always turned into the future. The course of a disease is followed by increase in number of symptoms and change of their relationship, and also emergence of new symptoms that leads to modification of a picture of an illness, transformation of one syndrome into another. The knowledge of an illness cannot be limited to knowledge of its reasons, the knowledge of communications of a condition (change of syndromes) of an illness, regularities on which one state passes into another is not less important.

The etiology and sequence of change of syndromes reflect the different parties of pathological process. Features of pathological process define nature of communication of its states and vice versa, nature of communication of conditions of this or that pathological process assumes its particular cause and effect relation.

Of syndromes and their serial change there is a clinical picture of an illness in its development. Otherwise, the illness is shown by the continuous change of syndromes — external expression of a pathogenetic chain reaction. Prevalence of one syndromes over others and the reference regularity of their change — the stereotypic mechanism of a course of a disease is peculiar to clinical implication of each nosologically self-contained mental disease. To all diseases, and mental in particular, various individual deviations from a stereotype are inherent. Nevertheless, despite similar deviations, typicalness in prevalence of one syndromes over others and the repeatability of their serial emergence peculiar to each separate mental disease remains quite strongly. The last also allows to allocate clinically separate mental diseases (nosological units). Each nosological unit has criteria: etiology, pathogenesis (mechanisms of a course of a disease), clinic (symptoms and syndromes), a current (emergence of

new syndromes, transformation of one syndromes in others), a disease outcome, a pathomorphology (lifetime or postmortem).

The stereotype of a course of a disease can act as a stereotype and a stereotype all-pathological, peculiar to all diseases nosological, inherent in separate diseases. Each mental disease, proceeding from features of the development and, therefore, regardless of nosological accessory, can be shown by various frustration. Need of detection of common to all psychoses of regularities follows from such situation. In the past similar regularities were studied by representatives of the doctrine about a unitary psychosis (Kiarudzhi, Zeller, Griesinger, Schüle, etc.) . Them it was revealed that each mental disease begins with a depression, in process of weighting it is replaced by a maniacal state, further becomes crazy and as a result of further progressing comes to an end with a dementia. Studying of the common regularities by followers of the doctrine about a unitary psychosis was limited to historical conditions. It was settled by research only of the seriously ill patients who were in walls of psychiatric shelters of that time. The subsequent supervision which are carried out already and in psychiatric out-patient clinics found out that all mental diseases at first of the development are shown asthenic, affective, neurotic, and further by paranoiac and hallucinative frustration, a stupefaction, the roughly organic phenomena. Any pathological process, having arisen once, develops as a chain reaction, putting into operation a link behind a link, keeping at the same time phases and the periods of the development. Follows from the modern reliability theory of technical and alive systems that at all failures in the functioning the system, refusing completely, surely passes all phases of partial refusal. Processes, the bound to refusal, are continuous in time. Diseases have a particular outcome depending on weight of an illness and structural changes of this or that body, i.e. the diagnosis can be confirmed with a larger share of accuracy and morphological changes. It can be convalescence, synchronization, remission with defect or without it.

TEST TASKS

(for self-checking)

Choose one correct answer

1. SUBSTRATUM OF MENTAL ACTIVITY IS
1) thalamus
2) reticular formation
3) cerebral cortex
4) hypothalamus

2. FOR DIRECTIONAL ACTIVITY OF THINKING AND SCHEDULING OF ALL MENTAL ACTIVITY THE FOLLOWING AREA OF THE BRAIN MATTERS
1) temporal
2) frontal
3) occipital
4) parietal

3. AT DEFEAT OF THE BASIS OF THE FRONTAL LOBE, ITS ORBITAL SURFACE, ARISES
1) the increased mobility owing to a disinhibition, with complacent or eyforichny mood
2) flaccidity, indifference, lack of activity, initiative, weakening of the especially arbitrariest attention
3) depression
4) change of consciousness

4. HOW MANY BLOCKS ALLOCATE IN THE BRAIN OF THE PERSON ON PREFERRED FUNCTIONING OF THESE OR THOSE STRUCTURAL SYSTEMS?
1) 2
2) 3
3) 6
4) 4

5. THE INITIAL LINK OF REFLEXES OF THE BRAIN ARE

1) external irritation and transformation by their sense organs in process of the nervous exaltation transferred to a brain

2) processes of exaltation and braking in a brain and emergence on this basis of mental states (feelings, thoughts, feelings, etc.)

3) external movements

4) anything from the above-mentioned

6. THE PARADOXICAL STAGE UPON TRANSITION OF EXALTATION TO BRAKING CONSISTS IN:

1) impulses of different force cause reaction, counter on force

2) the positive irritant causes braking, and the negative, i.e. brake, the irritant causes positive reaction – exaltation

3) impulses of different force cause reaction of identical force

4) nothing from the above-mentioned

7. THE ULTRAPARADOXICAL STAGE UPON TRANSITION OF EXALTATION TO BRAKING CONSISTS IN:

1) impulses of different force cause reaction, counter on force

2) the positive irritant causes braking, and the negative, i.e. brake, the irritant causes positive reaction – exaltation

3) impulses of different force cause reaction of identical force

4) nothing from the above-mentioned

8. IS THE CORNERSTONE OF SOCRATIC CONVERSATION …

1) a way of the so-called directing reflections which gradually lead the interlocutor to self-contained discovery of truth

2) "mental ventilation" - an opportunity to be uttered self-contained before the doctor

3) way of dialogue

4) materialistic direction of philosophy

9. THE SYNDROME REPRESENTS …

1) system of the interdependent standard frustration – symptoms (elements) united by a uniform pathogenesis

2) self-contained issued clinical implication of a disease

3) the partial symptom of an illness

4) anything from the above-mentioned

10. THE CLINICAL PICTURE OF THE ILLNESS IN ITS DEVELOPMENT DEVELOPS FROM …

1) from syndromes and their serial change

2) from symptoms

3) results of instrumental research techniques

4) all above-mentioned is right

Lecture No 2

Deception of perception. Crazy ideas.

Frustration of perception. Illusions, hallucinations. The true and pseudohallucinations. Verbal pseudo-hallucinosis and its clinical value. Metamorphopsias. Frustration of a body scheme. Crazy ideas as special form of violation of thinking. Super-valuable ideas. Division of crazy ideas according to contents, structure (systematized, unsystematized). Concept about paranoiac, paranoid, paraphrenic syndromes.

Psychopathological symptoms which are considered in this lecture fall into to disorders of process of knowledge. This process includes two main steps: a) a step of sensory perception (feeling, perception, representation) and b) thinking (abstract) - concepts, judgments, conclusions.

The partial mental act of sensory perception - feeling. Feeling — such type of mental activity which, arising at immediate impact of objects and phenomena of world around on sense organs, reflects only separate properties of these objects and phenomena. For example, only color or a consistence of a subject or a sound of some phenomenon etc. is perceived.

More difficult mental manifestation of a first stage of knowledge - perception. This complete reflection of those phenomena or pieces of world around which immediately influence our sense organs (the person perceives a flower in general, sees its color and a form, catches a smell, a subtlety of its petals).

Representation is a result of resuscitation of the images or phenomena perceived earlier in the past. It differs from perception in the following features: 1) falls into to a subjective inner world 2) does not depend on existence of object at the moment 3) it is based on trace irritants 4) cooperative, less legible, has the generalized character.

Frustration of feelings.

Treat frustration of feelings: senesthopathias, anesthesia, gipersteziya.

Cenestopathy (sensus — feeling + pathos — an illness, suffering) — pathological feelings in the form of the body arising in various parts or internals unpleasant, and sometimes very burdensome, painful feeling of a pricking, pressure, burning, twisting, shrinkage, not the bound to any somatic pathology.

Anesthesia — an anesthesia, disappearance of feelings that can concern as separate exteroreceptor (loss of tactile sensitivity, most often on separate parts of the body, loss of vision or hearing from one or both parties), and several at once (for example, loss of hearing and vision is simultaneous). At such pathology, in psychiatry having most often the hysterical nature other express methods of inspection are necessary the most careful objective inspection, first of all neurologic (at skin anesthesia, for example, sites of loss of feelings do not correspond to innervation zones), and also.

Hypesthesia — decrease of sensitivity to external irritants. Sounds are perceived hushfully, as if "on the sly", light seems dim, paints — some faded, erased ("all around some gray and a bulb so poorly shines»),

Hyperesthesia — the aggravated, reinforced sensory perception from the eksteroretseptor concerning as separate analyzers (perception of routine background smells, sharp to an intolerance, sounds — a hyperosmia; a hyperacusia etc.), and their combinations (for example, both the daylight, and street noise seem the very strong). The hyperesthesia is followed by reaction of irritation.

Illusions.

Illusions — frustration of perception at which the actual phenomena or objects are perceived by the person in the changed, inaccurate look. The illusory perception can take place and against the complete mental health when the distorted perception is bound to a lack of this or that sense organ or to manifestation of one of laws of physics. Classical example: the spoon in a glass of tea seems refracted what R. Dekart told about: "My eye refracts it, and my reason — straightens».

Illusions, the bound to violation of mental activity, are most often subdivided on affective or affektogenetic, verbal and pareidolia. Affective (affektogenetic) illusions arise under the influence of the strong feeling, such affect as the strong fear, an excessive nervous tension. In such stressed state of people inaccurately perceives

the transparent curtain as the shaking skeleton, the coat on a hanger seems the terrible tramp, a tie on a chair back — the creeping snake, in noise of the fan threats in the address etc. are heard.

Verbal illusions (verbalis — oral, verbal) are expressed in inaccurate perception of sense of words, speeches of people around when instead of neutral for sick conversation of people around he hears (that usually also happens against the strong fear) threats, the curses, charges which are allegedly falling into to it.

Pareidolia illusions (para — near, near + eidoles — an image) – frustration of perception when as really actual irritant serve not defined, finished object images, and shadows, cracks on a wall, spots, patterns, etc. They are usually perceived in a fancy and fantastic look. For example, stains from paint, cracks on a wall are never perceived as a huge toad, a shadow from a floor lamp – as the head of any terrible pangolin, patterns on a carpet – as fine, before not a seen landscape, the running shadows from clouds – as picturesque group of people.

Illusions subdivide on sense organs, but most often allocate visual and acoustical. Quickly they can arise also at the healthy people who are in a condition of alarm, intense expectation, strong nervousness. However, most likely, they signal about the beginning psychosis, about an illness, is more often than the toxic or infectious nature.

Hallucinations.

Hallucinations – frustration of perception when the person owing to violations of mental activity sees, hears, feels what at present, in this place does not exist. This perception without object.

It is impossible to carry mirages to hallucinations – the phenomena based on laws of physics (reflection in an upper atmosphere of this or that situation hidden behind the horizon). Like illusions, a hallucination are subdivided on sense organs. Usually allocate auditory, visual, olfactory, flavoring, tactile and so-called hallucinations of the common feeling to which most often carry visceral and muscle hallucinations. There can be also combined hallucinations (for example, the patient sees a snake, hears its hissing and feels its cold touch).

All hallucinations irrespective of whether they belong to visual, acoustical or other deception of feelings, also pseudohallucinations are divided into the true. The true hallucinations are always projected outside, are bound to the actual, specifically existing situation ("voice" sounds because of an actual wall; "devil", wagging with a tail, sits down on an actual chair, braiding with a tail of his leg etc.), most often do not cause in sick any doubts in their real existence, actual things are also bright and natural for hallucinating, as well as. The true hallucinations are sometimes perceived sick even more brightly and clearly, than really existing objects and the phenomena. In attempts of people around (exciting) to deny existence of these imaginary objects, the patient declares that he is deceived, hide "truth", is sure that people around test the same.

Pseudohallucinations are more often characterized by the following distinctiveness from the true: a) are most often projected in the patient's body, mainly in his head ("voice" sounds in the head, in the head of the patient sees the business card with the indecent words written on it, etc.) ; b) even if pseudo-hallucinative frustration are projected also out of characteristic body (that is much more rare), they are deprived of nature of the objective reality peculiar to the true hallucinations, not connected with an actual situation at all. Moreover, at the time of a hallucination this situation as if somewhere disappears, the patient perceives only the hallucinative image at this time, and also considers that this phenomenon is intended only for it; c) as pseudohallucinations are always followed by feeling of perfection, a rigged, homing of these voices or images, and people around cannot test it, pseudohallucinations are, in particular, a constituent of one of crazy syndromes which includes also nonsense of influence therefore patients also are convinced that "vision" by it "was made by means of special devices", "voices direct directly in the head transistors"; d) pseudohallucinations are close to representations.

Auditory hallucinations are most often expressed in pathological perception to patients of some words, speeches, talk (phoneme), and also separate sounds or noise (acousma). Verbal (verbal) hallucinations can be the most various according to contents: from so-called calls (the patient "hears" the voice telling his name or a

surname) to the whole phrases or even the lengthiest speeches delivered by one or several voices.

Imperative hallucinations which maintenance has imperative character are most dangerous to a condition of patients, for example, the patient hears orders to be silent, strike or kill someone, to put himself damage. In view of the fact that similar "orders" are a consequence of pathology of mental activity of the hallucinating person, patients with such morbid experiences can be very dangerous both to themselves, and to people around, and therefore need special supervision and leaving.

The hallucinations menacing are also very unpleasant for the patient as he hears threats in the address, is more rare to the close to it than people: he "is wanted to be killed", "to hang up", "to throw out from a balcony", etc. Treat auditory hallucinations also commenting when the patient "hears speeches" about all he thought of or whatever made.

The patient is 46 years old, the furrier by profession, is a lot of years abusing alcohol, began to complain of "voices" which "to pass do not give it": "here now sews skins, but it is bad, hands shiver", "decided to have a rest", "went for vodka", "what good skin stole" etc.

The antagonistic (contrasting) hallucinations are expressed that the patient hears two groups of "voices" or two "voices" (sometimes one on the right, and another at the left) with contradictory sense ("Give now we will finish with it". — "No, we will wait, it not such the poor»).

Visual hallucinations can be or the partial (in the form of zigzags, sparks, a smoke, a flame – so-called photopsias), or object when the patient very often sees the animals who are not existing actually or people (including those whom he knows or knew), animals, insects, birds (zoopsia), objects or sometimes parts of a body of the person etc. Sometimes it can be the whole scenes, panoramas, for example a battlefield, hell with a great number of the running, wriggling, fighting devils (panoramic, film similar). "Visions" can be the routine sizes or in the form of very shallow people, animals, objects etc. (Lilliputian, microscopic hallucinations), and also very larger, even huge objects (macroscopic, giant hallucination). In certain

cases the patient can see himself, an own image (hallucinations of the double, or autoscopic).

Sometimes the patient "sees" something behind himself, out of sight (extracampine hallucinations).

Olfactory hallucinations most often represent imaginary perception of off-flavors (the patient feels a smell of the decaying meat, ashes, decay, poison, food), is more rare — absolutely unfamiliar smell, is even more rare — began to smell something pleasant. Quite often patients with olfactory hallucinations refuse food as are sure that "in food to them pour toxicants" or "feed with rotten human meat».

Tactile hallucinations are expressed in feeling of hiting at to a body, burnings or cold weather (thermal hallucinations), in feeling of a touch (haptic hallucinations), emergence on a body of some liquid (hygric hallucinations). Most often patients have feeling of crawling under leather of insects, goosebumps, any movements of shallow objects.

Visceral hallucinations — feeling of presence at characteristic body of some objects, animals, worms ("in a stomach the frog sits", "in a bladder tadpoles bred", "the wedge is hammered into heart»).

Hypnagogic hallucinations – the visual deception of perception appearing usually in the evening before a backfilling at the closed eyes that does them by more congenerous to pseudohallucinations, than the true hallucinations (there is no communication with an actual situation). These hallucinations can be simple, multiple, scenic, sometimes kaleidoscopical ("I have in eyes some kaleidoscope", "I have characteristic TV now"). The patient sees some ugly faces which are grimacing, putting out the tongue him, winking, monsters, fancy plants. Much less often such hallucination can arise during other transient state – when awakening.

The functional hallucinations – those that arise against the actual irritant operating on sense organs and only during its action. The classical example described by V.A. Gilyarovsky: the patient, as soon as from the crane water begins to flow, heard words: "Go home, Nadenka". At twisting of the crane also auditory hallucinations disappeared, however they could arise also at other acoustical irritant at the same patient. The functional differ from the true hallucinations in existence of

an actual irritant, though have other contents, and from illusions – the fact that are perceived in parallel with an actual irritant is perfect (it is not transformed to any "voices", "visions", etc.).

Hallucinations – a symptom of morbid frustration (though sometimes and short-term, for example, under the influence of psychotomimetic tools). But sometimes, quite seldom, they can arise also at healthy (inspired in hypnosis, induced) or at pathology of organs of vision (a hallucination like Charles Bonne) and hearing, at a deprivation (isolation) from irritants.

Hallucinations at the same time are more often the partial (flashes of light, zigzags, multi-colored spots, noise of foliage, incident water, etc.), but can be also in the form of bright, figurative acoustical or visual deception of perceptions.

The patient of 72 years with a loss of sight to the photoperception level (a bilateral cataract) at which no mental violations are revealed except slight decrease in memory, after unsuccessfully last operation began to say that she sees on a wall of some people, mainly women. Then these people "descended from a wall and steel as the presents. Then on hands of one of girls the small doggie appeared. Some time was nobody, then the white nanny-goat appeared". Further the patient sometimes "saw" this nanny-goat and asked people around why suddenly in the house the goat came to be. The patient had no other mental pathology. In a month, after successfully performed other eye operation, hallucinations completely disappeared also during supervision (5 years) of any mental pathology, except decrease in memory, at the patient did not come to light.

Acknowledging the possibility of hallucinations at people with pathology of vision and hearing, it is necessary to collect the detailed anamnesis (existence in the past of a disease which recurrence arose during a disease of eyes), to conduct careful examination of a mental state now and follow-up study as a cataract, decrease in hearing and other violations come to light at advanced age when also the mental disease peculiar to this period can begin. It is very important to know and consider objective symptoms of hallucinations, dangerous character of some of them (for example, imperative hallucinations), inherent mentally sick aspiration to hide the morbid experiences (dissimulation). Quite often common inaccessibility,

impossibility to come to the patient into contact oblige the doctor to watch very carefully his behavior, a mimicry, gestures, pantomime. For example, patients can close ears or a nose, is attentive to something to listen, spit around itself, to sniff at food, to tell something, to hide, be aggressive, suppressed, lost etc.

Sick M., 35 years, the long time abusing alcohol, after the postponed pneumonia began to feel fears, to sleep badly and uneasily. In the evening with alarm called the wife and asked, pointing to a shadow from a floor lamp, "to clean this ugly ugly face from a wall". Later saw a rat with a thick, very lengthiest tail which suddenly stopped and asked by "a vile squeaky voice": "What, it was drunk up?". Closer by the night saw rats again, suddenly jumped on a table, tried to dump on the telephone set, "to frighten these creatures" is hollow. At hospitalization in an accident ward, feeling itself a face and hands, with irritation told: "Such clinic, and spiders were bred, to me the web stuck around all person».

Hallucinative syndrome (hallucinosis) – flow of plentiful hallucinations (verbal, visual, tactile) against clear consciousness, lasting from 1-2 weeks (a acute hallucinosis) till several years (a chronic hallucinosis). A hallucinosis can be followed by affective frustration (alarm, fear), and also crazy ideas. Hallucinoses are observed at alcoholism, schizophrenia, organic damages of a brain.

Disorders of touch synthesis (psychosensorial frustration).

Frustration of a body scheme, metamorphopsia concern to them (macropsias, micropsias, dysmegalopsias).

Frustration of a body scheme are expressed in violation of habitual ideas of the sizes and a shape of the body or its separate parts, about their arrangement or about position of all body. For example, it seems to the patient that his head became huge, does not find room not only on a pillow, but also in general in the room that his legs begin directly from the head, and the trunk disappeared. Another feels that at it the hand unreasonably increased – "became just pood", it "becomes small or, on the contrary, huge, "as Gulliver in the country of Liliputians", it "hands are extended", "legs forked and them became not less than four", "the head separated from a body", etc. Under vision monitoring these changed ideas of a form, the sizes and position of characteristic body or its separate parts, as a rule, disappear, the patient sees the body

in a look, routine, habitual for it, but once he closes eyes, the head becomes unreasonably big and etc.

Frustration of a body scheme quite often are followed by metamorphopsias – the distorted perception of a form and the sizes of environmental objects (from Greek meta — later, for, through; designates also transition to something to another, change of a state, transformation + a morph – a form). For example, the case seems to the patient increased, bent (dysmegalopsia), chair legs — zigzag, the window takes the rhombic form. Besides, the distorted perception of environmental objects is expressed only that they seem to the patient less or more than their full size (a micropsia, a macropsia).

Metamorphopsias and congenerous it symptoms differ from illusions in adequacy of perception (the patient knows that he sees a chair, though with curve legs, but not a huge spider instead of a chair as it can be at illusory perception). They differ from hallucinations in what in the distorted type of the patient perceives after all real-life things, but not what is not present in the real situation.

Comparative and age features of frustration of feelings, perceptions and representations

Features of pathology of feelings, perceptions, representations depend not only on character of a disease, a clinical form, sharpness and its stage, but also on age of the patient (children's, teenage, mature).

Senesthopathias can appear at children from 5-7 years, most often they are projected in the field of abdominal organs (though can have also other localization), arise usually in the form of short-term episodes. Repeatability of such short-term, but unpleasant feelings in a stomach which the child usually is not able to describe can be the first symptom of the epilepsy (M. A. Uspenskaya) beginning at children's age.

The girl of 7 years quite often, sometimes several times in day, showed to mother the same complaints: "Something at me in a tummy painfully presses". Careful somatic inspection did not find any pathology, and in 2 years the girl had typically epileptic symptomatology.

Pathological feelings in the form of a senesthopathia at teenagers are more issued, remind similar frustration at adults.

Owing to brightness, figurativeness of children's perception, backwardness still of the second alarm system at children of illusion can be and are normal when "actual often intertwines with fantastic". Tendency to imagination, ability to animate or perceive differently actual objects, to allocate them with some special characteristics ("the sun alive, it goes on a palate", "the sofa is a car, we on it go now to the south", etc.), but at the same time not to be disconnected from a real is peculiar to children of younger age.

At pathological imagination the child entirely comes off the actual world, it all in the morbid imaginations.

Besides, children can have and actually illusions as the pathology arising or against fears (affektogenetic illusions), or at intoxication and infections, at delirious frustration of consciousness.

The girl of 5 years who transferred a severe form of scarlet fever at high temperature asked, showing on standing in the room yet not cleaned Christmas tree: "Clean this Dragon, banish him».

The feature of children's age concerning perception pathology is frequent "vision" of various heroes of fairy tales and animated films. It concerns not only illusions, but also hallucinations. Children "see" "Baba-Yaga", "a terrible tiger of Cher Hahn", "the angry sorcerer" etc. Other feature is a dominance of visual deception of perception (even at schizophrenia unlike this illness at adults proceeding mainly with auditory hallucinations).

Children and teenagers can have also pseudohallucinations, and is frequent in a look the hypnagogic. The last arise most often against the illness which is especially proceeding with a stupefaction in the form of a oneiroid (schizophrenia, infections, including intracranial; intoxication).

The girl of 3 years who is already put to bed suddenly jumped and began to beat herself with cams the head, to cry and shout: "Again these terrible uncles in the head, I cannot banish them in any way».

Pseudohallucinations in a look the hypnagogic can arise at children and teenagers without any psychosis, but with such lines as emotional lability, an impressionability, the increased suggestibility.

Violations of touch synthesis in the form of frustration of a body scheme and metamorphopsias happen at children (usually after 6-7 years) at organic damages of a brain of various etiology.

In the second half of lecture we will consider frustration of a second stage of cognitive process - thinking, namely pathology of judgments: crazy, supervaluable and obsessions ideas (judgments).

Thinking - the generalized reflection by the person of objects and phenomena in their natural communications and the relations. intellectual activity proceeds in definite logical forms: concepts, judgments, conclusions. Concepts reflect the generalized properties of the homogeneous groups of objects and are put into words. For example, in the concept "person" we allocate from group of mammals of an entity, capable to the speech, work and having consciousness. Judgment - the thought, in it is expressed the relation of the person to objects and the phenomena is routine in the form of the statement or refusaling - "there is good weather". The conclusion is the logical result of comparison of a number of judgments leading to a conclusion.

Persuasive states.

Persuasive states (obsessions) are such phenomena when at the person in spite of himself arise ("are imposed"), thoughts, fears, quite often alien for it, inclinations, doubts, actions. Despite the critical relation to the similar phenomena, the person cannot get rid of them. The obsessive similar phenomena can meet also at mentally sane in the form of "bad" habits, rituals of superstition, etc. However it can be controlled by consciousness and die away under the influence of strong-willed efforts.

The notions of compulsion (obsessions) are in emergence of absolutely unnecessary thoughts (an intellectual chewing gum, thoughts parasites) rather emotionally neutral, for example, about why the person has two legs, and at a horse four why people have noses of a different form that would be if the sun arose in the west, but not in the east. In other cases the content of thoughts can have looking alike crazy ideas of the relation or even prosecution with the corresponding emotional charge. Understanding all absurd of such thoughts, falling into with them with the complete criticism, the person, nevertheless, to get rid of them not in forces.

The arithmomania consists in strong need to count everything in their surroundings: windows in houses, crossbeams in a fence, buttons on a coat of the neighbor, etc. A similar obtrusiveness can be also expressed and in aspiration to more difficult actions, for example in addition of the figures making number of this or that phone.

The persuasive doubts accompanied with usually unpleasant, feel qualmish are expressed in constant doubts concerning whether correctly the person made this or that business, whether finished it. So, the doctor who wrote out to the patient the recipe infinitely doubts then whether it made a mistake in a dose; the typist many times re-reads the printed text and, without finding a mistake, nevertheless again has doubts. The most frequent type of this sort of an obtrusiveness – painful doubts: whether the person before leaving switched off gas whether turned off light, whether locked a door. Quite often suffering from such persuasive doubts several times comes back home whether to check, for example, did he closed a door, but once it departs, he begins to worry again whether it finished this action, whether he forgot to turn a key, to take out it from the lock.

Persuasive memoirs are characterized by involuntary emergence of bright memoirs usually something very much for the person unpleasant, what he would like to forget: for example, some conversation, burdensome for the patient, all details of a humorous situation into which it once got, a situation of examination on which it with a shame failed is busily remembered.

Persuasive fears – phobias (phobos – fear). Experiences of the fear caused by the most various objects and the phenomena are very painful: phobia of height, the wide areas or, on the contrary, narrow streets, fear to make something indecent, criminal or unlawful (for example, fear to kill the only thing, hotly beloved child, fear not to hold in the public place intestinal gases, fear to be struck with a lightning, to drown, fear of underground passages, fear to redden in the public place, especially during ticklish conversation when all can think that the patient has "not absolutely clear conscience", fear of pollution, fear before sharp, the pricking and cutting objects. The special group is made by nosophobias — persuasive fears to ache with this or that disease (a cardiophobia, a syphilophobia, a cancerophobia) or even to die

of this illness or of some other reasons (fear of death — a thanatophobia; tapagoz – death). Quite often phobophobia meet: the person who was hard enduring an attack of persuasive fear feels then already fear of the fear (a new attack).

Emergence of persuasive fears usually is followed by emergence of the expressed vegetative reaction in the form of a sharp blanching or reddening, a sweating, heartbeat, a hurried breathing. It is characteristic that usually quite critical relation to the state, the comprehension of insolvency, groundlessness of persuasive fears at the time of an attack of the last in the form of panic attacks with the expressed vegetative maintenance disappears, and then the person is really sure that he "will immediately die of a heart attack", "will die from a hematencephalon", "will die from blood poisoning».

Persuasive inclinations (persuasive desires) are expressed in emergence of desires, unpleasant for the person (to spit in a nape ahead of the sitting person, to pull the passer's nose, to jump out of the car on the highest speed), which all absurd and morbidity the person understands. Feature of similar inclinations is that they usually do not turn into action, but for the person are very unpleasant and painful.

Also the contrast obtrusiveness which is expressed in the blasphemous notions of compulsion, feelings and fears offending moral and ethical, moral substance of the person is very painful for patients. The teenager who is very loving the mother busily has thoughts and ideas of her physical untidiness and possible dissolute behavior though he knows well that there is no it; very believing person has fears that he during church service "will make some obscenity"; mother at the sight of sharp objects has persuasive representations as she sticks them in a throat of the only child etc.

Like persuasive desires, inclinations etc., a contrast obtrusiveness also is never realized.

Persuasive actions are characterized by involuntary realization of this or that complexity of movements. Here such actions and the movements as a sniff, a snapping fingers, a bite one's lips belong and similar to hyperkinesias (in an expression form) shoulder shrug, the movements by the head and a neck it is similar to a release of the last from tightly collar, etc. These movements and actions are made

automatically, their realization is not followed by any unpleasant feelings, they are just not noticed if people around do not pay attention to them. Unlike hyperkinesias the sick person by effort of will can detain them for some period of time (in attempt to constrain a hyperkinesia its strengthening follows), but then as "category" persuasive actions amplify (become frequent).

Rituals – the persuasive actions and the movements made by patients as a necessary ceremony in the presence at them phobias or painful doubts. These ritual movements or actions (sometimes the very composite and the long-livedly) are carried out by patients for protection against the expected misfortune or calm at persuasive doubts. For example, the patient with persuasive fear of pollution so often washes hands that in day she spends on a piece of soap. During each washing she soaps hands not less than ten times, considering at the same time aloud; if for some reason or other loses count or it will be abstracted, then it right there has to treble this number of soapings, then again and again to treble etc.

The patient of 40 years addressed with complaints to existence of the various persuasive phenomena. For the first time began to feel persuasive fear from 13 years when, leaving a cinema hall, felt a sharp desire on an emiction. From this day there was a fear not to hold urine in the public place. For the rest felt healthy, successfully graduated from school, went to work. At 19-year age (against overwork and the long-lived sleep debt) there was a painful fear to go crazy (it was promoted by the story of the girlfriend about a disease of her uncle), and the fear to ache with an early sclerosis and an idiopathic hypertensia and to die of it joined a little later. Hardly worked, badly slept at night, read the mass of medical literature. It was treated, the state improved, however after a gap with the groom again with a larger force persuasive fears began to disturb and it is especially strong — fear to ache with an early sclerosis and an idiopathic hypertensia and to die of it. The patient understood absurd of the fears, but could not get rid of them. Felt some calm after commission of the following ritual actions: took off from herself clothes and, having twisted each thing 3 times, threw it on a floor, but so that one thing lay not less than at meter distance from another. The state especially worsened after accession of persuasive fear of the sharp and cutting objects which gradually became "most important, the

most awful" while former phobias more narrow almost did not disturb. Besides, there were very painful persuasive inclinations to put out of themselves eyes, to drag on a towel, to cut cheek skin.

Supervaluable ideas.

Pathology of thinking can be expressed in such phenomenon as supervaluable ideas – the thoughts arising in connection with some actual facts or events, but gaining the special importance for the person dominate in consciousness and define all his behavior. As a rule, these ideas are characterized by a big emotional saturation. For example, the person who is really writing verses and, maybe, received for it some approval, begins to think that he unusual, extremely talented, ingenious poet, and to behave as appropriate. Its people around he regards non-recognition as intrigues of ill-wishers, envy, misunderstanding, it is not considered with any actual facts. He addresses various authorities, in different instances. Eventually the supervaluable idea loses an emotional state of charge, relevance, the critical relation is formed to it. Other option of an outcome - transformation of supervaluable idea in paranoiac nonsense. It happens or at development of supervaluable idea on the pathological (morbid) soil, or in cases of special characteristics of the person (a paranoiac psychopathy) which appeared in the long-lived adverse situation. Difference of supervaluable ideas from crazy: a) can develop also out of the morbid soil; b) perhaps under influences of the actual facts formation of criticism to them; c) there is no rough (ridiculous) frustration of behavior peculiar go. Supervaluable ideas are especially characteristic of psychopathic persons.

Crazy ideas.

The most qualitatively expressed frustration of thinking is the nonsense. Crazy ideas (nonsense) – the improper conclusions, inaccurate judgments, chance conviction untrue. The nonsense differs from routine human delusions in the following: 1) it always arises on a morbid basis, it is always an illness symptom; 2) the person is completely convinced of reliability of the inaccurate ideas; 3) the nonsense does not give in to any correction, any dissuasion from outside; 4) crazy beliefs have the extreme importance for the patient, anyway they influence his

behavior, define its acts. Just mistaking person at a persistent dissuasion can refuse the delusions. No actual proofs of the crazy patient will possible to dissuade.

According to clinical contents (on a nonsense subject) all crazy ideas with the known share of sketchiness can be shared into three larger groups: 1) persecutory crazy ideas (prosecutions, influences, damage, sorcery, relation, etc.); 2) effusive crazy ideas (greatness, wealth, Messiah, high origin, reformism, invention); 3) depressive crazy ideas (self-abasements, sinfulnesses, self-accusations, hypochondriacal).

1) Group of persecutory nonsense:

The nonsense of the relation is in pathological belief of the person that all somehow suspiciously look, badly speak about it or laugh at it, exchange winks to his address, he summons their derisive or even fastidious relation. A kind of nonsense of the relation is the nonsense of special sense (special value). At the same time patients attach to the most routine things special significance, see in them sense, special for themselves.

The patient, having seen on a table the magazine with the photo of a tiger in a cage, with conviction declares: «I see. Expressly put this picture to prompt that will transport me to prison soon.» Other patient, having seen a yellow jacket on one of students, maliciously began to shout to the teacher: «Yes, I know, you purposely brought her here that all students knew of my impotence, you know that yellow color about it signals».

Sensitive (Sensibilis – sensing) nonsense of the relation is formed on the basis of such features of the person as shyness, an impressionability, vulnerability, suspiciousness.

The nonsense of poisoning is in morbid conviction of the person that he is wanted to be poisoned therefore he refuses food ("constantly poison in food is poured"), does not take medicine ("under the guise of treatment want to poison"), does not buy the packaged products ("I know that I will be given a bottle with the poisoned milk»),

The nonsense of influence can have many various options: the patient is convinced that apart influence him hypnosis, electricity, atomic energy, influencing, thus, his thinking, acts, causing in it sexual exaltation.

The patient reports: «There is a criminal group which by means of special devices constantly keeps me under laser beams. They steal my thoughts, burn down my interiors, create to me the poor mood».

The persecution complex in the true sense means pathological conviction that "persecutors" are in an immediate environment of the patient, walk behind it down the street, trap him under house windows, under the guise of patients get after it into clinic: "I constantly feel for myself shadowing, I am followed by some suspicious persons in caps where I will go, everywhere they trap me, want to kill».

The nonsense of the material damage is characterized by chance conviction that people around constantly rob the patient, steal his things and money, wear his clothes, receive for it his salary or pension, spoil his property, starve him: "Here and I sleep in a cap and felt boots, only remove – right there will steal, already glasses stole, all books took away, even carried away a coffee pot". The nonsense of the material damage is most typical for psychoses of late age.

Nonsense of decay, nonsense of sorcery. The sick person has a conviction that he fell a victim of sorcery, "it was spoiled plot", "allowed to drink some potion, and it became absolutely ailing now", "from it there was only one shadow", it "was maleficiated by evil eyes". Such nonsense should not be mixed with superstitions when similar ideas have character of prime delusion and are not a consequence of an illness.

Nonsense of jealousy – the patient is unmotivated jealous the wife, is for no reason at all convinced of marital infidelity, they in the most innocent things sees "indisputable proofs" of the correctness.

The patient reports: "The wife comes every morning to a balcony to water flowers, and actually signals these to the lover when is not at home me". Or: «The rug at doors is shifted aside, is clear that without me there was someone others, and I here, and the wife are very accurate».

The nonsense of jealousy can meet at various diseases, in particular at an alcoholism.

2) Effusive crazy ideas

The nonsense of invention is expressed that the patient is convinced that he made outstanding discovery, invented a perpetuum mobile, opened the cancer reason, found means for the maximal extension of human life, invented "an elixir of eternal youth", "means for improvement of human breed". Also the nonsense of a reformation when by the patient it is convinced that she "opened idea of transformation of the world" is close to this nonsense and will make "ingenious reform».

The nonsense of a high origin is in conviction of the patient that he is a son of the world famous writer, the movie star, "the last offspring of House of Romanovs" etc., and "those who are considered parents, only now tutors", "figureheads", "parents in the conditional sense". The nonsense of wealth is in conviction of the patient that it "the owner of infinite treasures", "possesses all gold reserves on the earth", "he can present to each student on a gold fur coat", at it "the house to one million rooms».

The love, erotic (sexual) nonsense is that the patient or the patient are firmly convinced of the unusually strong love to them of some person, perhaps, even unfamiliar which "madly loves apart". Such patients persistently try to obtain a meeting with "beloved" or "darling", literally pursue them, all behavior of people around and especially "object of love", in their opinion, validates their thought: "He pretends that we are unfamiliar because preserves me against attacks of the unloved wife", "She expressly put on a red dress to show how her love to me is strong", "He expressly married not to cast a shadow on my reputation».

The ridiculous nonsense of greatness (the grandiose sizes) – so-called megalomaniac (megas — big) ("all children on the earth were born from it", "all books what in the world are, I wrote, but only under different names", "I one can eat ten bulls at once") is characteristic of a general paralysis.

3) Depressive crazy ideas

Nonsense of self-abasement, self-accusation, guilt, sinfulness – the very close pathological ideas on clinical contents about the imaginary mistakes, nonexistent

sins, imperfect crimes ("in life nothing good is made", "I am an utterly worthless person", "all my life – a continuous chain of mistakes and crimes"). Such patients are very often convinced that the mistakes and acts they ruined not only the life, but also life of the relatives that they "all in burden", "eat around people around", "have no right even to a piece of stale bread". Also punishment expectation, conviction in its need or inevitability is characteristic of them ("I – a monster, do not understand how the earth holds me", "there is no such penalty which would correspond to my offenses"). Similar crazy ideas are especially characteristic of patients with presenile psychoses.

The hypochondriac nonsense is expressed in inaccurate conclusions concerning a condition of characteristic organism, morbid conviction available of a disease (cancer, syphilis, AIDS, "an inflammation of all interiors", a metabolic disorder), defeats of all organism or separate parts of a body ("blood was condensed, in heart some band and traffic jams, soon more narrow the complete end will come"). Sometimes patients claim that they do not exist any more, they have no stomach, there are no intestines ("the doctor as I can eat when I have no stomach any more and intestines all decayed"). Such kind of hypochondriac nonsense carries the name of a delusion of negation or nihilistic nonsense (nigi1u – anything).

Such crazy refusaling is more rare concerns not characteristic organism, but the outside world: "everything died", "the sun went out", "the earth failed", "the world disappeared somewhere" (the similar nonsense and is called – nonsense of death of the world).

At the same patient can be or one crazy idea, or at once a little (for example, existence of nonsense of greatness and prosecution is simultaneous). Besides, one type of crazy ideas can pass into another (so-called transformation of nonsense).

Patient, before quiet and cheerful, from 18-year age became more and more selfcontained, avoided public places, retired, cried. After a while "under a rigorous secret" told mother that she should appear somewhere as all right there pay attention to it, laugh at it, consider her as the little fool. After a while began to refuse food, said that it is wanted to be poisoned that it "was not an eyesore to all the foolish look».

The patient at the age of 45-46 years found larger alarm concerning the health, told the husband that "inside at it something turns over", "from rise in weight of a sheaf broke". In increasing frequency saw doctors of various specialties, asked "to check its organism", did not believe when it was found healthy. It was more and more claimed in opinion that it has a serious, incurable disease, "cancer", and doctors "just do not understand or not wanted to be upset". Became more and more suppressed, almost all the time lay in a bed. Eventually more and more clearly the depressive delusion of negation came to light (nihilistic): "All bodies fell off, the stomach dried, does not work at all, the bladder decayed, all nerves atrophied, intestines grew to a backbone».

Main crazy syndromes.

Paranoiac syndrome. It still call, with a particular share of convention, primary, due to the lack of frustration of perception. This syndrome is characterized by gradual formation of the systematized nonsense, especially at first emotionally rich and to some degree reasonable, deprived of apparent absurd. As it was already specified, at this nonsense there are no hallucinations, illusions, metamorphopsias. In some cases the considered type of nonsense can be formed on the basis of supervaluable idea. According to contents it is most often nonsense of invention, jealousy, a disfiguration, love, litigious. As a rule, he is very firm.

The translator for many years specializing in area of technical translations came to the conclusion eventually that all this "nonsense" that "the technique will not be perfect until there is perfect a human breed", and began to develop a scientific basis of this improvement. Was engaged in it several years, persistently visited scientific physicians and biologists, suggesting them "to realize its opening". Everywhere went with the thick folder, the full of references, cuttings from newspapers and magazines, mainly popular. Suggested to create such research institute, "where all employees would conduct experiments on themselves" and "by cross crossing tried to obtain receiving the best posterity". Did not find symptoms of weak-mindedness, with interlocutors it was polite and correct, but did not give in to any dissuasions and it was unshakably convinced of the correctness. With it (including outstanding scientists) explained variance with the fact that "all this is too

new" and "not everything it is allowed to look far forward", and further and the fact that "envious persons disturb it»).

Paranoica syndrome. This syndrome includes quite often politematichny crazy ideas and frustration of perceptions, a thicket - a hallucination. At this syndrome the persekutorny nonsense prevails. One of kinds of this syndrome is Kandinsky-Clerambault's syndrome (a syndrome of mental automatism). It is a hallucinatory paranoid syndrome as here the considerable specific gravity hallucinations get and, first of all, pseudohallucinations. The domestic psychiatrist, the described this syndrome (Kandinsky), called the monograph "About Pseudohallucinations". The prevailing place in it is taken by crazy ideas of influence (mental, physical, hypnotic) and the phenomena of mental automatism. The last are expressed in feeling of affectation, estrangement, "perfection" of characteristic feelings, feelings, movements, acts, characteristic thinking: "I do not belong to myself", "I as the automatic machine operated from outside».

All symptoms making Kandinsky-Clerambault's syndrome intimately are among themselves bound; pseudohallucinations are followed by feeling of perfection, i.e. are bound to nonsense of influence, the phenomena of mental automatism, and also such violations as "feeling of mastering" which are a part of a syndrome (the patient "seized", it "does not belong to itself(himself)") and a so-called symptom of internal openness also are bound to it. The last, usually very burdensome for patients, is in belief that all thoughts (thoughts) of the person including the most intimal, become known to all environmental now. Also such symptoms as "an echo of thoughts", "loud sounding of thoughts" are frequent (as soon as the person thinks of something, right there hears sounding of these thoughts and it is sure that all people around surely hear it). These symptoms fall into with one of kinds of mental automatism – idearum, or associative. Other kind of mental automatism is cenesthopathy – "cause", "do" extremely unpleasant, burdensome feelings - cenesthopathias. The third – kinesthetic automatism (operate the movements, acts).

The patient reports that already several years he is under continuous influence of some devices directing to it "beams of atomic energy". Believes that this influence proceeds from some scientists putting experiment. "They chose me because

I always had a good health". "Experimenters take away his thoughts", "show it some exemplars" which he sees in the head, in the head "the voice — too their work sounds". Suddenly during conversation of the patient begins to grimace, make a wry mouth, to pull a cheek. On a question why it does it, answers: "It at all not I, they burn down it with beams, direct them to different bodies and fabrics". Complained also that "these scientific fanatics", influence and on his internals — "cauterize genitals", "urine detain».

Paraphrenic syndrome. This syndrome consists of a combination of persecutory and an expansive delirium. Along with ideas of prosecution, influence the nonsense of greatness (usually fantastic character), accompanied by the phenomena of mental automatism and pseudohallucinations develops. It is quite often combined with the increased mood and confabulation nonsense (the invented, nonexistent events are given for actual, happened, allegedly, to the patient)

The patient, is a lot of years stating crazy ideas of physical impact (there is an express organization which some heavy-duty devices influences it, on its mentality, gives it imaginary orders, burns down her body), began to say that at her with "this organization established a two-way communication". Declared that it can influence now on people around too, "to transfer them the thoughts, entirely such ingenious". Assured that "these transfers" promotes world progress. The mood raised it is complacent though sometimes, mainly at the sight of relatives, becomes spiteful. Other patient declared that at night in office his enemies, persecutors whom he, having "the powerful force", "broke off" on part "rushed", "there was a lot of blood, parts of bodies". On a question of the doctor: "Where all this disappeared?", answered: "The personnel managed to clean everything».

The syndrome following crazy belongs according to contents to depressive – a Cotard delusion. This syndrome develops against a heavy depression. Allocate two of its versions: with megalomaniac depressive crazy ideas of death of the world, the negative greatness (evil power) with resistant conviction that already existence of the patient brings to all people around, and even the whole world, huge harm, irreparable injury. Along with such ideas, there is a nonsense of painful immortality – the patient and, quite often, his relatives "will never die", are doomed to "eternal tortures" that

sometimes leads to a suicide with murder, for example, children. For example, the patient obstinately refuses food because "I ate around the whole world as it is, soon all people with hunger will die"; other patient assures that her respiration "mephitic and vile" and can ruin all alive on the earth. The second kind of this syndrome is the nihilistic (refusaling) nonsense with statements that their internals "decay" or "decayed", "in nothing is not present", "empty as a keg", it is possible with accession of ideas of "painful immortality».

The patient of 60 years, in a condition of a deep depression, obstinately refuses food, explaining it with the fact that "there is no digestive tube more narrow", "it completely decayed", "the food can get only into lungs", "muscles too everything dried". "For ever I will remain such alive corpse", "I will only suffer", "constantly I think how it would be fair if I died and the death will not take me". Begs doctors to help it with it, to agree that "burned in the nuclear reactor.

Dysmorphic syndrome — dysmorphophobias. This syndrome is characterized usually by a triad (M. V. Korkin), consisting: 1) from ideas of a disfiguration ("so ugly legs", "a nose, like Pinokio's", "ears as burdocks", etc.); 2) nonsense of the relation ("all look and laugh", "it is pleasant to whom to look at the freak", "people on the street point a finger"); 3) the under mood, sometimes up to a heavy depression with thoughts of suicide.

The idea of a disfiguration most often is nonsense of paranoiac type (when thoughts of ugliness touch the absolutely exact part of the face or a body), is more rare — supervaluable idea (in this case small defect, for example a little curved legs, is perceived as "tremendous ugliness", "shame"). The aspiration to "correction", "correction" in one way or another of the imaginary or sharply overestimated disfiguration is extremely peculiar to patients with ideas of a disfiguration. Especially actively they visit surgeons, trying to obtain the cosmetic operation which is not shown them.

Much less often thoughts of this or that physical defect have character of persuasive educations. Therefore it is more lawful to speak in the majority of supervision not about a dysmorphophobia (from Greek dis — the prefix meaning frustration + morphe — a form) — persuasive fear concerning ungeometrical to this

or that part of a body (though such supervision too are available), and about a dysmorphomania (fmania — madness, passion, an inclination).

The patient of 20 years is firmly convinced that he has "awfully ugly nose", meaning a small small hump. It is convinced that it should appear somewhere as all immediately begin to examine it and to laugh at it. Therefore leaves the house only in the dark. If there is an emergency to leave in the afternoon, then sticks a nose with a plaster or causes its severe hypostasis, putting on area of a nose bridge of bees. In such look feels more comfortable and can even appear in public places: "Though the nose was also inflated, but all see that it just swelled from a sting of a bee, and uglinesses it is not visible". It is very suppressed, thinks of suicide. Multiply appealed to surgeons-cosmetologists "to clean this disgrace", "to exempt from ugliness". Actually, by definition of cosmetologists, the patient has the very exact beautiful face including a nose).

Crazy syndromes can arise at various mental diseases, separately from each other or at progredient process develop as chronic nonsense step by step: the paranoiac syndrome is transformed in paranoica which in turn in paraphrenic that quite often and happens at paranoica schizophrenia.

The school student of 16 years, before alive and sociable, began to retire even more often. Quite often, especially if believed that nobody watches it, considered the person in a mirror. Often cried. Told relatives that its dejectedness is bound to "awful ugliness of a mandible", "unreasonably big and wide". Asked surgeons to perform on it cosmetic operation, did not react to their assurances in any way that a jaw at it the most routine. In several years "began to notice that between it and people around there is some imaginary communication" that at it "special work of a brain", "ability to transfer of thoughts apart". It "influence from the outside" is capable not only to transfer thoughts, but also to have various other effect, for example, to cause reddening of eyes, their "enlightenment", a lacrimation etc. Besides, this "transfer" it is possible "to direct directly in the head various visions", "it is visible in the head, as in a foggy mirror". By this time almost did not remember a jaw and at this time also did not state crazy ideas of the relation (transformation of a paranoiac syndrome in Kandinsky-Clerambault's *syndrome). Some more years later it was possible to*

observe transformation and Kandinsky-Clerambault's *syndrome: it was gradually replaced by a paraphrenic syndrome. During this period of the patient assured that "it established imaginary connection also with other planets, hears voices and sounds from other planets, from other worlds". Demanded to connect it with scientists-physicists as it "opened the greatest law", "can develop system of improvement of life in all Universe" (fantastic nonsense of greatness).*

Comparative and age features of crazy ideas and persuasive states.

At children in connection with backwardness of the second alarm system crazy ideas arise very seldom. The pathological delusional imagination different from routine children's tendency to imaginations particular absurd, a disconnectedness with a concrete actual situation is more peculiar to them. Imaginations of the healthy child cope (arise, stop) consciousness, delusional imagination arises involuntarily and are uncontrollable. It is possible at them a phenomenon of transformation, a fantastic depersonalization. The child declares (more often at preschool age) that he is «the magic humpbacked horse», lays down on a rug at a bed, asks to give it hay, etc.

The nonsense at children can arise against the dulled consciousness, mainly delirious, and is bound thematically to bright illusions and hallucinations, is unstable, fragmentary, usually disappears with clearing of consciousness.

The nonsense of foreign parents (G. E. Sukharev) when characteristic parents are perceived as foreign people who are not loving the child, weighed it is characteristic of children of younger teenage age, and the real parents or it is unknown where, or actual high-ranking officials. Teenagers can have already quite created crazy system, for example, nonsense of a disfiguration, nonsense of the relation (see a dysmorphic syndrome).

It should be noted the following: in spite of the fact that a number of crazy ideas, for example a persecution complex, can be at any age, there is a particular age preference when influence of an age factor on character and their structure is expressed very considerably.

So, the nonsense of jealousy, love nonsense, a persecution complex in structure of a syndrome of Kandinsky-Clerambault is preferable to average age of human life. At late age it is much easier, than in other, there are a nonsense of self-

accusation, charge, nihilistic nonsense, nonsense of painful immortality, nonsense of death of the world, nonsense of the negative greatness or evil power (as a part of a Cotard delusion), and also nonsense of the material damage that is not peculiar or it is a little peculiar to younger age.

Persuasive states at children before everything are shown in the motive sphere in the form of a suction of a thumb (within the first year of life it is the phenomenon normal), any tics, an onychophagia (fonychos — a nail) – persuasive aspiration to nails biting (it is routine after 5 years), trichotillomanias (Trichos — hair) – persuasive aspiration to pull out hair (sometimes up to education of the considerable bald patchs) with their possible serial swallowing.

At early children's age quite often there are fears, especially darkness and loneliness, at more advanced age – fear of infection with any illness, the fire, these or those animals or insects, fear to lose parents. Such fears quite often arise after the frightened child of an actual event, terrifying stories, viewing of the movie with the corresponding plot. The notions of compulsion (an idearum obtrusiveness) arise usually only from teenage age.

TEST TASKS
(for self-preparation)

Choose one correct answer

1. THE DISTORTED PERCEPTION OF SIZE OR FORM OF OBJECTS AND SPACES

1) illusions

2) metamorphopsias

3) macropsias

4) pseudohallucinations

2. PERCEPTION OF THE ABSENT OBJECTS WITH ALL PROPERTIES OF ACTUAL OBJECTS - PROJECTIONS IN OUT OF, CONFIDENCE IN EXISTENCE OF OBJECTS, ETC.

1) hallucinations

2) illusions

3) dysmegalopsia

4) micropsia

3. PLENTIFUL, PERSISTENT HALLUCINATIONS, ARE MORE OFTEN VERBAL AT CLEAR CONSCIOUSNESS

1) pareidolia illusions

2) hallucinosis

3) paranoica syndrome

4) pseudohallucinations

4. THE PERCEPTION OF OBJECTS, PROCREATION OF IMAGES IS PROPORTIONAL INCREASED IS CALLED

1) illusions

2) hallucinations

3) micropsias

4) macropsias

5. THE DECEPTION OF PERCEPTION WHICH IS NOT IDENTIFIED BY PATIENTS WITH ACTUAL OBJECTS APPEARS IN THE HEAD, IN "THOUGHTS" ("IMAGINARY" OTHERS VOICES). ARE PERCEIVED AS IF BY THE INTERNAL LOOK, ARE FOLLOWED BY FEELING OF PERFECTION, ARE NOT PROJECTED IN OUT OF

1) the true hallucinations

2) pseudohallucinations

3) illusions

4) dysmegalopsias

6. THE MORBID JUDGMENTS UNTRUE AND WHICH ARE NOT GIVING IN TO CORRECTION BY LOGIC AND EXPERIENCE

1) supervaluable ideas

2) nonsense

3) obsessions

4) paralogical ideas

7. RATHER SYSTEMATIZED NONSENSE, MOST OFTEN, PROSECUTIONS ACCOMPANIED BY VERBAL HALLUCINATIONS

1) paranoica syndrome

2) paraphrenic syndrome

3) paranoiac syndrome

4) supervaluable ideas

8. THOUGHTS, INCLINATIONS, FEARS ARISING BESIDES DESIRE WITH THE CRITICAL ATTITUDE TOWARDS THEM

1) supervaluable ideas

2) Kandinsky-Clerambault's syndrome

3) nonsense

4) persuasive states

9. EXPERIENCE OF EXTRENEITY OF CHARACTERISTIC MENTAL PROCESSES, NONSENSE OF INFLUENCE, PSEUDOHALLUCINATION …

1) persuasive states

2) paranoiac syndrome

3) Kandinsky-Clerambault's syndrome

4) metamorphopsias

Lecture No. 3

Affective syndromes. Catatonic syndrome.

Depression as the most common form of violation of mentality. Psychotic and subpsychotic depression. Syndromes of an endogenic, agitated depression. Jet and somatization depressions, their value in all-medical practice. Maniacal syndrome. Apathy and abulia. Catatonic stupor and exaltation. Clinical value of affective and catatonic syndromes.

Emotions are a mental process of subjective reflection of the most common relation of the person to objects and the phenomena of a real, to other people and themselves concerning satisfaction and dissatisfaction of his requirements, the purposes and intentions, expressed in change of parameters of psychological activity and somatic manifestations.

The common favorable assessment of the real situation and the available prospects is expressed in positive emotions — pleasures, pleasures, tranquility, love, comfort. The common perception of a situation as adverse or dangerous is shown by the negative emotions — grieves, melancholy, fear, alarm, hatred, rage, discomfort.

Except the positive and negative emotions reflecting process of satisfaction of requirements mark out emotions sthenic (stimulate activity, increase energy and tension of the person, induce it to acts and statements) and asthenic (cause the under activity, uncertainty, doubts and a divergence).

Emotions are characterized by some dynamic signs. The mood is the long stable emotional state affecting on all mental activity. At the healthy person the mood is quite mobile and depends on a combination of many circumstances — external (good luck or defeat, existence of an absolute obstacle or expectation of result) and internal (a physical illness, natural seasonal fluctuations of activity). Along with stable emotional states short-term rough emotional reactions — the heat of passion take place also.

Affect – the strong, rough, but rather short-term emotional reaction to external incentive which completely takes mentality of the person and predetermines global reaction to a situation. Sometimes the starting incentive and reaction to it are realized insufficiently that is one of the reasons of possible uncontrollability affect. It quickly seizes the person and is followed by loss of self-control, violation of control of actions, and also changes of all activity of an organism.

The anger, rage, horror and other emotional experiences can be forms of manifestation of affect. The postponed affect can be fixed for a long time in consciousness – its traces can be actualized under certain conditions, amplify and be shown by time in sharper form (effects of "accumulation" and «discharge").

Development of affect is characterized by stages. In the beginning the person cannot but think of a subject of the feeling, be distracted by what is bound to it. In the field of perception only those objects which "entered" an affective complex keep. The expressive movements become more and more unaccountable. Tears and sobbings, a laughter and shouts, gestures and poses, nature of respiration and other vegetative reactions create a routine picture of the increasing affect. To restrain, not lose the presence of mind at this stage of people still can (physiological affect), but in the presence of a disease and other weakening factors the affect can develop into pathological.

At development of pathological affect braking covers a cerebral cortex more and more deeply – the consciousness is sharply narrowed, accrue disorganization of thinking, and the person loses control over himself, making automatic, unaccountable, senseless, quite often destructive actions. After affective flash there come weakness, a breakdown, an immovability. The pathological affect usually comes to the end with a dream with the subsequent amnesia (partial or the completely) perfect. In some cases the pathological affect is preceded by the long-lived psychotraumatic situation and the pathological affect arises as reaction to some "last straw».

The exact diagnostics of pathological affect is of great importance in judicial psychiatry since the persons who made illegal actions in such state admit deranged.

Symptoms of emotional violations.

Emotional reactions can be inadequate on force and degree of expressiveness, duration and a significance of the situation which caused them.

Explosiveness — the increased emotional excitability, tendency to rough manifestations of affect, reaction, inadequate on force. Reaction of anger with aggression can arise in a slight occasion.

Emotional jamming — a state at which the arisen affective reaction is fixed on the long time and affects on thoughts and behavior. The endured offense "gets stuck" for a long time at the vindictive person. The person who acquired particular dogmas, emotionally for him significant cannot accept new installations, despite the changed situation.

Ambivalence – emergence of at the same time counter feelings in relation to the same person.

Feeling of loss of feelings — loss of ability to react to the taking place events, painful loss of consciousness, for example at psychogenic "emotional paralysis" or an endogenic anesthetic depression (anesthesia of feelings).

Symptoms of frustration of mood.

Frustration of mood are characterized by two options: symptoms with strengthening and easing of emotionality. The hyperthymia, euphoria, an oligothymia, a dysphoria, alarm, emotional weakness belong to frustration with strengthening of emotionality.

Hyperthymia — the increased cheerful, joyful mood which is followed by cheerfulness inflow, good, even fine physical health, ease in the solution of all questions, revaluation of characteristic opportunities.

Euphoria — complacent, careless, carefree mood, experience of the complete satisfaction with the state, a poor assessment of the taking place events.

The term ***Moria*** designate foolish careless babbling, laughter, barren exaltation at deeply half-witted patients.

Oligothymia — the reduced mood, experience of depression, melancholy, a hopelessness. The attention is fixed only on the negative events, real, the past and the future are perceived in gloomy tones.

Dysphoria - spiteful and sad mood with experience of discontent with and people around. Often is followed by the expressed affective reactions of irascibility, rage with aggression, despair with suicide tendencies.

Anxiety — experience of internal concern, expectation of trouble, trouble, accident. The feeling of alarm can be followed by motive concern, vegetative reactions. The alarm can develop into panic at which patients rush about, cannot find any peace or stiffen in horror, expecting accident.

Emotional weakness — lability, instability of mood, its change under the influence of slight events. Patients can easily have conditions of affection, sentimentality with the advent of tearfulness (faintheartedness). For example, at the sight of the walking pioneers of people cannot hold tears of emotion.

Morbid mental loss of consciousness (anesthesia psychica dolorosa). Patients painfully endure loss of all human feelings — love to relatives, compassion, a grief, melancholy. They say that they steel "as tree, as stone", suffer from it, assure that the melancholy is easier as in it human experiences.

All listed symptoms demonstrate strengthening of an emotional state irrespective of what these emotions — positive or the negative.

Such states as apathy, emotional monotony, emotional roughening, emotional dullness belong to violations of mood with decrease in emotionality.

Apathy (apatia — insensibility; synonyms: an agrypnocoma, morbid apathy) — the frustration of the emotional and strong-willed sphere which is shown apathy to itself, environmental persons and events, absence of desires, motives and the complete divergence. Patients in such state do not show any interests, do not state any desires, are not interested in people around, often do not know how call neighbors in chamber, the attending physician — not because of memory violations, and because of apathy. On appointments to relatives, silently take away gifts and leave.

Emotional monotony — emotional coldness. At the patient the smooth, cold relation to all events irrespective of their emotional significance is observed,

Emotional roughening – is shown in loss of the most thin differentiated emotional reactions: sensitivity, empathy disappears, the disinhibition, importunity,

impudence appears. Such states can be observed at an alcoholism, at atherosclerotic changes of the person.

Violations of mood and emotional reaction can be followed by changes of a mimicry and expressive movements which can be inadequate on force and expressiveness to an emotional state or not to correspond to the experienced emotions.

Hypermimia — the frustration which is followed by the alive, quickly changing mimicry reflecting a picture of quickly appearing and disappearing affects. Manifestation of mimic reactions is often exaggerated, excessively violently and brightly. Expressive actions are strengthened, accelerated, quickly change, reaching in some cases maniacal exaltation.

Amimia, hypomimiya — easing, impoverishment of a mimicry, the monotonous stiffened mimicry of a grief, despair, the characteristic of depressions. On a face the stiffened mournful expression, lips densely are oblate, corners of a mouth are lowered, eyebrows are shifted, between them folds lie. Veragut's fold is characteristic: the skin fold of an upper eyelid on border of an internal third is delayed up and back in this connection, the superciliary arch turns in this place into a corner.

The expressive movements are weakened, slowed down, greased. Sometimes a physical activity is completely lost, patients become immobilized, but the mimicry remains mournful. It is a picture of a depressive stupor.

Paramimia — an inaaccurance of a mimicry and expressive actions of a situation. In one cases it is expressed in emergence of a smile on a funeral, tears and grimaces, crying at solemn and pleasant events. In other cases mimic reactions do not correspond to any experiences - it is various grimaces. For example, the patient narrows eyes and opens a mouth, wrinkles a forehead, inflates cheeks etc.

Syndromes of emotional frustration.

The states which are shown first of all frustration of mood belong to affective syndromes. Depressive and maniacal syndromes act as the brightest manifestations of frustration of the affective sphere.

Depression syndrome. The typical depression is characterized by a classical triad of symptoms: decrease in mood (oligothymia), delays of thinking (associative retardation) and motive retardation. It is necessary to consider, however, that decrease in mood is the main symptom of a depression. The oligothymia can be expressed in complaints to melancholy, depression, grief. Unlike natural reaction of grief in response to a sad event, the melancholy at a depression loses communication with an environmental situation; patients do not show reaction neither to joyful news, nor to new strokes of bad luck. Depending on weight of a depression the oligothymia can be shown by feelings of various intensity - from mild pessimism and grief to heavy, almost physical feeling – vital melancholy ("weight" behind a breast, pain).

Delay of thinking in mild cases is expressed by the delayed terse speech, long considering of the answer. In more hard cases patients hardly comprehend the asked question, are not capable to cope with the solution of the elementary logical tasks. Are silent, the spontaneous speech extremely poor, up to the complete mutism (silence). Motive retardation is shown in a restraint, sluggishness, slowness, at a heavy depression can reach stupor degree (a depressive stupor). Pose of struporous patients the quite reference: lying on a spin with outstretched arms and legs or sitting, having hung the head, leaning elbows on knees. On feature of a mental motility of patients it is possible to diagnose a depression almost unmistakably: the mimicry is sad, mournful, with the lowered mouth corners which are hanging down (atonic) cheeks, the mournful fold between the eyebrows, dim eyes hunched by a pose, the look avoiding the interlocutor directed most often down.

Statements of depressive patients find sharply underestimated self-rating untrue (nonsense of self-abasement): they declare themselves as about insignificant, "worthless" people who "in burden" to relatives and relatives. Not only the real state, but also the past and the future are pessimistically estimated. Report that "nothing could be done" to make in this life that they "brought many troubles" to the family, "were not pleasure for parents". They build the most sad forecasts; as a rule, do not trust in a possibility of convalescence. At a heavy depression crazy ideas of self-accusation are frequent: patients consider themselves deeply "guilty" before God, "guilty" in death of aged parents, bringing only misfortunes to the relatives.

Suppression of inclinations is, as a rule, expressed by a closure, loss of appetite to its total absence – anorexia which brings in hard cases to the expressed loss of physical weight, to exhaustion (is more rare bulimia attacks – a gluttony), the considerable obtusion or even lack of a libido that is followed by distinct changes of physiological functions: at men impotence, at women – frigidity with violations of a menstrual cycle and even the long-lived amenorrhea. Patients avoid any communication, among people feel awkwardly, is inappropriate, foreign laughter only emphasizes their sufferings. Patients are so shipped in the experiences that not in forces occupations by a household stop caring for someone another and taking into account psychomotor retardation, to look after juvenile children, do not pay any attention to the appearance, do not cope with favorite work, is not able to get up, gather and go in the morning for work, days carry out to beds without dream. Entertainments are inaccessible to patients, they do not read and do not watch TV. Attempts of people around to entertain them, to occupy them with any activity lead only to padding sufferings of patients.

One of the most burdensome experiences at a depression is obstinate sleeplessness. Patients badly sleep at night or cannot fall asleep in general (insomnia), not to mention day rest. Awakening early morning clocks (sometimes at 3 or 4 h) is especially characteristic after which patients do not fall asleep any more. Sometimes patients persistently claim that they did not sleep at night minutes, never closed eyes though relatives and medical personnel saw them sleeping (absence of feeling of a dream).

The greatest danger at a depression is constituted by emergence of thoughts of suicide (suicide), as about the "single" and "best" escaping of the created situation. Among alienations the depression is the most frequent reason of suicides. Though thoughts of death are inherent practically in all having a depression, actual danger arises at a combination of a heavy depression to an opportunity to some activity of patients. At the expressed stupor realization of similar intentions is complicated. Cases of an expanded suicide when the person kills the children are described that "to relieve them of the future torments". At steady aspiration to a suicide of the patient shows a sufficient ingenuity: secretly prepare for suicide attempt, chooses the place

and time of commission of this act that it could not be prevented (unlike a blackmailing-demonstrative suicide), save drugs with which want to poison themselves, dissimulating the state, sometimes suicides are made suddenly, in cases of "explosion" of melancholy, despair.

The depression, as a rule, is followed by a diverse somatic and vegetative symptomatology. As reflection of sharpness of a state is more often observed a peripheral sympathenic. Appearance of patients attracts attention. Integuments are dry, pale, shelled. Decrease in secretory function of glands is expressed in lack of tears ("cried the eyes out"). Quite often note a hair loss and fragility of nails. Decrease in a turgor of skin is shown that wrinkles go deep and patients look is more senior than the age. The atypical break of an eyebrow can be observed. Fluctuations of arterial pressure with tendency to increase are registered. Disorders of a digestive tract are shown not only a lock, but also deterioration in digestion because of anorexia. As a rule, body weight considerably decreases. Various pains are frequent (head, cardiac, in a stomach, in joints).

In most cases the depression proceeds several months. However it is always reversible. Before introduction to medical practice of antidepressants and electroconvulsive therapy doctors quite often observed spontaneous escaping of this state.

The depressive syndrome is not specific and can be display of the most various mental diseases: psychogenias (situational depression), maniac-depressive psychosis, schizophrenia (endogenic depression), organic damages of a brain (exogenetic and organic depression).

Situational (psychogenic) depressions differ in the fact that their emergence coincides with a mental trauma; the stressful experiences are reflected in a clinical picture of a depression, after permission of the stressful situation the depressive symptomatology becomes less expressed and after some time the situational depression disappears. The current of a situational depression depends both on the maintenance of a mental trauma, and on features of the person of the patient and his state by the time of emergence of an alienation. Situational depressions at the persons who had a craniocerebral trauma or weakened by serious somatic and infectious

diseases, and also elderly people with a cerebral atherosclerosis can drag on. The situational depressions connected with heavy, not resolved psychoinjuring situation happen the long-lived also.

The endogenic depression develops autochthonous, is caused by an endogenic disease (maniac-depressive psychosis and schizophrenia). Its weight, duration and existence of psychotic inclusions are not bound to biotic circumstances. The first in life episode of an endogenic depression can be reactively provoked, however fast loss of interrelation of experiences with actual circumstances is characteristic of its current. An important symptom of an endogenic depression is special daily dynamics of a state with strengthening of melancholy in the morning and some weakening of experiences by the evening. Morning clocks are considered as the period, the bound to the greatest risk of a suicide. The vital melancholy, i.e. experience of the deep, precordial melancholy which is combined with suppression of biotic instincts, the phenomena of morbid mental anesthesia (anesthesia psychica dolorosa) is characteristic: patients extremely suffer from loss of positive feelings to the family (anestetic option of a depression).

There are depressive phenomena of a derealization (environmental became dim, gray, deprived of the actual paints) and depersonalizations (patients speak about the change, mainly, in the sphere of feelings – became insensible, "wooden", «empty".

Unlike a situational depression existence of a somatic symptom-complex is more characteristic of it. The reference triad of symptoms is described: tachycardia, mydriasis and lock (Protopopov's triad).

Expressiveness of an endogenic depression can be mild, moderate and heavy.

When developing a depression of mild degree of expressiveness (a subdepression, a subpsychotic depression) the mood decreases, depression is noted, patients note that they lost ability to rejoice. There is no expressed delay of thinking, but patients clearly feel fatigue, difficulty of attention and other intellectual processes. They do not state ideas of self-accusation, but the environmental and characteristic future is represented gloomy. Distinct motive retardation is absent, however patients point to lack of motives to activity. They do not make plans for the

future. In some cases patients point not to melancholy, and to constant feeling of alarm and confusion, to "absence of mood».

It is necessary to pay special attention that the depression quite often is for the first time shown not by mental changes, but vegetative and neurologic frustration. Decrease in mood, loss of ability to rejoice, alarm come to light only at detailed research of patients. Such forms of depressions carry the name **masked**, or the **somatization**.

The masked depression (latent, somatization) – a kind of an endogenic depression at which the oligothymia masks the somato-vegetative frustration prevailing in a clinical picture, and also psychopathological signs of other, not depressive register (obtrusiveness). Patients at the same time feel various senestopathetic feelings — in a stomach, intestines, heart, a backbone. They are hypochondriacal — listen to the feelings, suspect at themselves a heavy somatopathy and explain these decline of mood. Among rather continuous somato-vegetative frustration: appetite loss, a sluggish lose of weight, the long-lived locks, women have the irregular and low-expressed menses; men have an easing or loss of a potentiality. Complaints to a short and not grateful sleep usually join it.

At the masked depressions patients sometimes for the purpose of facilitation of a state resort to alcohol, drugs or accept sedatives in great manies.

Actually affective depressive symptoms at the same time are overshadowed that creates the considerable difficulties in diagnostics as patients can not notice or even to deny existence of melancholy. Though usually patients answer a direct question of existence of melancholy and/or depression of mood negatively, however at directional inquiry it is possible to reveal inability to test pleasure, aspiration to avoid communication, sense of hopelessness, despondency the fact that routine household chores and favorite work began to weigh the patient. The aggravation of symptoms is quite characteristic in the morning. Reference somatic "stigmata" — dryness in a mouth, expansion of pupils are quite often noted. An important symptom of the masked depression — a gap between abundance of burdensome feelings and scarcity of objective data.

Patients with the masked depression as any other category of the insane, often fall into hands of experts not on a profile. They are treated at the neuropathologist, the psychotherapist, the physiotherapist, the sanatorium doctor even of the psychic. At the same time time is wasted, and weight of a depression is aggravated.

Always when subjective complaints of patients of somatic clinics are surpassed considerably by objective indexes or the last in general are absent, it is necessary to suspect a depression.

Symptoms which indicate endogenic character of the depression (which is not caused by overwork, somatic suffering or a psychotrauma):

1. Morning nature of frustration: falling of mood and somatic indispositions are felt most in the morning.
2. Feeling of localization of melancholy or alarm in a body.
3. Loss of appetite and falling of body weight.
4. Frequent locks.
5. Increase of arterial pressure.

At an endogenic depression with **moderate manifestations** the majority of the main symptoms are presented. Patients feel the melancholy which is usually localized in a breast. Very often the melancholy is followed by alarm or apathy. The morning accent of frustration is expressed. Are noted noticeable motive and speech retardation. Ideas of self-accusation express, patients supply about themselves with the insecure information. Periodically they have suicidal thoughts and even ways of suicide are thought over, but business does not reach suicidal actions. Sometimes thoughts of suicide have persuasive character, and patients try to overcome them and, as a rule, unsuccessfully.

The endogenic depression of **heavy degree** is characterized by the developed symptomatology with the reference triad in cases of its sad option: idearum and speech retardation reaches almost total absence of associations and a mutism, psychomotor - a substupor and a stupor; deeply vital feelings with development of an insomnia and anorexia suffer. However, at a dominance of alarming affect over sad, retardation is not noted, and patients continuously rush about on office (agitation). Requests express to kill them, not to torment. Clearly morning nature of frustration is

expressed, patients distinctly point to localization of affective frustration in a body ("the soul aches", "the soul is torn"). Ideas of self-accusation express — patients in despair speak about themselves as about responsible for death of a family, about the hardest offenses at work, ask them not to treat any more as they do not deserve that. This option of a depression carries the name an *alarming (agitated) depression.*

The apathetic depression combines affects of melancholy and apathy. Patients are not interested in their future, they are inactive, do not state any complaints. Their single desire — that they were left alone. Such state differs from an apathetic-abulia syndrome in instability, a reversibility. Most often the apathetic depression is observed at having schizophrenia.

It is important to consider the reference dynamics of endogenic depressive attacks, tendency to a fixing current and unexpected, as if to causeless permission. It is interesting that accession of an infection with high temperature of a body (flu, tonsillitis) can be followed by mitigation of feeling of melancholy or even to tear off a depression attack. In the anamnesis the periods of causeless "melancholy" which were followed by unlimited smoking, an alcoholization and passing without treatment quite often are found in similar patients.

At differential diagnostics it is not necessary to neglect data of objective inspection as simultaneous existence and somatic and an alienation is not excluded (in particular, the depression happens early display of malignant tumors).

The maniacal syndrome is shown by a classical triad of symptoms, opposite to depressive: increase of mood (hyperthymia), acceleration of thinking and psychomotor exaltation. The hyperthymia at this state is expressed by constant optimism, neglect to difficulties. Existence of any problems is denied. Patients constantly smile, do not show any complaints, do not consider themselves as patients. Acceleration of thinking is noticeable in the fast, jumping speech, the raised otvlekayemost, superficiality of associations. At the expressed mania the speech so will be disorganized that reminds "verbal hodgepodge". The speech pressure is so big that patients lose a voice, in corners of a mouth the saliva which is shaken up in foam accumulates. Their activity because of the expressed distractibility becomes inconsistent a little – or even barren. However in the majority, patients try to motivate

it. They cannot sit still, seek to leave from the house, referring to any urgent affairs, with the same motives, ask to release them from hospital.

Revaluation of characteristic abilities is observed. Patients consider themselves very charming and attractive, continuously try to convince people around of the talents which are allegedly existing at them. Begin to compose verses, show to people around the vocal skills. Nevertheless, the expressed nonsense of greatness at patients is not observed.

Increase of all basic inclinations is characteristic. Sharply appetite increases, tendency to an alcoholization is sometimes observed. Patients cannot be in loneliness and constantly look for communication. In conversation with doctors often do not keep a necessary distance, address on "you". Some patients try to decorate themselves with badges and medals, women use exuberantly bright cosmetics, clothes, try to emphasize the sexuality. Keen interest in an opposite sex is expressed in the impetuous compliments, immodest offers, declarations of love having the extremely surface character. Patients are ready to help and patronize all people around. At the same time quite often it turns out that for characteristic family there is just not enough time. They squander money, do unnecessary purchases. At excessive activity it is not possible to finish any of affairs as every time there are new ideas. Attempts to interfere with realization of their inclinations arouse reaction of irritation, indignation.

Sharp decrease of duration of a night dream is characteristic of a maniacal syndrome. Patients refuse to go to bed in time, continuing to fuss and at night. Wake up very much early in the morning and at once join in the vigorous activity, however never complain of a fatigue, claim that sleep quite enough. Such patients usually cause environmental a set of inconveniences, do harm to the financial and social status, however for life and health of other people, as a rule, do not represent immediate threat. In the physical relation, suffering from mania, look quite healthy, a little looked younger.

The maniacal syndrome most often happens display of maniac-depressive psychosis and schizophrenia (endogenic mania). Occasionally the maniacal states caused by organic damage of a brain or intoxication meet (Phenaminum, Cocainum,

Cimetidinum, corticosteroids, cyclosporine, Teturamum, hallucinogens, etc.). The mania is a symptom of acute psychosis. Existence of a bright productive symptomatology allows to count on the complete reduction of morbid frustration. Though separate attacks can be rather long (about several months), all of them are often shorter than depression attacks.

In clinical practice endogenic maniacal episodes of various expressiveness — mild, by average and heavy are observed. At the same time weight of a state can increase gradually, but quite often maniacal episode can be limited to manifestations of **mild degree**, a so-called **hypomaniacal state.**

At the same time the raising of mood seen outwardly and endured subjectively, feeling of the complete wellbeing, feeling of increase of intellectual and physical serviceability is noted. At the same time the true strengthening of efficiency in work does not arise as patients to themselves are noncritical, do not correct errors and inaccuracies. Any remarks, any unpleasant events is not able to change optimistic mood, they can cause only short-term irritable and irascible reaction. Patients are talkative, mobile, in conversation are quite often familiar. At a little increased appetite nevertheless slightly lose a flesh. They sleep a little (several clocks to them enough), wake up with the same feeling of the complete wellbeing; in general euphoria is most expressed in the morning. At patients sexual activity increases, there can be casual sexual communications, virginity loss that is remembered then with shame, sometimes with despair.

At the maniacal episode of **moderate degree of expressiveness** arising after mild manifestations, the mood is characterized as impetuous fun. Patients continuously speak, jumping from one thought on another, are importunate, persuasive, irritate other patients, sometimes cause illegal irritation and in personnel. Patients are in a condition of psychomotor exaltation, continuously move, approach one, other patient, one, other nurse, interfere with their work. Any productive work at patients at the same time is impossible though they undertake one, another matter. If do not come to them into contact or do them remarks, show irritability, irascibility which are quickly enough leveled. Patients are boastful, remember the real and

imaginary merits, speak about the special and big role in something (a becoming of plant, branch, in literature, painting etc.).

Patients in a maniacal episode of moderate degree sleep very short time too or do not sleep at all. Appetite is increased, they eat often, gradually, hurriedly and considerably grow thin. The reinforced alcoholization, a drug taking, random sexual communications is possible, the risk of infection with venereal diseases and AIDS increases.

At maniacal episodes with **heavy manifestations** acceleration of thinking and psychomotor exaltation reach, extreme degrees. Patients speak continuously, a voice their hoarse, they do not finish phrases and cry out on several words, passing to absolutely other thought. Such state carries the name "gallop of ideas". Patients continuously in driving, in everything interfere, try to give advice, without managing to state until the end of them, often sing, dance.

Though appetite at patients is also increased, they because of continuous exaltation significantly lose a flesh. They do not sleep at all. Euphoria can quickly turn into irascibility when patients are extremely inclined to aggression.

At maniacal episodes with heavy psychotic manifestations to patients the emergency aid has to be carried out. As well as at depressions, there is a division of maniacal syndromes on prime and atypical syndromes of the complex structure.

Selection of separate options of prime maniacal states is bound or to a dominance in structure of a syndrome of one of components of a maniacal triad, or emergence of the frustration altering character of a maniacal syndrome. If in a picture of mania cheerfulness prevails, and acceleration of thinking and aspiration to activity are expressed unsharply, then in these cases tell about *cheerful mania*. The "cheerful" mania is typical manifestation of the developed maniacal syndrome of average degree of expressiveness. "The inhibited mania" arises at schizophrenia with apathetic-abulia manifestations or the mixed maniac-depressive syndrome with motive retardation.

If acceleration of associative process at patients reaches degree of "a gallop of ideas" - the expressed inconsistency sometimes with the finished short phrases, and aspiration to activity — random, chaotic exaltation, then speak about the *mania confused*.

Dominance in a picture of mania of irritability, irascibility, fault-finding with sarcasm, irony, charges of people around of their any insolvency demonstrates *irascible mania*. At height of this state there can be an exaltation maliciously, rage, destructive tendencies, aggression — *maniacal violence*.

The apathetic-abulia syndrome is shown by the expressed emotional and strong-willed impoverishment. The indifference and apathy do patients rather quiet. They are hardly noticeable in office, spend in a bed much time or sitting alone, can be also for clocks at the TV. At the same time it turns out that they did not remember any seen transfer. Laziness appears in all their behavior: they do not wash, do not brush teeth, refuse to go to douche and to cut hair. Go to bed dressed because they are absolutely indifferent to everything including to the state. At such patients motives to any self-contained activity are extremely reduced; in performance even of prime actions they need continuous motivation. They cannot be made to activity, calling responsible and to call of duty because they are not ashamed. Conversation does not cause in patients of interest. They speak monotonically, often refuse conversation, declaring that were tired. If the doctor manages to insist on need of dialogue, quite often it turns out that the patient can talk for a long time, without showing fatigue signs. In conversation it becomes clear that patients do not suffer from any anguish, do not feel like patients, do not show any complaints.

The described symptomatology quite often is combined with a disinhibition of the elementary inclinations (gluttony, hyper sexuality, etc.). At the same time lack of bashfulness in hard cases leads them to attempts to realize the needs for the elementary, socially unacceptable form: for example, they can directly urinate and defecate in a bed.

The apathetic-abulia syndrome serves as manifestation of a **negative (deficiental) symptomatology** and does not tend to an involution. Most often the reason of apathy and an abulia are terminating states at schizophrenia at which emotional and strong-willed defect increases gradually — from mild indifference and passivity to conditions of emotional dullness. Other reason of emergence of an apathetic-abulia syndrome — organic defeat the convex departments of frontal lobes of a brain (a trauma, a tumor, an atrophy, etc.).

Catatonic and hebephrenic syndromes.

At the healthy person of driving immediately express internal experiences and are inseparable from emotions, will and inclinations. However at separate mental diseases (first of all at a catatonic syndrome) it is possible to observe states at which the motive sphere receives some autonomy, concrete motor acts lose touch with internal mental processes, cease to be controlled by will. In this case separate motive frustration gain some looking alike a neurologic symptomatology. It is necessary to recognize that similarity it only external as unlike hyperkinesias, a paresis, violations of coordination of movements at neurologic diseases motive frustration in psychiatry are deprived of an organic basis, are functional and reversible. As a rule, neurologic patients can estimate crucially the hyperkinesias and tics as display of an illness which are available for them. Suffering from a catatonic syndrome cannot explain somehow psychologically made movements, do not realize their morbid character up to the moment of knocking over of psychosis.

The catatonic syndrome originally was described by the French psychiatrist K.L. Kalbaum (1863). A catatonic syndrome – a state in which violations in the motive sphere prevail: retardation (stupor) or exaltation.

The catatonic stupor is shown обездвиженностью, increase of a muscle tone. A face of the patient hypomimia, usually contact with it is sharply complicated, often completely there is no speech (*mutism*). Sometimes the patient does not react to the questions asked by a loud voice, but responds to the whisper speech (*Pavlov's symptom*). *The negativism* which is shared on passive, expressed refusal to carry out instructions is often observed, and the fissile when the patient resists requirements of the doctor or even makes actions, opposite to those which expect from it (for example, in attempt to transfer the patient to other place it not only does not move a leg – passive negativism – and draws in them or in case of a substupor begin to eat only when the hospital attendant tries to take away from it a plate). Quite often the stupor is accompanied by a disinhibition of ancient reflexes — prehension, sucking. Along with negativism *automatic obedience* can be observed. This symptom is expressed that the patient literally fulfills all requirements, sometimes unpleasant for

it. In this case, if the interlocutor definitely does not specify what the patient has to make, he will be in the complete inaction, will not receive concrete instructions yet.

The symptom of an air (mental) pillow — the patient's head some time, sometimes long is sometimes observed, remains raised over a pillow.

Options of a stupor can develop at the same patient step by step, in that sequence as it is described below.

Stupor with the phenomena of wax-like flexibility (catalepsy). A condition of an akinesia at which any change of a pose of the patient remains more or less long time. The phenomena of wax-like flexibility arise at first in masseters, then is serial in muscles of a neck, top and bottom extremities, this symptom upside-down disappears.

Negativistic stupor - the complete akinesia of the patient, and any attempt to change a pose causes the sharp tension of muscles with counteraction.

The stupor with a consternation — the sharpest muscle tension at which patients constantly stay in the same pose, a thicket of so-called fetal is quite often observed a snout reflex: the lips extended forward at densely oblate jaws.

Catatonic exaltation is shown by concern of patients, the movements have them unmotivated extramental character, often they observe a stereotypy – senseless repetition of the same actions, the same phrases. The symptom of violation of thinking – disruptiveness is characteristic - at preservation of the exact grammatical structure of the speech semantic, logical communication between separate concepts of the statement and offers disappears. The speech of patients represents separate offers, are grammatical correctly constructed, but in the semantic relation they are unclear. At the same time the consciousness of patients is not broken.

The absurd, pretentiousness, airs and graces in behavior of patients are very characteristic. They do grimaces, accept unexpected plastic poses. Unlike maniacal (psychomotor exaltation), commission meaningless, with absence of motive and the perspective purpose which are not reflecting internal requirements and experiences of the subject *(motor exaltation)* is characteristic of catatonic exaltation.

One of the reference symptoms of catatonic exaltation – repetition of actions (echopraxia), speeches (echolalia), echomimia (copying of a mimicry) of people

around. *Motional and speech stereotypies* are often observed (rocking, jumping and an elaborate swinging hands during walking, howl, laughter).

The verbigerations which are shown rhythmic repetition of monotonous words and senseless sound combinations are an example of speech stereotypies. Commission of *impulsive (unmotivated) actions* is characteristic: patients can suddenly attack on people around, make unclear jogs, break glass in a window. Though similar actions constitute sometimes serious danger to people around, they as well as other acts of patients, are not connected with their psychological attitude towards object of aggression in any way, are automated and unpredictable.

In other cases exaltation has *ecstatic character (in embarrassment - pathetic)*. Patients accept theatrical poses, sing, recite verses, on a face expression of delight, mystical feeling, ecstasy prevails. The speech is elaborate, inconsistent. These features are defined by a condition of elation which is tested by patients. They do not count on an outer effect, on engaging to themselves attention as patients with hysteria with display behavior. Exaltation can be interrupted by episodes of a stupor or a substupor.

Sometimes the confused and pathetic option of catatonic exaltation gains character of *hebephrenic* - silliness, grimacing, a ridiculous, senseless laughter. Patients jump, wriggle, is inappropriate, plainly joke (clownism).

At further increase of exaltation it becomes impulsive – patients make unexpected acts, are aggressive, suddenly jump, somewhere run, seek to strike people around, fall into violent rage, become bare, jump, shout, attack personnel, for a while stiffen and again become exited. In the speech stereotypic repetition of words — heard (echolalia) or spontaneously said (verbigeration) prevails.

Mute (silent) exaltation — senseless, not targeted exaltation with aggression, furious resistance, drawing to and people around of heavy damages.

The listed symptoms can meet in the most unexpected combinations. An internal inconsistency of a symptomatology is typical. K. Jaspers characterized feature of a catatonia as a set of contrasts — "exaltations and immovabilities... contrast of unlimited counteraction and unlimited humility, the complete negativism and automatic obedience».

Patients in a catatonic state need careful leaving. Sometimes they do not even get up to go to a toilet. The immovability can lead to formation of decubituses. As patients in a stupor do not react to cold, do not feel pain, do not escape at danger, their life wholly depends on people around. The greatest problem is refusal of meal. Before it was necessary to feed patients through a nasogastral tube. In recent years serious catatonic conditions meet more and more seldom. Besides, introduction to practice of new psychotropic drugs allowed to overcome refusal of food in the first days of treatment.

Most often a catatonic syndrome — display of schizophrenia. However it can develop also at somatopathies, heavy with the expressed intoxication, or in cases of organic damage of a brain (especially many such cases are described in connection with an epidemic encephalitis of Ekonomo).

It is accepted to allocate ***the delirium catatonia*** proceeding against clear consciousness and shown, as a rule, a stupor with negativism and catalepsy and **a** ***oneiric catatonia*** - ecstatic, impulsive and hebephrenic exaltation, and also a stupor with the phenomena of wax flexibility and substruporous states at a oneiric stupefaction and partial amnesia.

At external similarity of a set of symptoms these two states considerably differ on a current. A oneiric catatonia — sharp psychosis with dynamic development and the favorable outcome. The delirium catatonia, on the contrary, is a sign of the proceeding malignant options of schizophrenia without remission.

The hebephrenic syndrome has essential looking alike a catatonia. A dominance of motive frustration with a lack of motivation, senselessness of acts is also characteristic of a hebephrenia. However at suffering from a hebephrenia the stupor is not observed, and ridiculous foolish exaltation, unmotivated cheerfulness, grimacing prevail. The name of a syndrome indicates infantile nature of behavior of patients: they often look younger than the age, cannot sit minutes without driving, ask the mass of unnecessary questions, do not listen to answers of the interlocutor, sometimes behave provocatively, say curses. The negativism is shown that remarks of people around force them to work even more not tolerably. The smile of patients never causes sympathy because does not express the true feeling. Patients do not

endure actually pleasure, it is necessary to call their state apathy more precisely: they are indifferent to relatives, to the appearance, are shameless, activity does not lead them to any result. As well as the delirium catatonia, a hebephrenic syndrome serves as manifestation of the most malignant options of schizophrenia.

TEST TASKS
(for self-preparation)

Choose one correct answer

1. AIMLESS EXALTATION WITH THE STEREOTYPIC MOVEMENTS AND PRETENTIOUSNESS, THE DISINTEGRATION OF THOUGHT AT CLEAR CONSCIOUSNESS

1) maniacal exaltation
2) dysphoria
3) catatonic exaltation
4) negativism

2. SAD AND SPITEFUL MOOD WITH IRRITABILITY, BENT TO AGGRESSION

1) apathy
2) depression
3) anxiety
4) dysphoria

3. THE LONG-LIVED PRESERVATION OF THE POSITION OF EXTREMITIES OF THE POSE GIVEN TO THE PATIENT

1) catalepsy
2) symptom of "airbag"
3) negativism
4) pseudohallucinations

4. ABSENCE OF ASPIRATIONS, INITIATIVES, STRONG-WILLED MOTIVES

1) apathy

2) abulia

3) depression

4) hebephrenia

5. THE IMMOVABILITY, LACK OF THE SPEECH AT CLEAR CONSCIOUSNESS

1) stupor

2) sopor

3) catalepsy

4) depression

6. LACK OF EMOTIONAL MANIFESTATIONS, APATHY. INDIFFERENCE TO AND PEOPLE AROUND

1) apathy

2) abulia

3) emotional paradoxicality

4) dysphoria

7. REFUSAL, RESISTANCE, COUNTERACTION TO REQUIREMENTS OR REQUESTS OF OTHER PERSON

1) anxiety

2) abulia

3) negativism

4) supervaluable ideas

8. THE SAD MOOD, RETARDATION OF MOVEMENTS, THINKING, THE SPEECH, IS FREQUENT – IDEAS OF SELF-ACCUSATION

1) apathetic-abulia syndrome

2) maniacal syndrome

3) depressive syndrome

4) persuasive states

9. FOOLISH BEHAVIOUR WITH THE APING, GRIMACES, UNMOTIVATED LAUGHTER, THE ELABORATE MOVEMENTS

1) catatonic stupor

2) depressive syndrome

3) hebephrenia

4) apathy

Lecture No. 4

Violations of memory and thinking. Dementia, oligophrenia.

Knowledge steps. Memory, judgment, criticism in cerebration. Value of other parties of mentality - will, emotions, the person in general for thinking and its level. A dementia as manifestation of a destruction of the device of thinking - a cerebral cortex. The congenital and acquired weak-mindedness. Globarny and lacunar dementias. Distinction between intelligence and a current of thoughts. Accelerated, slowed down, patholologically - the detailed, broken-off, incoherent thinking, syndromes and diseases at which they happen.

Process of knowledge is subdivided into several steps (levels). The first stage of sensory perception includes feelings, perceptions and representations, a second stage of rational knowledge – concept, judgment, conclusion. The rational step of knowledge is directly bound to cerebration.

Memory – such type of mental activity by means of which last experience is reflected.

Memory ("entrance gate of intelligence") is the necessary tool for more composite type of mental activity – thinking. Distinguish short-term (deduction of material during the short period of time) and long-term (preservation of material on more long term is characteristic) memory. On the mechanism of reminder mark out mechanical (learning without judgment of material) and semantic (associative – material reminder, thanks to assimilation of logical communications in contents) memory. Besides, memory is subdivided on a modality on visual, verbal, etc.

Memory consists of the following principal components: reception (fixing) — perception and reminder new for a short time (till 1 hour); a retention — ability to hold this new information for the long-lived period of time; a reproduction — ability to reproduce the obtained information.

Intelligence — rather steady structure of mental capacities of the individual (ability to rational knowledge, thinking, memory, strong-willed qualities, attention, orientation, critical abilities) which allows to adapt in a new situation.

Memory violations.

Hypomnesia – decrease in one of memory functions (weakening of reminder of the present or procreation of last events) which can arise as at defeat of primary mechanisms of memory, and indirectly, for example, at the expressed frustration of attention (arbitrariest).

Amnesia.

Amnesia (a — the particle meaning refusaling, + mnesie — memory, reminiscence) — memory loss, absence it; always arises as a result of organic damage of a brain (primary mechanisms of memory).

Fixating amnesia — loss of ability to remember, fix current events; everything that took at present place, right there is forgotten by the patient.

Ecmnesia — loss of memory on the events which took place immediately after the beginning of disease process. Duration in time can also be various.

Retrograde amnesia — loss of memory on the events preceding the beginning of a disease state. Can cover various interval of time. Quite often also the combination of these two types of amnesia meets, in that case speak about a retroecmnesia.

The progressing amnesia is characterized by gradual loss of stocks of memory, and first of all memory on recent events disappears, on events of the last years while the remote past of the patient remembers rather well, and then more remote events drop out of memory also. Such sequence of a dysmnesia (inverse to the experience accumulation course) was described by the French psychologist Ribot and defined as "Ribot's law". At the progressing amnesia function of a retention mainly suffers.

Paramnesias.

Paramnesia (para — a row, near, near + mneme — memory, reminiscence) — inaccurate, chance, perverse memoirs. The person can remember the events which

were really taking place, but carry them to absolutely other time. It is called pseudoreminiscences — chance memoirs.

Confabulations (con – with + fabula — the narration, history, the fairy tale, conversations) — other type of paramnesias — the fictional memoirs which are not untrue at all when reports to the patient about what actually never was. At confabulations often there is an imagination element.

Cryptomnesia (kryptos — hidden, secret + mneme — memory, reminiscence) — such paramnesias when the person cannot remember when there was this or that event, in a dream or in reality whether he wrote the poem or just remembered once read whether there was he at a concert of the famous musician or only heard conversation on it. In other words, the source of this or that information and heard, seen is forgotten, read is given for own events.

Very seldom the so-called photographic memory when the person having, just, read several pages of the unfamiliar text meets, can repeat everything for right there memory read almost without mistakes. Also the phenomenon called by an eydetizm, in general carried not only to memory, but also to area of representations is close to a photographic memory.

Eidetic imagery (eidos — an image) — the phenomenon at which representation mirrorly reproduces perception. Here too memory participates in its bright figurative look: the subject or the phenomenon after disappearance keeps the alive visual image in consciousness of the person. Eidetic imagery as the normal phenomenon is at small children to their ability to bright figurative perception and extremely seldom occurs at adults. For example, the child, having looked at the photo and having turned it the reverse, can describe seen in accuracy.

Very good memory absolutely not necessarily testifies to a high intelligence. At oligophrenic persons mechanical reminder without any its judgment can be very highly developed.

Main syndrome of violations of memory.

The amnesic syndrome or Korsakov syndrome is shown by fixating amnesia of which disorders of reminder, an amnestic disorientation in time and the place which is shown especially when changing a situation are characteristic. Obligatory

components of this syndrome are the ecmnesia and confabulations mnemonic, i.e. falling into to the real ordinary events, character. The reference sign of an amnestic syndrome are paramnesias — memory deception: memories of the events which actually were not occurring — pseudoreminiscences or displaced in time — confabulations (now there is a tendency to unite confabulations and pseudoreminiscences under the common term "confabulations"). At dysmnesias there are, as a rule, confabulations of common contents which as if "replace" gaps of memory and are defined as "the replacing confabulations».

All information entering to the patient instantly disappears from his memory, patients are not capable to remember just heard and seen. They do not remember whether they talked to the doctor as the doctor looks, cannot remember a conversation subject. Many times greet the same person, can ask the infinite number of times the same question, re-read the same page of the book, without having an opportunity to reproduce read. Patients do not remember whether they ate food what dishes were offered them.

Patients most often have a consciousness of an illness, despite poor criticism to the state; they it is frequent by means of various tricks, evasive answers to questions try to hide memory violations. During a disease patients are usually inactive, sluggish, they observe asthenic frustration in the form of increased fatigue, an emaciation, irritable weakness, sometimes affective lability or euphoria. The Korsakov syndrome can meet at a cerebral atherosclerosis, during the sharp period of a craniocerebral trauma, at an alcoholism, etc.

Intellectual frustration.

Disorders of intellectual activity — change of process of rational knowledge, conclusions, judgments, critical abilities.

Weak-mindedness.

Distinguish the weak-mindedness acquired – a dementia (de — the prefix meaning decrease, decrease, driving down, + mens — mind, reason) and congenital - to a mental retardation (oligos — small in sense of quantity + phren — a thought, mind).

To a dementia syndromes treat with permanent, irreversible or low-reversible impoverishment of all mental activity, mainly, of memory and thinking: weakening of cognitive processes, impoverishment of feelings, changes of behavior. Assimilation of new information is almost impossible, use of last experience is extremely complicated. Increase of weak-mindedness is followed by essential change of nature of positive psychopathological frustration. If hallucinations take place, then they turn pale and arise incidentally; crazy concepts break up to separate fragments and cease to define a state and behavior of the patient.

At an oligophrenia there is an underdevelopment owing to various reasons of structures of a brain therefore development of intelligence in general is impossible (idiocy) or stops at the children's level (moronity). Figuratively speaking the dementive patient is the ruined rich man, and the patient with an oligophrenia – the poor from the birth.

The dementia on features of a clinical picture differs on the following types: on depth of defeat of mental functions on lacunar (partial, dysmnesic) and total (globarny).

Lacunar (dysmnesic) weak-mindedness is characterized by nonuniform defeat of mental functions, with more expressed memory violations. At it skills of behavior, education (a "moral and ethical" core of the person) remain. The thinking is mainly rigid and concrete, ability to generalization, categorial concepts and selection of the main thing from the minor suffers. Also the criticism, but nevertheless perhaps some comprehension of the intellectual insolvency, mainly, to dysmnesias suffers. They try to use constantly a notebook, write in advance that it should be told or made, however, quite often lose it. Try to justify intellectual мнестическую insolvency with the little significant, minor, unessential reasons (there is no calendar, clocks to watch time, "half-awake" - badly think, etc.) . Such justifications are called organic twaddle. Typical manifestations of such dementia are peculiar to vascular damage of a brain.

Total (globarny) weak-mindedness is characterized by rather uniform defeat of all intellectual functions, leveling, a roughening of premorbidal personal lines, loss of moral and ethical properties, a disinhibition of instincts, lack of criticism to the state, concrete and primitive, ridiculous judgments. The dysmnesia can be various

depth – from dysmnesias, to rough amnesia. The so-called senile dementia of Alzheimer's type, and also weak-mindedness can be an example of that at a general paralysis (a paralytic dementia).

For demonstration of a syndrome of a globarny dementia we give the following supervision.

Patient of 79 years. Since 74 memory decreased, the sleep was interrupted. Began to state nonresistant ideas of damage in relation to neighbors. Made gross errors in common household activity, when cooking could salt or mix several times dish components (for example, to put in soup instead of potato grain, instead of salt to pour pepper). In the apartment insanitary conditions – did not wash the floors, put things randomly, accumulated garbage, collected plastic bottles in a great many and put under a bed. Trying to justify such slovenliness, referred to the fact that was not in time with cleaning or quickly was tired. Aggravation of symptoms the last 1,5 years (from 77 years) when dysmnesias, "ingenuity" accrued, became careless, ceased to wash, brush the hair, earlier reserved, began to shout roughly at neighbors, to constantly accuse them of theft of potato, in theft of the gone things, was rude, in quarrels of never considered guilty. In attempt to dissuade the patient began to shout, swear, accuse neighbors of bias. The last three months appeared night collecting, tore the things, linen on pieces, ideas of damage remained. At the initiative of neighbors, after survey by the psychiatrist of a psychoneurological clinic, came on inspection and treatment to an insane hospital.

Mental state. *Entered an office with assistance. Appearance is slovenly. Shows complaints of somatic character ("heart sometimes hurts"), complaints to headaches. In time and the place it is disoriented. Current year calls 1949, month - "February-March", a season – "fall". Reported that is "at mother". At the instruction on scrubs testee for a short time relatively oriented: is "in some office, probably, in hospital". The age defines in 59 years. The speech is poor, phrases terse. Constantly touches hands, knits clusters from a tail of the robe. Fussy, in situ keeps hardly, touches the objects standing on a table, tries to leave an office. Often is distracted by foreign irritants. Sees a doctor on "you", at the end of conversation told the doctor -*

"I somewhere saw you". Quickly is irritated, becomes spiteful. Declares that all stole from it ("slippers stole ..., these here..., the dressing gown beautiful ... new ... was stolen"). Ability to generalizations is sharply reduced, judgments are primitive. Treats prime metaphors, proverbs literally, the prompted direction does not perceive ("forge iron ..." – "that iron did not break", "do not spit in a well ..." - "throw into water, water alone there, and then drink"). Reports that "1 kg of iron is heavier than 1 kg of down". Memory is roughly broken on the current and last events. Did not remember a name, a middle name of the attending physician, could not report anamnestic data, date the known historical events. Mentally the patient of does not consider. Upon stay in office it is not weighed. By the evening in office packs things in clusters. Clinical diagnosis. Senile atrophy in combination with an atherosclerosis of vessels of a brain, a syndrome of a globarny dementia, a prime form.

The illness arose in 74 years, with development of nonresistant crazy ideas of the material damage, the person's roughening (which was shown by collecting of stuff, neglect to the partial norms of sanitation reaching ridiculous slovenliness) and noncriticality to the insolvency, acts. In the next 1,5 years there is a resistant disadaptation, skills of self-service, impossibility of critical evaluation even are lost at the immediate instruction on rough frustration of behavior, the progressing amnesia with shift of a situation in the past and frustration of a "moral and ethical" core of the person, primitiveness of judgments, crazy ideas of damage – increase that indicates progressing senile-atrophic damage of a brain with development of a syndrome of a globarny dementia. Rather fast progressing intellectual мнестического defect with loss of criticism, leveling of a "moral and ethical" core of the person, rough decrease in abstract and design opportunities of thinking, dysmnesias as the progressing amnesia, inversion of a dream confirm a syndrome of a globarny dementia (senile type).

On character of a preferred symptomatology of a dementia differ on amnestic, euphoric-noncritical, non-spontaneously apathetic, asemic.

Euphoric-noncritical type of a dementia (paralytic, pseudoparalytic) — a condition of total weak-mindedness, the shown euphoria, complacency, falloff of

criticism, dysmnestic syndrome, absurd superiority complex and wealth delirium, and also leveling of characterologic lines of the person. Superiority complex and wealth delirium which differ in absurd, grotesqueness (are possible mainly at the general paralysis arising in the tertiary period of a lues). Patients call themselves the presidents, emperors ordering armies speak about the infinite riches which are in their hands about the huge sums of the money which is saved up by them, etc. Put on ridiculously, decorate the suit with self-made awards and distinctions. At patients the feeling of a step, behavior of their usually inadequately environmental situation which judgment is inaccessible for them is lost. They are inclined to commission of thoughtless, often ridiculous acts, ambiguous flat jokes; differ in extreme untidiness, do not watch the appearance, eat with hands, take without the permission the things which are not belonging to them, find aggression in attempt to select them. Against the reference euphoria periodically there are an irritability, malignancy, incontinence of affect. Mnestic violations are shown by a dysmnesia on events of the past and the present, not reaching the expressed amnesia. Speech violations in the form of delayed or, on the contrary, excessively hasty speech greased and muffled are observed at a general paralysis, frustration of a dream. Such type of weak-mindedness is possible at syphilitic damage of a brain, chronic intoxications, serious consequences of craniocerebral injuries, progreduated organic diseases of a brain at advanced age (vascular diseases, the Peak illness).

Amnestic (presbyophrenia with a Korsakov's syndrome) a dementia – with the expressed fixating amnesia, shift of a situation in the past, mnemonic (falling into to the present) and ecmnestic (falling into to a past tense) confabulations, mental vivacity, "business" fussiness, complacency, the relative safety of feeling of an illness. Such type of weak-mindedness is noted, for example, at a senile dementia of Alzheimer's type, especially in cases of a combination to a vascular disease of a brain, but is possible also at a "clear" atherosclerosis of vessels of a brain.

The non-spontaneously apathetic type of a dementia is characterized by decrease or loss of the initiative expressed by indifference, absence of desires, interests, small mobility, stereotypic reactions (speech and motive stereotypies),

poverty of speech manifestations up to an initiative mutism (against mainly globarny dementia). Such type of a dementia is characteristic of the Peak illness.

Asemic type of a dementia - with accession of focal violations of the highest cortical functions (an aphasia, an apraxia, an agnosia) as, for example, at Alzheimer's disease (against mainly lacunar dementia), an insultny current of a vascular disease of a brain (Gakkebush's syndrome – Geymanovich - Geyera), sometimes meets at a combination of a senile dementia of altsgeymerovsky type and an atherosclerosis of vessels of a brain.

Distinguish also schizophrenic and epileptic weak-mindedness from the acquired weak-mindedness. Selection of schizophrenic weak-mindedness was criticized since the description by E. Krepelin "dementia precox", in the subsequent the called schizophrenia as the deficiental symptomatology at this disease does not correspond standard (and then) to criteria of organic weak-mindedness. Now it is accepted to speak most of researchers about schizophrenic defect which is characterized by an intellectual divergence, lack of initiative while prerequisites to cerebration still the long time can remain. For this reason the intelligence of such patients is compared to a case, the full of books which nobody uses, or with the musical instrument locked and never opened. Primary mechanisms of memory also do not suffer at schizophrenia.

The epileptic weak-mindedness belonging to organic syndromes is expressed not so much by decrease in memory, how many a peculiar change of thinking when the patient begins to lose ability to distinguish main and the minor, all it seems to it important, all trifles — the considerable. The thinking becomes viscid, barren, pathologically detailed, the patient cannot express the thought in any way (not without reason epileptic thinking call sometimes labyrinthine). Changes of the person also have the features not inherent in other organic dementias. Narrowing of a focus of interest, concentration of attention only on the state (concentric weak-mindedness) is characteristic. The egocentricity, rancor, vindictiveness, the expressed inertness of all mental processes is expressed.

Oligophrenia — heritable, congenital or acquired in the first years of life (till 3 years) the weak-mindedness which is expressed in the common mental

underdevelopment with a dominance first of all of intellectual defect and thereof in difficulty of social adaptation. Distinguish three degrees of an oligophrenia. The heaviest degree of an oligophrenia is called an idiocy (IQ on Wexler's scale less than 20) at which the thinking and the speech are almost not developed, perceptions are poorly differentiated, reactions to surrounding are sharply lowered and often inadequate, emotions are limited to feelings of pleasure and discontent, any intelligent activity, including skills of self-service, is inaccessible, children are often slovenly owing to an incontience of urine and a feces. Static and locomotar functions in this connection many children are not able to stand and go self-contained are roughly underdeveloped. Life of such patients passes at the instinctive level. They need constant surveillance and leaving. Imbecility – average degree of a mental retardation (IQ = 20 - 49) with the expressed concreteness and situational nature of thinking, inability to formation of abstract concepts, a speech underdevelopment with agrammatisms and tongue-tie. Imbeciles cannot be trained according to programs of auxiliary schools. At the same time skills of self-service are available to them, and it is frequent also the partial labor skills. The most mild degree of an oligophrenia – moronity (IQ = 50 - 70), is characterized at children of school age and teenagers by sufficient development of the everyday speech, ability to assimilation of express training programs. Such children can seize simple labor and an art. At moronity the relative adequacy and independence of behavior in a habitual situation, satisfactory social adaptation in the conditions which are not imposing new and the becoming complicated requirements to the person is noted.

Thinking disorder

Thinking — the generalized reflection by the person of objects and phenomena in their natural communications and the relations mediated by the available knowledge and realized by means of the speech. A basic element of thinking is the concept — reflection in consciousness of the person of the most common and essential properties and qualities of the homogeneous objects and phenomena unlike feelings, perceptions and representations which reflect or separate concrete properties of objects and phenomena (feeling), or these concrete phenomena and objects in general (perceptions), or procreation of the images apprehended in the

past (representation). For example, the concept "house" reflects the common properties of the most various constructions of different architecture, size, style, a location, contains sense of "characteristic dwelling" etc.

One of the most important features of concepts is that they are based not only on own experience of the person, but also include the experience of the previous generations fixed by means of language. For this reason language acquisition promotes assimilation of all knowledge base, saved up by mankind.

To be guided in environmental, to adapt to environmental, it is necessary to put objects in the relations among themselves; these relations are created in our consciousness by means of concepts and reflect the actual relations of objects and the phenomena. Using several concepts, combining and comparing them, we express such relations in judgments. In turn, on the basis of two or several judgments conclusions or chance judgments are formed. Formation of concepts, a combination of concepts in judgments, a combination of judgments in conclusions is and there is a thinking. It also allows the person to get into substance of things deeply.

Ideational operations include the analysis, synthesis, comparisons and generalizations, abstraction and a specification with the subsequent transition to formation of concepts. Process of association can be broken in the most various way depending on character of an illness, its stage, type of a current and an outcome.

Disorders of associative process.

Acceleration of thinking is expressed in the accelerated course of associative processes; thoughts very quickly replace each other, there is a lot of them that patients, despite very fluent ("machine-gun") speech, after all do not manage to state them. Superficially such speech of patients can resemble a schizophasia (the broken-off speech), however if to record it, for example, with the tape recorder, then then it is possible to find in it particular sense that is not present at a schizophasia.

For pathololologically the accelerated course of associative processes also the distractability is characteristic: the thinking of the patient becomes the surface, inclined to momentary switching; everything that comes into the view of such patient, right there draws his attention, occupies his thoughts, channelizes recent to his ideas. Extreme degree of an distractability is expressed in "jump of ideas" (fuga idearum)

when think of patients, immediately replacing each other, switch from one subject to another so quickly that already difficult happens to catch in them some common sense.

Delay of thinking is characterized by poverty of associations, a retarded flow of associative process, its retardation. Patients with such phenomena complain that they "for clocks have in the head of no thoughts", "nothing comes to mind". They usually answer questions very laconically, in monosyllables, sometimes only with the words "yes" or "no", often after very long pause when at asking already the impression can be made that the patient did not catch or did not understand a question. Patients in such state do not begin to say anybody they do not address for anything.

Pathological thoroughness of thinking consists in extreme viscosity, a rigidity of thought processes; it is very difficult for patient to switch from one subject to another, they get stuck on the most slight details, all it seems to them important, necessary — each trifle, each stroke; they cannot allocate main, the main, essential. Pathological thoroughness of thinking is characterized by very small efficiency, sometimes in general is unclear that the patient wanted to tell what sense was made by its lengthiest wanton speech (labyrinthine thinking).

Thinking perseveration (perseveratio — persistence, persistence) — pathological jamming, a delay on the same representations that it is clinically expressed in repetition (sometimes the very long-lived) the same phrases or words in response to various questions. Most often such patients can answer correctly only the first question of the doctor, and then monotonously repeat the same answer or parts it.

Verbigeration (verbum — the word + gero — the Veda, I make) — a speech stereotypy — senseless, quite often rhythmic repetition of the same words, is more rare — phrases or their scraps.

The paralogical thinking is characterized by absence in thinking of logical communication; conclusions which are drawn by the patient in such cases not only are not natural, but are often absolutely ridiculous: "I got sick with schizophrenia because I in the childhood ate cream of wheat a little" or "I want to sleep, and therefore teach me, please, to music».

Twaddle — tendency to empty reasonings, when as speak, "there are a lot of words and few thoughts". Such thinking is characterized by futility, lack of concreteness, focus: "You see how it is important, I would like to tell and note that it is very important, importance the considerable, it should be noted, you will not think that it is not important».

Thought disorder is indistinct, contradictory use of concepts at which grammatical correctly constructed speech gains indistinct, casual character, and the main conclusion remains to not formulated or unclear people around.

There can be an intermittence of associations (so-called shperrung; from the German sperrung — a blocking, a barricading, obstruction) – a thinking stop, involuntary break, absence of thought.

Mentism – violent flow of thoughts.

The disintegration of thought is expressed in lack of communication not only between separate thoughts, but also separate words (concepts). The speech of such patient can be absolutely unclear, deprived of any sense. At the same time particular grammatical links remain, and outwardly the speech can make impression of coherent.

The paralogical thinking, twaddle and disruptiveness, shperrung and amorphy of thinking are most characteristic of schizophrenia.

Incoherence of thinking (incoherence, incoherent thinking; in — a refusaling particle + coheerentia — coupling, communication) it is characterized by absence not only a logical, but also grammatical link, the complete randomness, senselessness of thinking, the speech consists of a set of separate words, among themselves not the bound in any way: "Wonderful miracle... once upon a time there were... ah, as cold... day, stub, laziness... good-bye...". In these cases speak about "word salad". Difference from the broken-off speech consists also that the broken-off thinking arises against clear consciousness; incoherent is always a consequence of a stupefaction (usually as an amental syndrome, an amentia).

Symbolical thinking. The symbolics is peculiar also to normal thinking when it reflects the standard ideas, views, is bound to this or that reality (for example,

symbolics of the coats of arms, mathematical characters, at last, of drawings in the form of the heart pierced with an arrow).

At pathological symbolism (peculiar mainly to patients with schizophrenia) this pathology of thinking is especially individual and unclear to people around. This symbolics can concern as separate words, concepts, and all system of thinking in general. The patient can symbolically perceive and the speech of people around.

Patients with symbolical thinking can give special sense to the most common things ("yellow color of wall-paper — means, there live people, unreliable, inclined to treason here"; the words "good appetite" say that this person "will be the death of all to it objectionable».

At the expressed changes of thinking the speech of patients can consist of one to them clear symbols including neologisms (the use of word formations, new, not similar to anything; the patient at expression of pleasure speaks "blyum-blyam", and at discontent with something — «puri-prur").

Drawings, verses and in general any creativity of patients can be a bright example of symbolical thinking. Maeterlinck is very talented person, unfortunately, who had schizophrenia, removed in the widely famous play fairy tale an image of the Bluebird of happiness who became then for all people a symbol of inaccessible, illusive happiness.

TEST TASKS
(for self-preparation)

Choose one correct answer

1. FIXATING AMNESIA, ANTERORETROGRADE AMNESIA, IT IS FREQUENT – CONFABULATIONS

1) Korsakov's syndrome
2) weak-mindedness syndrome
3) the progressing amnesia
4) paramnesias

2. LOSS FROM MEMORY OF ALL EVENTS OF THE RESTRICTED PERIOD PRECEDING THE DISEASE

1) ecmnesia

2) the progressing amnesia

3) retrogradna amnesia

4) retroanterograde amnesia

3. COMPLETION OF GAPS OF MEMORY FICTIONS OR MEMOIRS FROM THE PAST

1) paramnesias

2) confabulations

3) cryptomnesias

4) eidetism

4. IMPOSSIBILITY OF REMINDER OF CURRENT EVENTS

1) ecmnesia

2) fixating amnesia

3) the progressing amnesia

4) hypomnesia

5. DECREASE IN MENTAL CAPACITIES WITH THE DOMINANCE OF VIOLATION OF CRITICISM AND CHANGES OF THE PERSON

1) lacunar dementia

2) asemic dementia

3) non-spontaneous-apathetic dementia

4) globarny dementia

6. EASING OF MEMORY AND JUDGMENTS AT THE RELATIVE SAFETY MORAL BASES OF THE PERSON AND CRITICISM

1) lacunar dementia

2) asemic dementia

3) non-spontaneous-apathetic dementia

4) globarny dementia

7. LACK OF COMMUNICATION BETWEEN WORDS, THE DISORIENTATION, INABILITY OF JUDGMENT ENVIRONMENTAL

1) twaddle
2) disintegration of thought
3) paraplogic thinking
4) incoherence of thinking

8. FAST CHANGE OF THOUGHTS, THE OTVLEKAYEMOST, LACK OF EFFICIENCY BECAUSE OF HASTY CONCLUSIONS

1) delayed thinking
2) thinking rigidity
3) the accelerated thinking
4) stereotypic thinking

9. REFLECTION IN CONSCIOUSNESS OF THE PERSON OF THE MOST COMMON AND ESSENTIAL PROPERTIES AND QUALITIES OF THE HOMOGENEOUS OBJECTS AND PHENOMENA

1) judgment
2) conclusion
3) concept
4) feeling

Lecture No. 5

Impairment of consciousness. Symptomatic psychoses.

Consciousness as philosophical category. "Wakefulness" as physiological basis of impairment of consciousness, value of a reticular formation. Criteria of mental alertness. Syndromes of the broken consciousness: aproduktivny - an obnubilation: obnubilation, somnalention, sopor, coma; produktivnopsikhotichesky: delirium, oneiroid, amentia, twilight state. Concept of symptomatic psychosis. The place of frustration of consciousness at symptomatic psychoses. "The transitional syndromes" - it is hallucinatory - crazy, affective. Korsakov's syndrome. Asthenic and psychoorganic syndromes. A pathogenesis - toxic, circulatory and other factors." The soil" and a harmfulness at symptomatic psychosis. Infectious psychoses. Somatogenias, their value in mental incidence of the present. Infectious asthenia, delirium, amentia. Fixing, remittent, chronic infectious psychoses. Neuroinfections and mental violations at them. Somatogenic frustration of mentality and their pathogenesis. Jet states in connection with a physical illness. Iatrogeny and their deontological prophylaxis.

Before we pass to the characteristic of syndromes of violation of consciousness, we will stop on some general provisions of a philosophical and psychological order which are falling into to a consciousness problem. The consciousness – is the highest form of reflection by the person of world around and own activity. Proceeding from materialistic outlook, matter is primary, consciousness for the second time and is accompanied by the material source. Activity of a brain, mainly, bark of larger hemispheres is the cornerstone of consciousness. The consciousness marks a particular stage of development of the material world. It arose in the course of improvement (evolution) of matter which top is the person now. Content of consciousness cannot be measured in the material units. In too time we can give to register, for example, the physical characteristic of those processes which are the cornerstone of consciousness biocurrents of actively operating brain at the

person (electroencephalography) in clear consciousness and to compare them to the biocurrents characteristic of an unconscious or pathological state. The consciousness not only reflects world around, but also those phenomena which, occurring in the person, his mentality, that is in this case it is about a self-consciousness, self-reflection. Property to reflect itself as the person, the person can realize the mental processes only. Whatever prerequisites of consciousness we found at the highest animals, the consciousness remains the specific property of the person, property inherent only in human mentality. It is formed only at people and only in the course of their social development which animals do not have. The animal can be capable to the elementary comparisons, that is at part from highly organized mammals (monkeys, dolphins, dogs) there are thinking rudiments, the animal is capable to feel, but it is not capable to understand the thoughts and feelings.

The consciousness provides a possibility of a set of communications which unite in a whole a number of processes and the phenomena in mentality of the person. Thanks to these communications the present unites with the past, also those processes which take place in the present unite among themselves. As S. S. Korsakov spoke, the consciousness requires a combination of the knowledge acquired by the person ("consciousness"); but it is not enough, it is necessary that this combination was made in the known order, by the famous rules. Communication, integration of all mental processes at the highest level also gives the chance of education of the fact that in psychology call the person. In the presence of such integration there is an ability to oppose itself as the person to world around and other persons, to understand itself as the person. It is possible only at the person. Integration of mental processes provides the most important property of consciousness – ability of anticipation. The most prime forms of prediction of the future are peculiar also to animals. But at animals this anticipation, prediction of the future is included in structure of the action, only at the person it becomes rather independent of specific action, it can be expressed by concepts, receive the verbal formulation.

Function of consciousness of the person is possible only if particular rate of strain is provided, to intensity of neurodynamic processes in the consciousness device, that is first of all in a cerebral cortex. This intensity constantly changes.

Respectively in structure of a brain there has to be a mechanism or the device which carries out the regulating role in a condition of a wakefulness/dream, conscious and unconscious activity. This device has to come into action and into pathologies when suppression or switching off of the most difficult forms of activity which are the cornerstone of consciousness is necessary. From positions of the modern neurophysiology such device in a brain is the reticular formation.

The reticular formation is anatomically the education allocated with O. Deyters in the central part of a brainstem consisting of diffuse congestions of cages of various types and the sizes which densely intertwine a set of fibers (under a microscope reminds a network – a retikul). It represents important point on the way of the ascending nonspecific somatosensory system. Viscerosomatic afferent go as a part of a spinoreticular tract (ventro-lateral funiculus), and also, perhaps, in structure the propriospinal (polysynaptic) tracts and appropriate ways from a core of a spinal trigeminal path. To a reticular formation also paths from all others afferent the cerebral nerve, i.e. practically from all sense organs come. The padding afferentation enters from many other departments of a brain – from motor areas of cortex and touch areas of cortex, from a thalamus and a hypothalamus. There is also a set of efferent communications – descending to a spinal cord and going back through nonspecific thalamic cores to a cerebral cortex, a hypothalamus and limbic system. The majority of neurones forms synapses with two-three afferent of a different origin, such polysensory convergence is characteristic of neurones of a reticular formation. Other their properties are big receptive fields of a surface of a body, often bilateral, the long-lived latent period of the response to peripheral stimulation (owing to multisynaptic conduction), weak reproducibility of reaction (stochastic fluctuations of number of action potentials at repeated stimulation). Functions of a reticular formation are studied not completely. It is considered that she participates in the following processes:

1) in a regulation of level of consciousness by impact on activity of cortical neurones, for example, participation in a cycle dream/wakefulness;

2) in giving of affective and emotional coloring to touch incentives, including the painful signals going on a ventro-lateral funiculus by conduction of afferent information to limbic system;

3) in the vegetative regulating functions, including in many vital reflexes (circulatory reflexes and respiratory reflexes, reflex acts of a swallowing, cough, sneezing) at which different afferent and efferent systems have to be coordinated mutually;

4) in the targeted movements as an important component of the motive centers of a brainstem.

But the main substratum of consciousness is the cerebral cortex. It has structure much more composite, than a reticular formation that corresponds also to its more difficult activity. As if there were functions of a reticular formation, they can have subsidiary value only. In the simplified comprehension it is possible to speak about tonic influence of a reticular formation on bark of larger hemispheres. Neurodynamic and physiological supervision convincingly show that the reticular formation is under the influence of bark: there are not only reticular-cortical, but also cortical-reticular communications.

Let's pass to ***impairment of consciousness*** now. Forms of the broken consciousness exists the common signs on the basis of which we also define that at the patient the consciousness is broken have several, but all these forms. These signs are formulated by the German psychopathologist Karl Jaspers in 1911.

The first sign – detachment from world around, detachment from its real. The outside world, its events, the phenomena, its changes do not draw attention of the patient. If they are also perceived, then is only fragmentary, inconsistent. Synthesis and the analysis of the phenomena of the outside world is sharply weakened, and at times and completely lost.

The second sign – a disorientation in the place, time environmental and persons. The patient do not learn people around, does not perceive their attempt to come into contact with him.

The third sign – the thinking of the patient, his associative processes are sharply stratified, the thinking of the patient becomes inconsistent, fragmentary, sometimes reaching incoherence.

Fourth sign: at detuned consciousness, owing to impossibility of reflection of reality, reminder falls apart. Therefore after a condition of detuned consciousness of reminiscence of this period not always happens the complete, it is more often scrappy, and sometimes (at serious conditions) is absent at all, that is it is about an ecmnesia.

Respectively Karl Jaspers formulated also criteria of mental alertness which are contrast to criteria of detuned consciousness. Namely: a) orientation presence; b) ability to mental contact, c) to realization of intellectual operations; d) preservation of a necessary excitation threshold and adequate perception of environmental; e) lack of dysmnesias. The consciousness is considered broken if there is a violation of all listed criteria because each of criteria of the broken consciousness can arise also at other syndromes. So detachment from the actual world is observed not only at the broken consciousness, but also in a condition of a catatonic stupor, apathy. The disorientation can be observed at dysmnesias (fixating amnesia). Not recognition of people around can be at Capgras syndrome when familiar people, are perceived sick as absolutely unfamiliar (a symptom of the negative double). Disorders of associative activity can meet at weak-mindedness, affective syndromes. And, at last, amnesia can arise at various forms of a dysmnesia. Thus, for establishment of a condition of the broken consciousness there have to be all five signs. But as soon as you diagnosed a condition of frustration of consciousness - it is always the certificate of a serious condition of the patient demanding emergency aid.

All syndromes of the broken consciousness on existence or lack of a psychopathological symptomatology (pathological production), such as frustration of perception, nonsense, motive exaltation, it is possible to divide on aproduktivny (lack of production) or syndromes of switching off of consciousness, and productive or syndromes of a stupefaction.

The obnubilation of various degrees belongs to aproduktivny frustration of consciousness.

The obnubilation is always shown in increase of a threshold for all external irritants, for example, at the most mild extent of obnubilation to draw at least for a while attention of the patient it is necessary to ask by a loud voice questions, several times to repeat them. Environmental sounds are perceived as very far, there is an indistinct orientation at the place, in time is lost completely, at the patient it is possible to reveal at persistent inquiry safe orientation in characteristic person. The patient at the same time is sluggish, sluggish. He understands the prime, common questions more composite leaves without answer because he does not comprehend them. There comes impoverishment of consciousness, poverty of associations. The name comes from the Greek word "obnubilis" or "cloud". "Aged" psychiatrists called also "clouded" or "covert" ("a veil on consciousness"). Quite often in a condition of an obnubilation of people also reminds drunk with the speech inattentively, violation of focus of actions. Expressiveness of a condition of an obnubilation quite often fluctuates; it is observed at a concussion of the brain and often it is found at brain tumors. Heavier degree of an obnubilation is shown by a ***somnalence***, or a dreamlike state. In this case the depression of reflex activity of a brain becomes more pronounced. The condition of the patient reminds deeply sleeping person who is very difficult for waking. Orientation in the place, time is absent, in characteristic person inexact (can tell the name or a surname, but completely the middle name does not reproduce a name). The excitation threshold considerably raises – the irritant is necessary high force (for example, spraying of the person cold water) that the patient opened eyes, for several seconds recorded a look, more often inattentively said separate phrases, and then again "fell asleep". Speech reaction can be absent completely, but the possibility of fixing of a look on the interlocutor testifies to a somnalence, but not to more deep switching off of consciousness.

Further on extent of depressing of consciousness there comes the sopor and a coma. Unlike a coma at a sopor the elementary physiological reflexes are kept, motive reaction, most often on the most strong irritant – painful (can draw aside a hand at an injection) is possible, however intelligent activity is impossible. The most serious condition of aproduktivny frustration of consciousness – a lump. Not only the highest, but also more partial levels of nervous activity are switched off. In a coma

even the elementary reflexes disappear: pupillary, conjunctival, spinal (for example, knee reflex), corneal. The beginning of a coma marks emergence of pathological reflexes, in particular,-foot (Babinsky, Zhukovsky, etc.). At attenuation of all reflexes disorders of the vital functions – respirations, blood circulations, thermoregulations develop. They are known to you from pathological physiology and internal diseases.

One of the most common forms of productive frustration of consciousness is the ***delirium***. The beginning of a delirium is preceded by a so-called predelirious stage. Most often it arises early morning clocks and is shown by the expressed alarm, feelings that it happens, something unpleasant. All this can be followed by vegetative frustration (the increased sweating or dryness mucous and integuments, heartbeat and pressure roughness, gastrointestinal symptoms, etc.) . The patient owing to alarm has a physical activity, he "cannot find any peace". Quite often there are illusions. For example, the electric cord from the refrigerator is accepted to a snake, noise of cars behind a window is perceived as illegible whisper. The anxiety amplifies in the evening – in attempts to fall asleep there can be hypnagogic hallucinations. Then there are true hallucinations, and there is a disorientation that testifies to the beginning of a delirium. At deliriums the disorientation has the features. Orientation of a delirant is called chance or productive. The delirant to the place of the real, calls other situation corresponding not actual, but to hallucinative images. Being in hospital, the patient claims that he at work, houses or as it happens at alcoholic deliriums that it at restaurant with drinking companions. Such disorientation happens to procreation of a common situation at deliriums of habitual occupation or as still it is called, professional deliriums if the situation of a habitual working situation prevails. In other cases patients instead of actual carry themselves to an unusual, fantastic situation, consider that they in some other country, in other city, even in the unusual place which is represented to a delirant objective actual. Typical example are hell pictures at alcoholic deliriums with the running and attacking devils who want to thrust the patient into a copper with sinners. In this case it is about fantastic chance orientation. The colourful perception of the changed reality is promoted by an obligatory symptom of the developed delirium picture – the true hallucinations, is more often visual which kaleidoscopically replace each other and to a lesser extent,

acoustical. Owing to this fact the patient cannot distinguish environmental reality and the experiences, they as if merge for him in a whole, gradually moving away from reality further and further deep into of delirious perception. It is promoted also by productive frustration of thinking in the form of crazy ideas, is more often than persecution contents (prosecution). Nevertheless, orientation in characteristic person at the patient is rather kept, he opposes himself to hallucinative experiences, tries to resist to them. In particular, watching change of reality and emergence in it of frightening characters which are more often unfriendly adjusted concerning a delirant, he makes attempts to escape, hide from them, quite often actively being protected and putting to itself and environmental physical wounds. And here we see one more sign of delirious frustration of consciousness – motive exaltation. The delirium reason – most often intoxications. Besides alcoholic or other exogenetic intoxication (for example, poisoning with chemicals), the sharp infection, and also a hypoxia, owing to poor supply of a brain blood owing to violation or in brain vessels (strokes), or in connection with a heart failure (a so-called cardiogenic or cardiac delirium) can be the cause of a delirium. After escaping of a delirious state at the patient only fragmentary memories of morbid experiences remain.

Are close to delirious – both on a picture, and under the terms of emergence (though quite often develop at an endogenic disease – schizophrenia, unlike a delirium), in particular, on the dependence on intoxication – ***oneiric*** violations of consciousness. At this form of the patient does not drop out completely of reality, and as if puts it outside brackets. This successful expression belongs to the French psychiatrist Claude. At the patient the plentiful scenic hallucinations connected by the common plot not the true can be observed as at deliriums, and chance according to the characteristic (pseudohallucination), at the same time often there is a discrepancy between the content of frustration of perception and behavior of the patient owing to the fact that at the patient also orientation in characteristic person (frustration of a self-consciousness) is broken. The oneiric catatonia when the patient who is in a struporous state (not to confuse to a sopor), with the stiffened mimicry and indifferent expression on a face, endures scenic pseudohallucinations in which it not the actual, for example, mechanic Ivanov, but the captain of the intergalactic ship, struggles with

newcomers for rescue of the planet can be an example, participates in battles, gives teams subordinated (as a rule, the patient plays a major role in the oneiric experiences). At this type of productive frustration of consciousness the disorientation is called double. The patient as if at the same time is present at several places. For example, is in hospital and it is simultaneous on other planet or in the center of training of astronauts. So the patient, narrating about the oneiric experiences, declared that in the hospital yard (the patient was in a hospital) there takes place solemn delivery of an award of the Hero of the Soviet Union by it (a gold star) with creation of a division in which it served during the Great Patriotic War, presence of the highest command structure of the country: banners developed, played an orchestra. During these experiences the patient quietly lay in a bed with the look released from an environment. After escaping of a oneiroid at patients quite detailed memories of endured quite often remain.

Following, one of the most severe forms of productive frustration of consciousness – ***an amentia***. Emergence of an amentia the sign, very alarming in respect of the biotic forecast, demonstrating the heavy processes happening in a brain. Now they happen very seldom owing to the fissile pharmacological treatment of infectious processes (the main reason for an amentia) and rather exceptional cases of development of the expressed psychological exhaustion at which the amentia preferably develops. The syndrome of an amentia is characterized by incoherence of mental processes, first of all thinking. The patient tests visual and auditory hallucinations (true). A physical activity is limited most often to bed limits – a so-called symptom of a jactitation – pendulum rocking of a body in a sitting position or random scattering of hands, legs, a waggle head in a prone position. The behavior of the patient is deprived of any intelligence, he says only separate scraps of phrases (the senseless mere verbiage is more often). Orientation – both in environmental, and in characteristic world – is absent.

The following major syndrome of violation of clarity of consciousness – ***a twilight state***. "Aged" psychiatrists called it still "blinkered" (from the word "blinders" - in a harness of horses the side guards at the level of eyes of an animal which are not giving the chance to look in the parties) or tunnel, comparing

perception of the patient to the person who got to a narrow tunnel or a pipe. The name - "twilight" - also reflects a state at this look upset consciousness: everything is perceived mainly in black-and-white color, is deprived of brightness, also as at approach of twilight – the twilight between sunset and nightfall. For receiving idea of twilight frustration of consciousness get acquainted with a case history of one of patients of psychiatric clinic (supervision at lecture of professor Yu.E. Rakhalsky).

At the patient epilepsy after a series of attacks within 2 days the behavior sharply changed. She answered questions inattentively or answered nothing, tried somewhere to go. Here is how her behavior in the history of an illness is described: "... Having entered an office, she smiles, in embarrassment looks around, smacks the lips, makes stereotypic actions, makes a helpless gesture, gathers something from a dress, does the pincer prehension, chooses garbage from a pocket, tries to put it in a mouth. Hardly it was succeeded to seat her. Feels the wall, a table and objects lying on it. Suddenly rises and tries to leave. In response to a question of where she lives, silently shows a hand on a case. With tension, as if trying to remember something, says: "It is necessary to play a wedding". Where she is, cannot tell, looking around, speaks: "Here", - stares. If the doctor asks it: «Are you in hospital?", - answers: "In hospital". – «Are you at home?» - «At home". Times possible to achieve the separate correct answers: told that she lives with the son and with mother, in response to a question of how call her son, called the year of birth. As it was already told, in such state the patient was 2 days, from time to time at her fussy stereotypic exaltation accrued and she hardly managed to be kept in a bed. After escaping of this state it was found out that she remembers nothing the previous three days of the unusual behavior. Therefore talking to it, we will not receive data which would add that description which you heard. Nevertheless we will look at the patient and we will talk to her. «Hello, Eudoxia Sergeyevna. How do you feel?" - "It became better now". – "And what is your disease?" - "Attacks". – «How did they occur at you?" - "Not that every day, and here at night often". – "How do you got us?" - "I do not remember this". – "But now you, possibly already know?" - "I know only from the sister: she said that with me it became bad, arrived to me and took away in hospital. It's all.

The sister and the brother speak to me, I remember nothing. As woke up, I think, why I got to Orenburg? Three days absolutely dropped out of memory. Then I felt better, I see why some people walking around me". – "When this state when you understood nothing began?" - "Attacks since 30 years" - "No, I mean the state in which you put in the hospital". – "Attacks, perhaps?" - the Patient cannot understand a question. «What is your memory?" - "The poor memory, attacks strike". – "Continue to be treated, it will help you. Good-bye". The patient leaves.

You probably paid attention to what the patient tells sluggishly, hardly finds words, repeats, gets stuck in the description of separate details. Together with decrease in memory these phenomena are typical for her illness – epilepsy. But you learn about it in more detail when you expressly study violations of thinking and clinic of alienations at epilepsy. Today I wanted to use supervision over this patient for acquaintance you with violations of clarity of consciousness depending on alternations in a head brain which are characteristic of epilepsy. With switching off of consciousness, such as at a coma attacks proceed, after attacks gradually the patient passes into a condition of an obnubilation of the lesser and smaller degree. The patient had the long-lived state when she was capable to go, talk, make various actions. At the same time it was not focused in time and the place at all, its actions – though sometimes had the quite composite character, but, generally, were senseless, the same as her answers to questions. As we were convinced from conversation with it, any memories of what with it was, it did not keep, it has the complete amnesia those two-three days during which it was in a pathological state. This state is called a kind of a twilight state – the fugue - and is observed, mainly, at epilepsy. The basic at it – automatic nature of actions at the patient when he does not realize neither the acts, nor the experiences. Being switched off from an environmental real, the patient remains in a narrow circle of some experiences which we only guess. In certain cases there are crazy ideas and hallucinations, then actions of patients are defined by these phenomena and happen especially dangerous as change of mood is characteristic of such state – there is a sad and spiteful affect.

The twilight state is subdivided into a syndrome with productive hallucinatory-delusional, sad and spiteful experiences with the expressed social danger (attacks and murders of the imaginary enemies) and syndromes with lack of those – ambulatory automatism: absentia (epileptica), fugue, trance, somnambulism .

In some cases the twilight state proceeds at outwardly the ordered behavior. Patients make automatic actions, for example, can go to the station, buy the train ticket and leave far from the house. At the same time they can answer in monosyllables questions and make on the people surrounding impression tired or dispelled. Having regained consciousness in absolutely unfamiliar place, they do not remember at all how they got here, at times rather long-lived period of time drops out of memory. The specified state is called ***a trance.***

At the ***somnambulism (a lunacy)*** arising at night is more often at children's age, the patient, without waking up, moves, for example, about the room, makes the automated movements, sometimes ridiculous – moves things, approach a window or a door, try to open them, either do not answer questions, or speak beside the point. Having woken up, nothing is remembered the night adventures and very much are surprised when they about them are told. Short-term switching off of consciousness with a stop of activity is called ***an absentia (epileptica)*** («absence"). For example, during conversation, the patient "is as if switched off" from it. At this moment he can drop a pencil with which wrote, looks a little confused, on a question that is with it, can not answer, having recovered consciousness remembers nothing an event.

The following part of lecture is devoted to symptomatic psychoses.

Carry the psychoses developing at the common noninfectious diseases, infections and intoxications as one of manifestations of a basic disease to symptomatic.

Relationship of mental and somatic frustration forms the extensive and heterogeneous field of psychiatry. It is accepted to differentiate:

- Somatic psychiatry (somatogenias) – the secondary alienations caused by somatic pathology. Somatogenic alienations often call symptomatic as they are secondary in relation to a basic disease, the caused their symptoms or complications.

- Psychosomatic frustration which emergence is in many respects bound to personal features and stressful situations.
- Various combinations mental and somatopathies, developing self-contained, independently from each other. For example, combination of a peptic ulcer of a stomach and pulmonary tuberculosis.

Doctors of any specialty regularly resolve various medical and diagnostic issues connected along with somatic and alienations.

In the 19th century ideas of specificity of somatogenic alienations prevailed. Supporters of such approach claimed that on a picture of only one psychosis (without somatic violations) diagnosis of a visceral disease is possible. However medical and diagnostic practice of it of narrow and specific approach did not find confirmation.

At the beginning of the 20th century the German psychiatrist Carl Bonhöeffer (K. Bonhöeffer) formulated the concept of exogenetic type of reactions in which he made attempt to explain what development of different pictures of somatopsychoses and degree of their specificity depends on. This concept gained the recognition and further development based in many respects on materials of the First and Second world wars.

The concept of exogenetic type of reactions includes several original positions.

There is a set of the external harmfulness causing exogenetic (symptomatic) psychoses (various infections, intoxications, craniocereberal injuries, internal diseases), and possibilities of responses of a brain to this harmfulness are limited. Originally C. Bonhöeffer fall intoed to pictures of somatogenic psychopathological reactions (***exogenetic type of reactions***) a delirium, an amentia, epileptiform exaltation (a twilight condition of consciousness), conditions of an obnubilation, a verbal hallucinosis, the Korsakov's syndrome, emotional гиперестетическую weakness (a kind of an asthenia). Later the list of exogenetic psychopathological reactions was expanded it at the expense of depressive, maniacal, depressive and crazy, hallucinatory-delusional and some other states.

One of original positions of the concept of exogenetic type of reaction of Bonhöeffer consists that any external harmfulness (an infection, intoxication, a

craniocerebral trauma, a visceral disease) can cause any of the listed above pictures of somatogenic psychopathological states. For example, as it was already specified, the delirium can have alcoholic, infectious, traumatic, postoperative, cardiogenic or other nature. Thus, other keyest provision of the concept of Bonhöeffer consists in not specificity of exogenetic alienations. The picture of a syndrome is defined not so much by quality of an external harmfulness, how many force, rate of action and a point of its application.

Bonhöeffer's statement that features of a clinical picture of exogenetic psychoses are defined by a stage of a basic disease is especially important: a prodrome there correspond the asthenia phenomena, at height of fever the delirium or psychomotor exaltation (usually epileptiform type) develops, at decrease in body temperature — an amentia, in the convalescence period — an asthenic syndrome.

The concept of exogenetic type of Bonhöeffer's reactions gained wide recognition, but over time was partially revised. It turned out that alienations are really not specific, but at a different exogenetic harmfulness differ in a number of features (in different degree of expressed). According to representations of the author, one syndromes have the exogenetic nature (mainly conditions of the dulled consciousness), and others (maniacal, depressive, crazy, hallucinative – endoform syndromes) – an endogenic origin with participation of heritable predisposition and other internal factors. Late rigid division on exo - and endogenic symptom-complexes was confirmed only partly.

Uniformity of psychopathological syndromes of an exogenetic origin, for example at infections, is defined by existence of the identical pathogenetic moments. One of them toxic. But the hypothetical interstitial link of Bonhöeffer operating on a brain cannot be the same poison at all infections. It can be both waste products or disintegration of microbes, and the endotoxins which are formed owing to change of function of a liver, a digestive tube, endocrine glands. Other pathogenetic moment – fever and the related circulatory violations – a brain hyperemia, and at critical temperature drop the relative failure of brain blood circulation. The brain hypoxia playing an essential role in emergence of mental violations is bound to circulatory changes (at the infections affecting lungs, for example, at a lung fever – with disorder

of respiration). Depending on these moments in one cases the infectious delirium can appear at height of rise in temperature – a febrile delirium, or at the time of the collapse accompanying its sharp recession – a collapse delirium.

The defined value has nature of immune reactions. If reactions rough, there is a great opportunity for acute psychoses if immunologic processes sluggish, delayed, and psychoses gain chronic character.

To sharp symptomatic psychoses since the time of Bonhöeffer, states with a stupefaction (deafenation, a delirium, an amentia, twilight state, a oneiroid), and also pictures of a acute verbal hallucinosis traditionally belong.

Endoform syndromes, and also apathetic stupor, confabulation, H. Wieck carried a pseudoparalytic and transitional Korsakov syndrome to the "transitional" syndromes which develop at the fixing course of symptomatic psychoses. Fixing (protracted) symptomatic psychoses usually proceed from 2 weeks to 2-3 months and come to an end with the so long-lived condition of an asthenia or are (less often) replaced by heavier (low-reversible) frustration — a psychoorganic syndrome. Transitional these syndromes were designated by Vick taking into account risk of development of a psychoorganic syndrome. In particular, the larger risk of formation of a psychoorganic syndrome was caused further by fixing maniacal states, the Korsakov syndrome.

The chronic current at which psychosis can proceed for years most often happens at hallucinatory-delusional states. In cases of a remitting current observe repeated hallucinative and hallucinatory-delusional states, depressive (flowing past usually in combination with asthenic and hypochiondrial symptoms) and maniacal states. There are they or in connection with recurrence of the infection (as it happens at rheumatism), or in response to any padding influences – overwork, mental and physical injuries, casual additive infections. In some cases it is not possible to find any circumstances which could promote a repeated attack of psychosis.

The following supervision is also given from lecture of professor Yu.E. Rakhalsky.

The patient whom we will meet, the worker of garment factory, to it is 25 years. Four years ago she transferred the first attack of rheumatism with all typical phenomena: the long-lived temperature increase, a swelling in joints, pain in them. On the third week of an illness it got to us from therapeutic office of a municipal hospital. It was disturbing. Having jumped in the night from a bed, she demanded that she was immediately allowed to go home since she heard how other patients arranged to kill her. She saw how in a window someone looked, heard steps on an attic, was very lost and excited. In our hospital it turned out that it hears voices of people unfamiliar to it. These voices exchanged words among themselves, some man told how it took a piece of fabric at factory that she has to be punished for it. Voices from time to time abated, by the evening they became more distinct. It was physically weak, whining, irritable. In 15-20 days deception of perception at it disappeared, fatigue decreased. Even before it reduced temperature, and there passed the phenomena from joints (the patient received antirheumatic treatment). It was written out in a satisfactory mental and somatic condition. After a while she started over again working, married, gave birth to the child. Pregnancy and childbirth proceeded at it safely, only at survey in consultation for pregnant women found heart disease in it.

Two months ago at it temperature increased again, there was a weakness. It was placed again in somatic hospital where the diagnosis of a rheumatic carditis was established. There she in several days began to behave irregularly. Again she was alarming, ran up to a window, peered at it. She heard voices, this time some woman ordered her: you do not eat, do not talk to people, run from hospital. Under the influence of these orders she poured out the tea given it once and burned. In hospital it again observes distinct auditory hallucinations. This time it less expressed weakness and fatigue, but periodically she is sad and alarming. Now it becomes better for it.

«How do you feel?" - "From time to time nothing, only the head hurts, a left-hand side". – «Are you get tired quickly?" - «Yes.». – "And how is your mood?" - "Now quite good, and the melancholy and the strong fear will find after a while, itself I do not know why". – "Are you hear voices now?" - "Not always, sometimes I hear".

– "What do they tell?" - "Order to look in a window, order to be thrown out of it". – «Are this voices distinct?" - "Distinct, more than one woman say". – «Are they distributed at you in ears or go from outside?" - "No, not in ears as the living person speaks". – «Is it really living person speaks or it seems to you?" - "Is not present, apparently, now I know". – "And you did not understand it earlier? " - "And now when I have a melancholy and when the voice speaks: be thrown out of a window, I am ready to jump out. When I for the first time here lay, I nearly jumped out". – «Is it better for you now?" - "Yes, it is better".-"Continue to be treated, you will recover absolutely soon. Good-bye».

The patient has remittent or, more correctly, a recurrent acoustical hallucinosis in connection with a repeated exacerbation of rheumatism. Except auditory hallucinations the asthenia phenomena are noted, and during the last attack of psychosis – episodes of an alarming depression. After the first attack of psychosis at the patient some phenomena of defect are not noted. The second attack arises in connection with an exacerbation of the infection and is similar to tentative.

Curt Schneider formulated conditions of emergence of somatopsychoses:

- expressiveness of visceral pathology;
- chronological coincidence, parallelism in dynamics of mental and somatic violations (as a tendency, but not rigorous regularity);
- frequent existence of organic psychoneurological symptoms.

The Korsakov syndrome, dementia and psychoorganic syndrome belong to organic syndromes. You got acquainted with the first two syndromes at the previous lectures. Let's stop in more detail on a psychoorganic syndrome.

The psychoorganic syndrome which is formed after symptomatic psychoses is a residual state. Its manifestations not only are not inclined to progressing, but, on the contrary, can smooth out to a certain extent further. Many authors prefer to call in this regard it not a psychoorganic, but encephalopathic syndrome. Allocate 4 main options of a psychoorganic syndrome: asthenic, explosive, euphoric and apathetic.

At asthenic option in a picture of a psychoorganic syndrome permanent asthenic frustration in the form of the raised physical and mental emaciation, the

phenomena of irritable weakness, a hyperesthesia, affective lability whereas disorders of intellectual functions are expressed slightly prevail. As a rule, only some decrease in intellectual efficiency is noted. Regarding cases also mild dysmnestic frustration come to light.

The combination of affective excitability, irritability, explosibility, aggression with mild expressed dysmnestic violations and decrease in adaptation is typical for *explosive option* of a psychoorganic syndrome. Tendency to supervaluable paranoiac educations is characteristic. Quite often there are a weakening of strong-willed delays, self-checking loss, increase of inclinations.

Both at asthenic, and at explosive option of a psychoorganic syndrome there is an expressed state decompensation in connection with intercurrent diseases, intoxications, change of weather conditions and mental injuries. In the latter case at patients follow-up various hysterical frustration can develop.

The picture of *euphoric option* of a psychoorganic syndrome decides by increase of mood on a shade of euphoria and complacency, stupidity, falloff of criticism of the state, dysmnestic frustration, increase of inclinations. At part of patients the explosions of irascibility with aggression which are replaced helplessness, tearfulness, an affect incontience are observed. At patients serviceability is considerably reduced.

The apathetic option of a psychoorganic syndrome is characterized by an aspontannost, sharp narrowing of a focus of interest, apathy to environmental, including to characteristic destiny and destiny of the relatives, and the considerable dismnestichesky frustration.

In a clinical picture of symptomatic psychoses, besides the common manifestations peculiar to all somatic (infectious and noninfectious) to diseases and intoxications, some features typical for separate somatic diseases or poisonings are found. The description of features of symptomatic psychoses at a number of separate diseases explicitly is provided in textbooks of psychiatry and monographs which list is specified in the management to a practical training.

Several remarks on infectious psychoses.

On nature of the action on a CNS all infections divide into two groups. One of them, the greatest, is so-called common infections. Another – neuroinfections at which the nervous system is surprised with the relative selectivity: virus encephalitis, epidemic cerebral meningitis, poliomyelitis, general paralysis, brain lues, etc. Border between neuroinfections and the common infections not really particular, it is possible to say with relativity that at neuroinfections the harmful agent immediately gets through a hematoencephalic barrier and strikes nervous tissue, the common infections more have the damaging effect on nervous system through the toxins which are formed in the course of activity of the infectious agent. Both at neuroinfections, and at the "common" infections there can be destructive changes of brain fabric which are clinically shown by decrease in memory and powers of thinking, epileptic seizures and other symptoms which fall into to group of organic syndromes. The frustration which are most extended at infections are asthenic conditions and violations of clarity of consciousness.

Developing of psychosis at infections, character of symptoms and its current are defined not only properties of the somatopathy, but also the soil. For example, at the patient weakened by the previous disorders and overwork, flu can cause the serious psychotic condition proceeding with an amentia. The people who had a skull injury, abusing alcohol are more subject to danger to ache with acute psychosis. These pathological moments also contribute to the chronic course of infectious psychosis.

In conclusion we will stop on concepts of a iatrogeny and jet states in connection with a physical illness. We already touched upon this subject when studying the subject "medical psychology". The iatrogeny acts as one of consequences of violation of relationship between the doctor (medical personnel) and the patient. Iatrogeny – the common name for designation of the alienations arising owing to the negative hurting influences on the patient of words (actually a iatrogeny) or actions (iatrogeny) of the doctor either nurse (sorrorgenia), or other medics. Iatrogeny kinds of jet states about which it will be in more detail explained in one of the following lectures fall into. Besides, alienations can arise as psychologically caused reaction of the patient to the illness fact (a so-called nosogenia). In this case

matters, both disease severity, and the patient's person who is subjectively experiencing weight of an illness. That is it is about an internal picture of an illness and its components – emotional, strong-willed, sensing - concepts which also explicitly were considered on medical psychology.

TEST TASKS
(for self-preparation)

Choose one correct answer

1. LACK OF ORIENTATION IN ENVIRONMENTAL AND IN CHARACTERISTIC PERSON, THE DIVAGATION, CHAOTIC EXALTATION (IN THE BED) WITH THE SUBSEQUENT AMNESIA
   1) delirium
   2) amentia
   3) twilight frustration of consciousness
   4) jactitation

2. INCREASE OF THE PORG OF PERCEPTION, SLEEPINESS, NOT ROUGH DISORIENTATION, SLUGGISHNESS, DECREASE IN THE MUSCLE TONE
   1) coma
   2) amentia
   3) somnalention
   4) obnubilations

3. THE CONDITION OF WAKEFULNESS WHICH IS CHARACTERIZED BY THE FULL ORIENTATION, THE COMPENDENCY OF THE SPEECH, FOCUS OF ACTIONS, ABILITY TO SWITCHING OF ATTENTION
   1) clear consciousness
   2) aproductive frustration of consciousness
   3) productive frustration of consciousness

4) sopor

4. ONEIROID WITH DOUBLE ORIENTATION, WITH SCENIC VISUAL HALLUCINATIONS, EXPERIENCE OF FANTASTIC SITUATIONS, NOT FOLLOWED BY ADEQUATE ACTIONS

1) delirium
2) amentia
3) oneiroid
4) trance

5. SWITCHING OFF OF CONSCIOUSNESS FOR A MOMENT WITHOUT FALLING AND SPASMS

1) fugue
2) trance
3) absentia epileptica
4) catalepsy

6. VIOLATION OF CONSCIOUSNESS WITH THE CHANCE ORIENTATION, EXALTATION, FEAR, VISUAL HALLUCINATIONS WHICH REMAINED IN MEMORY

1) oneiroid
2) delirium
3) twilight state
4) somnalention

7. SWITCHING OFF OF CONSCIOUSNESS WITH THE AREFLEXIA, PATHOLOGICAL REFLEXES, VIOLATION OF VEGETATIVE FUNCTIONS

1) coma
2) sopor
3) obnubilations
4) delirium

8. COMMISSION OF THE DIFFICULT AUTOMATIC ACTIONS, MOVING IN THE UNCONSCIOUSNESS

1) fugue

2) absentia epileptica

3) trance

4) dysphoria

9. SHORT-TERM SWITCHING OFF OF CONSCIOUSNESS WITH ASPIRATION TO RUN

1) trance

2) fugue

3) oneiroid

4) absentia epileptica

Lecture No. 6
Alcoholism, drug addiction

Social and medical value of an alcoholism. Intoxication as disorder of psychological functions of the toxic nature, "Routine" intoxication and its special options – pathological, amnestic, dysphoric-explosive. Concept of tolerance. Preclinical stage of an alcoholism. Tolerance strengthening, habit. Psychological dependence Clinical stage. Hangover syndrome. Hard drinking. Alcoholic deterioration. Alcoholic psychoses. Delirium tremens, alcoholic hallucinosis, acute paranoid, nonsense of jealousy. Korsakov psychosis. Treatment and prophylaxis of an alcoholism and alcoholic psychoses. Definition of the concept "drug addiction". Classifications of drugs. Clinic of drug addiction.

In the real lecture it will be a question of the diseases which are falling into the specialty "Addictology" which studies diagnostics and develops methods of treatment and prophylaxis of diseases, the bound to dependence on the psychoactive materials. The tools capable to influence in a special way the central nervous system are considered as the psychoactive materials (PVA), causing the stimulating, euphoric, stimulating, somnolent effects, and also hallucinations. The majority of these substances at the long-lived use **causes dependence**, that is such condition of an organism when rather comfortable mental and physical health requires their continuous use and which is expressed in emergence at a **sick withdrawal** at the termination of introduction to an organism of the psychoactive material. Morbid frustration, the bound to dependence on the psychoactive materials, call also **addiction**. All these substances are divided into three groups. The first group is, actually, not group, and one, but very widespread psychoactive material — alcohol. Alcohol – toxicomaniac means, as well as other PVA which are not entered in the list of narcotic. An illness, the bound to alcohol, is called an **alcohol addiction** (the former name an alcoholism).

The second group — *narcotic substances*, belong to them the psychoactive materials capable in rather short terms to cause the dependence which is followed by

a heavy withdrawal (or an abstinence syndrome), and entered in the express register (list) of narcotic substances; manufacture, distribution and pirate storage of these tools is pursued by the law. This list is approved by the Minister of Health or his deputy. Thus, drug is a concept not only medical, but also legal. To this group, on the basis of the resolution of the Government of the Russian Federation from 30.06.98. No. 681 "About the approval of the list of the drugs, psychotropic substances and their precursors which are subject to monitoring in the Russian Federation" heroin, opium, poppy straws, cannabis (marijuana), phencyclidine, эфедрон, a psilocybin belong (according to the list No. 1 forbidding turnover of these substances in the Russian Federation); Codeinum, Cocainum, Morphinum, Omnoponum (according to the list No. 2 limiting turnover of substances and establishing strict measures of control of them). In the same list Sombrevinum equated to drugs, ketamine, Barbamylum appear, etaminat sodium.

At last, the tools causing dependence, but which are not entered in the register (list) of the narcotic and equated to them tools belong to the third group of the psychoactive materials (Cyclodolum, Dimedrolum, tranquilizers, caffeine, volatile psychoactive materials — gasoline, solvents of nitropaints and some types of glue).

Though the use of the psychoactive materials by the person originates in the depth of the millennia, idea of dependence on the psychoactive materials as about an illness was created only within the 19th century.

Gravity of the tasks facing an addictology as science is bound to spread of diseases of dependence, as a rule, among the young, developing generation (teenagers and young men) and people of an average — the most fissile and creative — age. Besides, these diseases have chronic (incurable) character. A condition of these diseases not only biological (genetic), personal, but also social factors (influence of customs, the subcultural moments) puts forward an addictology in a row of the most actual sciences, the bound to various public disciplines: psychology, pedagogics, sociology, law, etc. Together with these disciplines she, besides purely clinical questions, has to solve prophylaxis problems the addictive diseases.

Diseases, the bound to dependence on the psychoactive materials, and first of all an alcoholism, are considered as one of the most widespread in the world: in

economically developed countries from 1 to 9% of persons at the age of 15 years is also more senior indulge in unlimited alcoholism, that is daily use on average more than 150 mg of absolute alcohol that is equivalent to 375 ml of 40-degree vodka, 1 l of wine with a strength of 15-16 degrees or 3 l of beer (fortress of 5 degrees).

In the Russian Federation on the account consists 4,6 million alcoholics that makes 3,3% of the population; considering a large number of the patients using services of the private narcological organizations and who were not treated at all this figure has to be increased in 2, and even by 3 times.

Today it is difficult to present absolute figures of incidence of drug addiction and toxicomanias. The figure of 390 000 patients consisting on the narcological account about the country is given, it, probably, is strongly underestimated and does not reflect a real. It should be noted at the same time what in the majority of regions of Russia of drug addiction is generally city "achievement". In rural areas, mainly using psychoactive agent is alcohol. Among patients addicts the ground mass at us in the country is made dependent on opiates, namely from heroin.

The type of drug addiction prevailing on a particular interval of time depends, as a rule, on the offer of goods in the narcotic market. A few years ago, when international "supply" of drugs to our country was substantially complicated, the use of the drugs prepared by a crude method prevailed (poppy straws, ephedrone , etc.).

For further illumination of questions of an addictology it is necessary to specify two keyest concepts. It is about accepted in the modern classifications, in clinical practice, and also in the corresponding express literature the concepts "abuse" and «dependence".

Abuse is understood as the term the frequent use by an individual of any psychoactive material with safety of control over its receptions, "normal" reaction (symptoms of poisoning) to overdose of the psychoactive material. At the same time still there is no main syndrome — physical dependence (a withdrawal, an abstinence syndrome) which clinical description, various for each psychoactive material, will be given further. At this option of the use of the psychoactive materials the so-called mental dependence which is expressed in the notions of compulsion and memories of an ebrietas, not excluding, however, continence from the use of substance in each

case can be noted. The subjects abusing the psychoactive materials can have problems, the bound to health, with behavior in a family and in public places in an inebriety, with the derelictions of duty caused by abuse of these substances. Such problems at the patients abusing alcohol where the period of abuse can be extended for several years (in cases of drug addiction it takes usually several months) are especially actual. Therefore the period of formation of an alcoholism (when the person abuses alcohol, but it is not sick yet) call the period household (habitual or problem) alcoholism. Abroad these people are called problem drunkards. A number of domestic authors refer this abuse of alcohol with formation of mental dependence and some other symptoms to the 1st stage of an alcoholic disease.

Dependence on the psychoactive material is the state which is undoubtedly demonstrating presence at the "dependent" person of an illness which, according to MKB-10, is called as dependence on the psychoactive material (from alcohol, heroin, Cocainum etc.) . The speech, as a rule, goes about physical dependence (though there are substances, such as a hasheesh or tranquilizers when dependence is limited to a mental phase). As for physical dependence, its presence can be stated on emergence of a withdrawal (or an abstinence syndrome). Existence of such syndrome testifies to chronic poisoning of an organism with the psychoactive material. The concept of dependence is not limited to the sphere of the use of the psychoactive materials. Are available for each person mental dependence on these or those stereotypes of behavior, habits which violation conducts to a psychosomatic discomfort (for example, a habit to particular hygienical procedures and physical dependence, in particular, on water and food.)

Cardinal sign of the developed illness stage also is the pathological inclination to the psychoactive material. The composite symptom-complex includes an affective component (internal stress, alarm), a vegetative component (tachycardia, hyperaemia of the person, a tremor of hands, a sweating, etc.), an ideational component (the notions of compulsion about need to accept the psychoactive material), a behavioural component (fussiness, restlessness, readiness to rush on searches of the psychoactive material).

The main reason of alcohol intake and other psychoactive materials is an aspiration to cause in itself an ebrietas – euphoria, feeling of internal content, slackness, disappearance of alarm, detachment from all everyday adversities. For the sake of it people overcome even negative initial reactions of an organism to alcohol or drug (phenomenon of sharp poisoning).

To join the use, and then and to abuse of the psychoactive materials any person can, however at one people risk ache with alcoholism or drug addiction more, others – have less. And to that there is a variety of reasons of biological, psychological (personal) or social character. At the same time at one people the group of the biological reasons, at others — personal etc. can play a large role in dependence formation, and the others play the supporting, supporting role. Let's list the common factors promoting formation of dependence on the psychoactive materials irrespective of character of these substances.

From **biological factors** are main: aggravation narcological and mental diseases, the use by mother of the psychoactive materials during pregnancy, pathology in labor, early somatic, including infectious, the diseases involving violation of physical and intellectual development, and also a mental dismaturity. **The psychological factors** able to promote formation of dependence on the psychoactive materials, is an existence of frustration of the person in the form of accentuation of character or psychopathies, the instability of mental activity which is expressed in tendencies to neurotic reactions, and also such lines of the person as lack of resistant attachments and interests with preference of "the mild solution of any questions", lack of depth in labor installations, an egocentricity. The most widespread **social factors** are: inexact family, alcoholic customs and the conflict relations in a family, the low educational level of parents and the improper education, besides, such environment in life, on production or in the place of study in which the use of the psychoactive materials, and also stay in criminal environment is widespread.

The alcohol addiction (alcoholism) is the most widespread disease from all options of narcological pathology. According to WHO data, an alcoholism is the third disease on the frequency of the death caused by it (after cardiovascular and oncological diseases). Frequency of accidents with a lethal outcome among

alcoholics in 2,5-8 times more, than among other population. Physical dependence on alcohol is the cornerstone of a disease (ethyl or spirit of wine).

The alcohol addiction, as well as any addiction disease, can be provoked as it was already specified, by many reasons (often there is a complex of the biological, psychological and social reasons). Certainly, people with psychopathic traits of character among which conformal, hypertemic, epileptoid and unstable types prevail get sick more often. Let's emphasize that the most essential role in formation of an alcohol addiction is played by social factors: trouble in a family, the parents abusing alcohol fellow workers, colleagues (microsocial factors) suffering from an alcohol addiction. Besides, in the last 15 - 20 years and macrosocial factors, main of which - unemployment, migrations, loss of the former material and social statuses, etc. For teenagers an important role is played by imitating mechanisms, unwillingness to seem "black sheep" and aspiration to pass for the "cool" guy and the girl. The low educational level and low-skill work which is (quite often well paid) are also frequent risk factors of an alcoholism disorder.

The special look, and in fact the acutest psychotic state, represents **pathological intoxication**. This twilight frustration of consciousness arising suddenly after reception of slight doses of alcohol (on average about 150 ml of vodka). There is it quite often against overwork, sleeplessness, malnutrition or at the people predisposed to various paroxysmal manifestations (having epilepsy or organic damage of a brain). The picture is similar to twilight frustration of consciousness at epilepsy. The person as though sobers and makes, without paying attention on people around, a number outwardly of the targeted actions leading to serious consequences. Being in a condition of pathological intoxication make arsons, murders, rapes and so forth. Distinguish two main forms of pathological intoxication: delirant (paranoica) of which except visual hallucinations crazy ideas of prosecution and the relation are characteristic, and epileptoid, differing markedly the increasing motive exaltation and the strong affect of fear. The period of psychosis is completely forgotten by the patient who usually fills up directly in situ offenses.

A. A. Portnov and I.N. Pyatnitskaya allocated three stages in development of an alcoholism (alcoholic disease) which reflected dynamics of a symptomatology of an illness from its initial manifestations to terminating states.

First (I) stage of an alcoholism (stage of mental dependence). In the (I) stage of an illness gradually arise and there are more relief its main manifestations. One of the first is **the reactivity change phenomenon — at the patient the emetic reflex** on the use of the considerable doses of alcohol disappears. It is bound to the fact that at the patient tolerance grows (an opportunity to transfer high doses of alcohol), the organism gets used to alcohol. There is one of axial symptoms of an illness — **a pathological inclination to alcohol** (thirst of alcohol which the patient can not realize). In the ideational sphere of the patient alcohol takes the increasing place, and in its activity the aspiration to create an alcoholic situation or to join it prevails. The pathological inclination to alcohol can be shown by indirect signs: to resuscitation of the patient at talk on binge, an involuntary smile, the swallowing movements, the fussiness which is shown at the same time. Internally the patient has the expressed desire to take alcohol. However this desire remains at the ideational level, is not followed by any physical feelings and gains persuasive (obsessive) character. Mental dependence is defined by the fact that the patient at this stage cannot reach mental comfort in particular situations (mainly situations of leisure, rest) without reception of particular doses of alcohol. In this regard there is a symptom of "a shot glass advancing", i.e. the patient cannot quietly conduct conversation, exchange impressions waiting for approach of all guests: he tries "to intercept" somewhere some dose of alcohol, having agreed with the owner of a celebration. During a feast interrupts people around, often suggesting "to drink at first". Taking into account a situation the patient at this stage can refuse alcohol intake: obligations for service, a family debt resist to his desire. The euphoric phase of intoxication is shortened and becomes more narrow at this stage quite often dysphoric. The characteristic of this stage is loss from memory next day after binge of separate episodes of intoxication – palimpsests (erasing). After alcohol intake the sleep is quite often interrupted, there are vegetative violations after binge next morning. The patient's person changes at this stage also: loses the former friends who are not

sharing its aspiration to alcohol, interests of a family begin to play the supporting role. Irascibility, irritability and even aggression in relation to relatives develops, especially at their reproaches in abuse of sick alcohol. Duration of this stage is 5-8 years.

The second (II) stage of an alcoholism (stage of physical dependence) is characterized by formation of strong indications of an illness from which main thing is the abstinence syndrome (withdrawal) which existence does not allow to doubt final formation of an alcohol addiction. This state is called still a hungover syndrome, a syndrome of a separation or a syndrome of deprivation, it demonstrates that at the patient the chronic drunkenness takes place, and the changes which happened in an organism are already irreversible. Only the complete continence from alcohol can recover the patient health now.

The abstinence syndrome develops at patients with an alcohol addiction after the termination of the alcohol intake continuing several days or more long time. The abstinence syndrome is shown by a various somatic-vegetative and psychopathological symptomatology. A sweating, tachycardia, hyperemia of integuments, a cold fit, the expressed tremor of fingers of hands, dizziness, heartburn, nausea, intestines dysfunction are noted. The psychopathological symptomatology is presented by sleep disorders (sleeplessness or the surface dream with dreadful dreams). The reduced mood with an alarm shade often is expressed by expectation of any troubles. Quite often there is both a repentance, and experience of fault for deeds (money is spent on drink, someone's expectations etc. are deceived). Soon the patient is convinced that only alcohol can facilitate this state in routine conditions, and it shows an reanimation phenomenon which leads to multi-day dipsomania.

The termination of alcohol intake happens or owing to the external reasons (lack of money, threat of dismissal or divorce, etc.) that is characteristic of pseudo-hard drinkings, or sharp deterioration in physical condition with impossibility to transfer alcohol (exhaustion, renewing of an emetic reflex) that is inherent in the true hard drinkings which, however, are more often observed in the third (III) stage of an illness. Usually in the (II) stage patients have a high tolerance to alcohol (they without catastrophic consequences transfer its very high doses). Nature of

intoxication becomes dysphoric (irritability, malignancy, a conflictness, aggression). There is a so-called amnestic form of intoxication when patients almost completely forget what happened to them in this state. Problems, the bound to alcohol, at these patients increase many times over. They are promoted by loss by the patient of the quantitative and situational control of alcohol intake. The patient with the second stage of an alcoholic disease not only cannot refuse the presented opportunity to drink, moreover, he constantly looks for opportunities to realize the not surmountable pathological inclination to alcohol (a compulsive inclination).

All occurring phenomena considerably are bound to formation of alcoholic encephalopathy, i.e. the irreversible pathological processes in a brain caused by an alcoholic poisoning. It is more expressed, than in the 1st stage also the person of patients – the person's psychopatisation changes: they become irresponsible, false, lightweight in judgments, illegible in acquaintances. At some the traits of character inherent in them to an illness amplify: theatricality, suspiciousness, explosibility or other lines. Also moral and ethical decrease attracts attention: neglect family duties, neglect of the work, tendency to immoral acts.

In the (II) stage quite often there are acute alcoholic psychoses, and sometimes and convulsive attacks as displays of the formed alcoholic encephalopathy.

At this stage of an illness, especially in its second half, there are multiple somatic violations, the bound to a chronic drunkenness – toxic hepatitises, gastritises, pancreatitis, a myocardial dystrophy, violations (easing) of sexual function.

Duration is (II) stages on average 7-10 years.

The third (III) stage of an alcohol addiction (encephalopathic) is shown in increase of symptoms of toxic damage of a brain, and also other systems of an organism. At this time tolerance (patients get drunk with slight doses of alcohol, pass to less hard liquors) decreases, there can be an emetic reflex again, the abstinence syndrome (withdrawal) proceeds rather hard with the expressed somatic and psychopathological frustration. Alcohol intake has double character: a) continuous alcohol intake in small amounts through particular time terms; b) the true hard drinkings which differ from pseudo-hard drinkings in periodic (cyclic) character with

the use in the first days of hard drinking of high doses of alcoholic drinks, emergence of heavy intoxications with amnesia, a soporous condition and the subsequent falloff of tolerance to alcohol, up to its intolerance. During the long-lived continence from alcohol there can be pseudo-abstinent frustration which are completely imitating an abstinence syndrome. Changes of the person develop into an **alcoholic deterioration** when individual traits of the person are erased, and into the forefront apathy to everything, the cynicism, a lying, rough alcoholic humour act. Clearly psychoorganic violations act: memory impairment and difficulty of switching of attention, decrease in intelligence.

One of the most essential signs of an alcoholic deterioration is loss of ability to productive work.

It is possible to allocate **three main types of degradation of the person** of topers:

a) Degradation on explosive type. The affective instability, an incontience of affects, an explosibility, irascibility which are combined with эйфоричностью, rough alcoholic humour, revaluation of the person, хвастливостью, a lying, loss of moral ethical standards of behavior are characteristic of patients of this group.

Mnestic-intellectual violations at this group of patients can be expressed slightly, quite often they keep stocks of earlier acquired knowledge and skills, the professional opportunities. However they are not able to realize these opportunities as evade from work or get into a conflict situation because of violations of labor discipline, the characterologic features.

b) Degradation on organic type. The mnestic-intellectual decrease reaching forms of a partial dementia is characteristic for this purpose like degradation. It is observed mainly at patients at whom an alcoholism is combined with vascular, traumatic and other organic diseases of a brain. Into the forefront at this form of degradation symptoms of mnestic-intellectual decrease act: deterioration in attention, memory, apathy, the considerable decrease in working capacity, frustration of a dream, sharp faintheartedness, depressive hum noise of mood.

As extreme forms of an alcoholic deterioration on organic type can be observed *apathetic and euphoric syndromes.* At the first of them it is routine at an

alcoholism combination to heavy traumatic encephalopathy, an atherosclerosis of vessels of a brain and so forth apathy, emotional dullness, apathy to environmental, reaching such degrees that the patient makes impression of the devocalization which is in a state takes place. At a thicket the found pseudoparalytic syndrome which is characteristic of alcoholism combinations to more mild degrees of an atherosclerosis of vessels of a brain, takes place complacency, garrulity, boastfulness at the complete loss of the critical relation to the state.

During the abstinence periods patients in the (III) stage of an alcoholism in the presence of degradation on organic vascular type can have heavy depressions with suicidal attempts.

c) Degradation on the mixed type. Besides the listed two extreme types of an alcoholic deterioration, at a number of patients the mixed forms at which lines of alcoholic and psychopatholike and organic changes are combined take place. During a disease expressiveness of these or those symptoms at one patient can change, and, as a rule, mnestic-intellectual decrease forces out alcoholic and psychopatholike personal changes.

At this time patients finally lose family relations, cannot restore the production status even on much the reduced level and conduct a parasitic, and even criminal way of life.

The somatic state is considerably made heavier: by this time cirrhosis and the expressed cardiomyopathy develop. They are accompanied so-called alcoholic polyneuropathy with an atrophic paresis, first of all the lower extremities, gait violation. Conditions of an abstinence often come to an end with acute alcoholic psychoses or sharp alcoholic encephalopathies. In this stage there are also chronic alcoholic psychoses.

Alcoholic psychoses.

Developing of alcoholic psychoses, as well as convulsive attacks, demonstrates existence of symptoms of alcoholic encephalopathy (toxic organic damage of a brain). Acute alcoholic psychoses usually develop on third day after the termination of a large alcoholization. Their emergence can be promoted also any

padding harmfulness (infectious or a somatopathy, a surgical intervention with the common anesthesia, etc.).

The tremens ("delirium tremens") is characterized by chance orientation in environmental which depends on the maintenance of visual hallucinations. Visual microhallucinations are quite typical. Patients see insects, mice, snakes, little men, devil (sometimes other fantastic humanoids). There are hallucinative frustration in the form of a web, a grid, threads, water flows which are followed by also hallucinative feelings of a touch, conformal coating, an oputyvaniye. The hallucinative images replacing each other are not connected by the common subject line, but, as a rule, have frightening character. The behavior of patients reflects nature of the hallucinative experiences experienced by them: they shake something from themselves, dodge, untangle imaginary threads, run away in fear, catch someone. For example, the patient, "pursued by doctors" which were in cars size about a coat button escaped for 40 km from the residence, was not detained by militia yet.

Alcoholic hallucinosis is shown by auditory hallucinations, as a rule, of unpleasant contents. Voices have the character commenting and condemning his behavior: accuse the patient of alcoholism, that he causes troubles and misfortunes to a family, relatives. Sometimes voices have imperative character, order to make dangerous to people around or the most sick action, for example, to commit suicide. Though a hallucinosis as well as delirium tremens, develops sharply, its further current often happens fixing. Despite the carried-out treatment, hallucinations remain from several days to several weeks (*a acute hallucinosis*). At part of patients more long-lived is observed, sometimes lifelong existence of symptoms (*a chronic hallucinosis*). In this case it is necessary to carry out differential diagnostics with the schizophrenia provoked by alcohol.

At an alcoholic hallucinosis orientation in an environmental situation and in time is not broken. At a chronic hallucinosis the critical relation to acoustical deception is quite often formed eventually, patients can distinguish actual sounds and morbid manifestations. However at temporary strengthening of hallucinative experiences (flow of hallucinations) is more often after a padding harmfulness including alcoholic excesses, the criticism is lost.

The alcoholic paranoid (persecution complex) is shown by crazy ideas of various contents, is frequent in combination with hallucinations. The alcoholic paranoid proceeds sharply more often, however its fixing (chronic) current is sometimes observed. At a acute paranoid patients are excited, have sensation of fear, on crazy estimate the situation surrounding them. Illusions and fragmentary hallucinative experiences are observed. Duration of such psychotic state it is routine from several days to 2-3 weeks. If the acute alcoholic paranoid passes in fixing, outwardly the behavior of the patient is ordered, he becomes as if quieter, however persistently states ideas of prosecution or jealousy. The nonsense mainly paranoiac (nonsense of interpretation), develops sluggishly, gradually. As the arguments which are allegedly confirming validity of statements of the patient he gives unilaterally the selected everyday situations. Their description looks sometimes reasonable.

Alcoholic paranoids in case of the termination by the patient of abuse of alcoholic drinks fade, are reduced, gain lines of residual nonsense. At a diagnostic assessment of paranoica alcoholic psychoses it is necessary to consider anamnestic data on abuse of sick alcohol, existence of psychological and physical dependence on it.

Alcoholic paranoia (nonsense of jealousy). This rather infrequent alienation meeting at men paranoiac or epileptoidny accentuation of character in a premorbidal state. The nonsense develops gradually. At first in intoxication or during an abstinence patients begin to accuse the wife or the cohabitant of incorrectness. Originally these charges can seem to people around reasonable. Then reproaches become more and more ridiculous. Patients begin to watch gradually the wife, subject her to shameful checks, to force to recognitions, to bring far-fetched evidence of "treason". From strangers of idea of jealousy they can skillfully hide. Usually do not show any aggression against imaginary rivals — blame the wife for everything.

In a nonsense pathogenesis a part is played decrease in a sexual potentiality, routine at an alcoholism of the II-III stage, and also the conflict relations and alienation between spouses because of alcoholism of the patient.

Alcoholic depression. This affective frustration quite often develops at patients with an alcohol addiction after escaping of a condition of an abstinence

(withdrawal), that is in 7-10 days after the termination of abuse of alcohol. In certain cases this frustration; it is bound to congenital predisposition of patients to affective fluctuations, and in others — immediately to a chronic drunkenness.

The alcoholic depression is characterized by the reduced mood, alarm, a sleep disorder, loss of appetite. Patients grow thin at this time, at women the menstrual cycle can be broken. Daily mood swings with morning or evening improvements are noted. The depression has atypical character. The retardation peculiar to a classical depression is not noted. Besides alarm in a depression at patients with an alcohol addiction dysphoric manifestations (sad and spiteful affect), asthenic frustration (a physical and mental emaciation, irritability, affective instability), hypochiondrial frustration (unjustified fixing of the patient on the physical condition with supervaluable ideas about presence at it of serious illnesses), apathetic frustration can be noted (when the depression is followed by slackness, apathy to environmental, disappearance of former interests). Such states can proceed from several weeks to 2-3 months.

Other forms of psychoses which are shown mainly negative symptomatology are ***alcoholic encephalopathies***. Alcoholic encephalopathy can be sharp and chronic.

Sharp alcoholic encephalopathy of Gayet — Vernike proceeds against a deep stupefaction (an amentia, a sopor) with psychomotor exaltation. Patients are physically exhausted. A fervescence to 38-39 °C, the raised staxis (petechias, hypodermic hematomas, hematencephalons), and also neurologic symptoms – an ataxy, extrapyramidal and oculomotor frustration are observed. Constantly there is a danger of emergence of disorders of respiration and cardiac activity, wet brain. The lethal outcome is possible. In several days the sharp symptomatology can be reduced, and process to be transformed to the chronic current with the clinical picture typical for korsakovsky psychosis (alcoholic polyneuritic psychosis).

Korsakovsky psychosis often develops after completion of a heavy tremens, but sometimes arises gradually against systematic abuse of alcohol and the accruing alcoholic deterioration of the person. The main alienations at this psychosis are fixating also the retroecmnesia, an amnestichesky disorientation, paramnesias (a Korsakov syndrome) which develop against polyneuropathy. The criticism is usually

lowered, mood most often complacent or indifferent. Patients try to hide defect of memory by means of fiction (confabulations). Neurologic frustration are shown by disorder of sensitivity in distal departments of extremities, a numbness and pains. At the abuse termination psychoorganic and neurologic frustration can regress (especially at patients of young age), however the complete recovery of a former state of health usually is not observed.

Quite infrequent option of alcoholic encephalopathy — ***the alcoholic pseudoparalysis*** which is shown heavy frustration of intelligence (total weak-mindedness). Decrease in criticism, silliness, underestimation of a situation, ridiculous statements, helplessness in the solution of the elementary questions are observed. At all weight of observed frustration, at this option of encephalopathy the termination of alcohol intake and well-timed treatment can lead to the considerable improvement of a state and partial restitution of brain functions.

The term "drug" comprises **three criteria: medical, social, legal.** They are mutually dependent and in legal aspect oblige to recognize means narcotic only at unity of three criteria: **medical** - if the appropriate means, substance, a dosage form have specific effect on a CNS (stimulating, sedative, hallucinogenic, etc.) that is the reason of their not medical application; **social** – if this not medical application increases in such scales that gains the social importance; **legal** — if, proceeding from these two prerequisites given above, the relevant authorities, on that authorized (the Ministry of Health of the Russian Federation), recognized this means narcotic and included in the list of drugs, storage and/or distribution of which attracts criminal liability. Lack of one of these criteria does not give the grounds to consider medicine or chemical (synthetic, biological, vegetable) as drug even if this substance or medicine can become a subject of abuse and can cause respectively a disease state.

The psychoactive materials possessing the same properties, but which are not entered in the list of drugs are called toxicomaniac substances, and diseases, the bound to dependence on them — toxicomanias.

At these diseases, just as at an alcohol addiction, all clinical phenomena peculiar by addiction (that is the bound to dependence on the psychoactive materials) to diseases are observed. Mental and physical dependences (with a withdrawal), body

height of tolerance (acceptability) to the psychoactive material, a pathological inclination to it, and also mental and physical consequences of chronic intoxication are noted.

Classification of drug addiction and toxicomanias.

1. Thebaic drug addiction.
2. The drug addiction caused by abuse of hemp preparations
3. Abuse of sedative hypnagogues:

- the drug addiction caused by hypnotic drugs;
- the toxicomanias caused by abuse of tranquilizers.

4. Abuse of psychostimulants:

- amphetamine drug addiction;
- abuse of crude preparations of ephedrine and efedrinsoderzhashchikh of mixes;
- cocaine drug addiction;
- abuse of a coffeine.

5. Abuse of hallucinogens:

- action of a mescaline and psilocybin;
- abuse of an acid;
- abuse Phenihydinum;
- abuse of cholinolytics;
- the toxicomania caused by atropine-like tools;
- toxicomania when using antihistamine preparations;
- cyclodol toxicomania.

6. The toxicomania caused by inhalation of volatile organic solvents.
7. Polydrug addiction, the complicated drug addiction, polytoxicomanias.

Causal factors of emergence of dependence on the psychoactive materials.

The factors promoting emergence drug and toxicomanias — common for all the addiction of diseases, they are described at the beginning of lecture. Among the reasons promoting developing of drug addiction the singular is the criminal factor: drugs are as if imposed to people (it drug trafficking demands). First of all teenagers

and young men are caught in this net. There is also a fashion on drugs which victims are people "without; a core", easily coming under others influences, not having resistant attachments and great interests. Toxicomanias (in certain cases even toxicomania epidemics) affect mainly teenagers where the tendency to grouping is one of the main age characteristics of behavior. Therefore abuse of toxicomaniac substances extends among them extremely quickly.

Frustration, the bound to the use of volatile solvents. These diseases are called still inhalant toxicomanias. They are formed at steam inhalation of gasoline, stain removers, some grades of glue. Teenagers whom availability these the psychofissile tools attracts, a possibility of their group use, a funny nature of the experiences caused by them are ill them mainly.

Intoxication is characterized by euphoria and visual hallucinations, the quite often bound to imaginations of teenagers. At the long-lived steam inhalation of these substances there can be oneiric (fantastic oneiroid) states. In cases of overdose there can come the sopor and a coma. When forming dependence the number of episodes of inhalation within week, and then and day grows. Also time of each inhalation is extended. The individual use of inhalant can be a sign of the created dependence. Soon patients cease to hide the addiction and breathe in couples of inhalant in the face of relatives. The impossibility to inhale inhalant causes depressive and dysphoric frustration in patients.

Consequences of the use of inhalant are expressed in manifestations of a psychoorganic syndrome: memory easing, difficulty to concentrate, the poor ingenuity, delayed orientation. Apathy to everything increases. Patients are disturbed by headaches, dizzinesses. The neurologic symptomatology in the form of a tremor, a nystagmus, a poshatyvaniye in Romberg's pose, increase of tendinous reflexes is noted.

Frustration, the bound to abuse sedative and hypnagogues. Most often dependence on derivants of the barbituric acid — barbiturates meets. This type of dependence drug addiction fall into and calls the barbituric drug addiction as barbiturates according to the list No. 2 mentioned in the beginning of the head are equated to drugs, and the illness flows very malignant (dependence is formed quickly

and leads to serious consequences). Intoxication reminds alcoholic and is expressed in euphoria, hyperactivity, impudence. Euphoria can be changed by irascibility and aggression. Unsteadiness of a gait and disproportion of movements are noted. Besides, bradycardia, arterial hypotonia and a hypothermia are noted. In 1-3 h there comes the deep sleep which is replaced weakness and slackness. At overdose the sopor, then a coma develops, can drink us death from respiratory standstill.

The abstinence syndrome (withdrawal) proceeds quite hard: a sweating alternates with a cold fit. Arterial pressure increases, tachycardia, a tremor of fingers of hands, muscle spasms, nausea and vomiting are noted. For the 3-5th day epileptiform attacks develop, then several days keep the suppressed mood with alarm, and sometimes malignancy.

Toxic encephalopathy at this type of drug addiction develops quickly enough. At the same time thought processes are slowed down, memory is weakened, the speech greased the movements wide, inaccurate, a gait shaky. Mask like face, pale with an earthy shade. The mood is oppressed and spiteful.

At treatment of dependence on barbiturates the dose of the psychofissile means needs to be reduced gradually unlike treatment of other types of dependence. The dose exceeding therapeutic by 3-4 times is reduced to cancellation within 1-2 weeks (in order to avoid development of attacks or even the epileptic status). After that deintoxication, and then if it is necessary, treatment is carried out by antidepressants and psychotropic drugs. Besides barbiturates abuse of tranquilizers is noted. Persons of young age use them together with alcohol, passing often after that to heavy drugs. Abuse of tranquilizers at persons of middle and advanced age is noted (for mitigation of alarm, finding of self-confidence). Here it is about mental dependence.

Frustration, the bound to the use of cannabinoid. Narcotic substance is extracted from various grades of the Indian hemp. In our country hemp (a hasheesh, the plan), abroad — often marijuana is used. Use drug by smoking. Intoxication is characterized by a psychotic condition of various degree of expressiveness. Attacks of fun can be replaced by horror attacks. Got drunk with hemp are usually talkative, grimace, aggressively gesticulate, the hearing becomes aggravated, objects move

away. Pupils are narrowed, eyes shine, the injection of scleras is noted, dryness in a mouth is felt. In more strong intoxication oneiroid of consciousness when patients see themselves from outside participating in various fantastic scenes is noted. At the regular smoking of hemp 1-2 times a day develop the mental dependence which is expressed that in the absence of drug there are an alarm, concern, the under mood, fatigue; further, at emergence of physical dependence, except these symptoms nausea, muscle pains, unpleasant feelings in heart, arterial hypertension develop.

Drug addiction, the bound to the hemp use, is the transitional option of dependence and is dangerous that after it patients get sick with more malignant options, most often — thebaic drug addiction.

Frustration, the bound to the use of opioids – now it is the most widespread type of drug addiction. First of all it is about heroin drug addiction which in our country nowadays incorporates more than 90% of cases of drug addiction. Opioids which treat Morphinum, Omnoponum, Promedolum, Codeinum, heroin are derivants of opium which was received from heads of some grades of poppy. Now the majority of these drugs produce in the laboratory path. Thebaic drug addiction is a symbol of drug addiction; speaking about them, most often mean thebaic or, more precisely, heroin drug addiction.

All thebaic drugs are injected intravenously (heroin is intranasally taken sometimes — it is smelled). After drug introduction (we will speak about the heroine) a hyperemia of the person is noted, on a body there passes the hot wave which is followed by feeling of a pricking of needles under skin.

At poisoning with heroin which arises quite often the coma develops. Pupils do not react to light, respiratory violations accrue — two-three deep breaths alternate with a breath holding which is complicated, becomes faltering and noisy. The death can occur from respiration paralysis.

Mental and physical dependence is formed, according to some information, after 15 injections, and sometimes quicker. Drug becomes meaning of life of the person having drug addiction. Lack of drug causes a depression and apathy to everything. The dose of drug increases by 2-3 times.

The abstinence syndrome is characterized by muscle pains, spasms of muscles, spasms in a stomach, vomiting and a diarrhea, pains in heart, the cold fit alternates with profuse then. The hypersalivation and irritation mucous a nose with the continuous sneezing are noted. Pupils extend, pulse is speeded up. Such state lasts several days. After passing of these mild phenomena rather strong pathological inclination to drug which is followed by decrease in mood and alarm, as a rule, remains. Tolerance (acceptability) to drug at the same time sharply increases and several times exceeds a lethal dose. Pleasant experiences gradually disappear, and drug becomes means for preservation of rather "normal" activity (serviceability, a dream, appetite). There are various physical frustration: dryness and fragility of hair, skin peeling, fragility of nails, destruction of teeth. Most of patients has hepatitis, threat of infection with AIDS is big, without speaking about thrombophlebitises, the bound to negligent injections of drug any more. Mortality among patients with heroin drug addiction is very big.

The states demanding emergency aid arise at drug overdose (for their knocking over antagonists of opium appoint), and also at the somatic complications (collapses) coming in the last stage of an illness up to which, however, patients with heroin drug addiction live infrequently.

Frustration, the bound to the use of stimulators. The most widespread of this group of drugs at us in the country is ephedra, prepared by a crude method from various drugs containing ephedrine. The ecstasy extended now in discos, and also Phenaminum and Pervitinum possess similar action.

Ephedra intoxication on a picture reminds a hypomaniacal state. The mood at the same time is raised, hyperactivity, thirst for communication, abundance of larger, but often impossible plans are noted. The speech at patients is accelerated, they often jump from one thought on another. At objections and attempts to limit them to something they can flare up, showing anger. Eyes at patients shine, lips dry. Arterial hypertension, tachycardia are observed. Such state can last several owls, and then is replaced by a flaccidity and a depression.

Pleasant subjective experiences promote quite fast (literally from the first injections) to dependence formation. Patients constantly aspire to repeated injections of drug.

The condition of an abstinence (withdrawal) is expressed the under mood with irritability and malignancy in relation to people around, sleeplessness, a cold fit and потлив a message, pains in heart and muscle pains, an ischuria, hypersensibility to sound light irritants, sharp fatigue.

The course of ephedra drug addiction can remind dipsomania. Patients within several days, sometimes several times in day, use drug, bringing themselves to the complete exhaustion its stimulating action I eat, and then several days are forced to be eaten off and sleep off after a while to enter to itself эфедрон again.

Quickly there is a social degradation, patients spend all the time for searches of drug or its manufacture, more them nothing interests. Early somatic complications in the form of a myocardial dystrophy, gastritis, a coloenteritis, decrease in a sexual potentiality join.

Frustration, the bound to Cocainum use. Cocainum is prepared from leaves of the South American bush of the cook; in the beginning it was used intranasally — inhaled through a nose. Then the preparation for parenteral introduction, also for smoking was received. It is similar to Cocainum on action and the crack is more active.

Cocaine intoxication also reminds a maniacal state with a superactivity, loquacity, revaluation of characteristic abilities, impossible plans. Arterial hypertension, tachycardia, expansion of pupils are noted. At overdose of drug there are psychotic phenomena in the form of alarm, fear, ideas of prosecution, feeling of crawling of goosebumps under skin. Dependence is formed rather sluggishly and expressed in conditions of a dysphoria (sad and spiteful mood with a projection of the negative affect in out of — on people around).

Frustration, the bound to the use of hallucinogens. These frustration are caused by group of the substances capable to cause, along with euphoria, bright hallucinative experiences. The acid (a diethylamide of lysergic acid), Cyclodolum, Asthmatolum, Dimedrolum belong to these substances. The acid is under our

conditions used rather seldom, the hallucinogenic fungi containing substances of similar action are more often. We show extremely infrequent the use of a hallucinogen of other action — phencyclidine.

Sharp intoxication these preparations (it it is difficult to call intoxication) is followed by some euphoria in the beginning, and then is characterized by developing of the plentiful and quickly replaced visual hallucinations. The state can have and clearly psychotic character when the delirium develops: in the presence of plentiful hallucinative frustration there is a disorientation in environmental, the fear appears. Content of experiences can depend on a situation in which (or after which) the person used the psychoactive material (if it was the menacing situation then and hallucinations have the same character). Dryness of mucosas, expansion of pupils, a hyperemia of the person, tachycardia are noted.

The common principles of treatment of drug addiction and toxicomania consist in single-step cancellation of drug now. The exception is made by patients with a heavy somatic decompensation (cardiac, pulmonary, hepatic, renal) and the patients suffering from dependence on barbiturates (there cancellation can lead to a series of attacks or even to the epileptic status). In other cases as considers most of narcologists, the patient has to begin treatment in a hospital (in the relative or complete isolation) where cancellation of drug is made and the measures directed to smoothing of manifestations of a withdrawal are taken. Thus, treatment begins with deintoxication, then, during the so-called post-abstinent period, treatment of the psychopathological manifestations taking place at this time is carried out (a pathological inclination to drug, the fixing psychotic states arising after reception of some drugs, depressive and dysphoric states). When weakening a psychopathological symptomatology the psychotherapy directed to development of the negative relation to drugs and to installation of continuation of life without drug is carried out.

Prophylaxis of drug addiction and toxicomania has to be carried out at all levels — family, school, production, public, state and, of course, professional — medical. It is necessary to tell at once what health workers which main task — to treat, one nothing in this regard will be able to make. Participation of all experts involved in this problem is necessary — teachers, lawyers, psychologists, social

workers. Along with prohibitive measures (legally they at us concern only drugs — prosecution for their manufacture, storage and distribution) there have to be sanitary and educational paths of the prevention of these diseases. This work has to be carried out very skillfully and delicately not to turn "prevention" into "tutoring", i.e. acquaintance of teenagers to drugs, to their "positive" properties. Thus, in a family the exact, healthy education, at school — training of the cultural people capable to work for the benefit of society has to be carried out and to organize to itself normal leisure. The state has to care for body height of the material well-being and carry out fight against drug dealers. The health workers supported by the state have to improve methods of diagnostics and treatment of diseases, the bound to dependence on the psychoactive materials, and in respect of prophylaxis to find new methods of early diagnostics of the symptoms demonstrating dependence formation in order that in the earliest terms to begin treatment of drug addiction and toxicomania.

Considering the increasing abundance of drug addiction and their huge danger as for life of each certain person, and) for society in general, and even incomparably larger danger, than alcohol, scheduled maintenance has to be carried out among all children's and teenage contingent. Naturally, especially intensively it has to be carried out in risk groups: future addicts very often are natives of "alcoholic", inexact families; from the families which are teared by the conflicts. Quite often addicts are those children in whom are not engaged in supersafe families at all or where hyper guardianship or permissiveness take place.

Question of what should attach larger significance in prophylaxis of drug addiction: to education of healthy requirements and suggestion of value of health or serious belief of children and teenagers in harm of drugs, up to the end it is not solved. Without denying formation value at the person of skills of a healthy lifestyle at all, nevertheless it is necessary to recognize priority work on an explanation of danger of death of drug addiction.

Dependent are quite often convinced that their destiny – a corollary of poor awareness on drugs. They consider that children and teenagers should impart deadly horror before drugs.

In scheduled maintenance it is necessary to use a maximum of figurative tools, including video and movies, stories of addicts, narcologists, other employees of narcological institutions. It is necessary to remember that persons of children's and teenage age are affected, first of all, by concrete examples. Also discussions are useful. It is necessary to try to obtain that children and teenagers gave up thought simply to try the psychoactive materials because it inevitably involves desire of repetition and the child imperceptibly gets to a narcotic trap.

As well as at an alcoholism psychoprophylaxis, in conversations it is necessary to mention inevitable collapse of dream, hope, plans – in career, creation of a family etc. The mention and of suffering of the sexual sphere, and of cases of low-reversible alienations (is useful at the use of psychostimulants, hallucinogens).

TEST TASKS

(for self-preparation)

Choose one correct answer

1. HABITUAL ALCOHOL INTAKE IN THE SAME OFTEN REPEATING SITUATIONS, DISPLEASURE AT IMPOSSIBILITY TO REALIZE THE HABIT

1) mental dependence

2) physical dependence

3) pseudo-hard drinkings

4) the true hard drinkings

2. VEGETATIVE DISORDER, THE TREMOR OF HANDS AND REQUIREMENT TO FRESHEN THE NIP AFTER ALCOHOLISM

1) asthenic syndrome

2) astheno - vegetative syndrome

3) abstinence syndrome

4) convulsive syndrome

3. THE CONTINUOUS ALCOHOL INTAKE AND THE INCLINATION, INSUPERABLE TO IT, WITHIN SEVERAL DAYS (IT IS ROUTINE AT CHRONIC ALCOHOLIC)

1) hard drinking
2) physical dependence
3) systematic alcoholism
4) habit

4. THE ALCOHOLIC TWILIGHT STATE – UNCONSCIOUS COMMISSION OF ACTIONS WITH THE SUBSEQUENT AMNESIA AFTER THE USE OF SMALL AND AVERAGE DOSES OF ALCOHOL

1) pathological intoxication
2) atypical intoxication
3) amnestic intoxication
4) tremens

5. THE PROFESSIONAL AND FAMILY DISADAPTATION, DECREASE IN STRONG-WILLED MONITORING AND THE ORIENTATION, INDIFFERENCE TO RELATIVES, INSTABILITY OF EMOTIONS, DECREASE IN CRITICISM, THE LYING

1) alcoholic deterioration
2) alcoholic psikhopatization
3) mental dependence on alcohol
4) alcoholic weak-mindedness

6. THE DEGREE OF RESISTANCE TO EFFECT OF ALCOHOL (THE DOSE RATIO WITH INTOXICATION MANIFESTATION) CHANGING IN PROCESS OF DEVELOPMENT OF THE ALCOHOL ADDICTION

1) hard drinkings
2) tolerance change
3) loss of the quantitative monitoring

4) loss of situational monitoring

7. FIXATING AMNESIA, THE DISORIENTATION IN TIME AND THE PLACE, THE ECMNESIA, CONFABULATIONS, THE POLYNEURITIS DEVELOPING AT CHRONIC TOPERS

1) Korsakov syndrome

2) alcoholic weak-mindedness

3) degradation of the person

4) Korsakov psychosis

8. VISUAL HALLUCINATIONS, CHANCE ORIENTATION, EXALTATION, FEAR OF IDEA OF PROSECUTION, SEPARATE VERBAL AND TACTILE HALLUCINATIONS, THE EXPRESSED TREMOR OF EXTREMITIES

1) alcoholic paranoid

2) tremens

3) alcoholic hallucinosis

4) alcoholic paranoia

9. VERBAL HALLUCINATIONS, FEAR, SEPARATE IDEAS OF PROSECUTION AGAINST CLEAR CONSCIOUSNESS

1) alcoholic paranoid

2) alcoholic hallucinosis

3) tremens

4) algogolny paranoia

10. THE SYSTEMATIZED CRAZY IDEAS OF MARITAL INFIDELITY AT PATIENTS WITH THE ALCOHOLISM

1) alcoholic paranoid

2) supervaluable ideas of jealousy

3) jealousy delirium tremens

4) tremens

Lecture No. 7

Endogenic psychoses (schizophrenia and maniacal depressive psychosis)

Concept about endogenic psychoses. Value of heredity. Polygenic concept of an etiology of schizophrenia. An illness, premorbidal deviations (schizoid character), deviations at relatives. An external harmfulness in emergence and the course of schizophrenia, the Main forms of schizophrenia: prime, catatonic, paranoica. Hebephrenic, circular. Current stages. Features of the initial stage, difficulty of the diagnosis. Current types - periodic, falteringly and continuous and progreduated. Principles of treatments of schizophrenia. Short data on clinic and current of MDP.

Schizophrenia – the endogenic chronic progreduated mental disease with a polymorphic clinical picture, the continuous or paroxysmal current resulting in a peculiar defect of the person, shown disintegration of mentality, mainly in the emotional and strong-willed sphere and thinking.

Abundance of schizophrenia (morbidity, i.e. number of patients on 1 thousand inhabitants), according to different data, makes from 2 to 10, i.e. from 0,2 to 1%, 0,5% are most often specified by-1%.

This mental disease as self-contained, it was allocated at the end of the 19th century by the great German psychiatrist E. Krepelin under the name "early weak-mindedness" (dementia praecox), i.e. developing in youth or in young years. Before different forms of schizophrenia were considered as self-contained mental diseases. The name "schizophrenia" was given in 1911 by the Swiss psychiatrist E. Bleyler who also expanded a circle of the alienations carried to it, but pointed to a possibility of the favorable outcome even without treatment.

Etiology. The role of heredity is considered undoubted. Among the blood relatives having the same disease it is reliable more, than in the common population. If one of monozygotic twins gets sick with schizophrenia, then probability of a disease of another - 60-90%. Education of the children born from patients with schizophrenia in healthy families as receiving since the early childhood does not reduce the frequency of this disease among them (a method of adopted children).

The risk of a disease of schizophrenia for children of the patient averages about 15% on condition of healthy heredity from other parent. But if on the other hand there are data on a disease of schizophrenia among blood relatives, then this risk depending on degree of relationship can reach 40%. For nephews and nieces, grandsons, cousins and sisters the risk decreases to 3-4%. Regularities of transfer of a heritable deposit of an illness and the more so its mechanisms are not clear. It is supposed that the same heritable factor at other blood relatives can be shown by some types of psychopathies and accentuation of personality traits (schizoid, paranoiac, sensitive, etc.).

Besides a heritable factor, the importance in development and the course of schizophrenia is played by the exogenetic and psychogenic moments which quite often provoke the beginning of a disease and its aggravation. Therefore began to speak about the polygenic concept of schizophrenia which is more precisely reflected now in biopsychosocial model of a disease according to which, at the leading role of a genetic predisposition in developing of an illness, exert on its development, a current and an outcome, and also effectiveness of treatment and rehabilitation, a great influence padding biological (a sex, age, intoxication and other exogenias), psychological (premorbidal features of the person, stressful situations, etc.), social and psychological (marital status, the relations in a family and collective, etc.), social and economic (the financial position, living conditions, the remained or lost working capacity, etc.) factors.

The pathogenesis remains not clear, despite numerous researches within decades. The hypotheses reflecting theoretical views of the corresponding era or which are based on the appeared new methodical approaches in the field of a neurophysiology, biochemistry, endocrinology, an immunology, etc. were one by one replaced. Recently the special attention is paid to violations of an exchange of neurotransmitters (in particular, Dofaminum, glutamatergic system), and also to structurally functional violations in a brain, shown a failure of any structures (hypofrontal).

Similarity of different forms of schizophrenia is defined by the main ("basic", "negative") symptoms, distinctions — padding ("facultative", "positive") symptoms.

These symptoms meet at all forms of schizophrenia, but degree of their expressiveness is various. Them call also "negative", "deficiental" as they reflect the damage to mentality caused by an illness, mainly in the emotional and strong-willed sphere and thinking.Similarity of different forms of schizophrenia is defined by the main ("basic", "negative") symptoms, distinctions — padding ("facultative", "positive") symptoms.

These symptoms meet at all forms of schizophrenia, but degree of their expressiveness is various. Them call also "negative", "deficiental" as they reflect the damage to mentality caused by an illness, mainly in the emotional and strong-willed sphere and thinking.

The main emotional frustration is emotional decrease. It is shown in different degree. Begins with the increasing coldness of patients to the close and people, significant for them, indifference to events which immediately touch the patient, losses of former interests and hobbies. Manifestations of emotions are weakened and become simpler, apathy develops. The voice becomes the monotonic, deprived of emotional modulations. Monotonously say also about things indifferent, and about what, apparently, has to concern. The person becomes hypomimicry, thin expressiveness of a mimicry is lost, it is replaced by the rough, exaggerated grimaces. There are a ridiculous and inappropriate giggling and snickers. In extreme cases these violations become so expressed that they are called "emotional dullness».

In other cases business goes about perversions of emotions, they become inadequate, paradoxical. For example, being insensible, cruel to the close, mothers, the patient shows unusual sentimentality: writes lyrical verses, speaks about improbable experiences which bring it imperfections of the world and human adversity, sheds tears over the birdie who died from a frost.

The third negative emotional symptom is ambivalence – emergence of at the same time counter feelings in relation to the same person. For example, the patient himself says that he tests to whom - or at the same time love and hatred or interest and disgust for something at once. In more expressed cases it affects behavior: the patient caresses and pinches, kisses and bites at the same time.

The main frustration of will – an abulia (literally "lack of will") is shown by falling of an initiative and activity, a divergence. In hard cases patients even elementary do not serve themselves, do not wash, defecate anywhere, urinate under themselves, the whole days lie in or sit in one pose. Begins with the fact that they throw occupations and work, start all household chores, cannot be accepted to anything, cannot be going to do something in any way. All this is connected with lack of motives to actions and call also "falling of an energy potential".

Other reference strong-willed frustration is the ambitendency (strong-willed duality, coexistence of polar motives to activity), for example, the patient gives to the doctor a hand and, without having greeted, right there hides it; takes a spoon that is, and it is hard puts it back, making several times; asks that he was treated, and refuses drug intake. Except the specified violations, the negativism (aspiration to do everything on the contrary, at a request to open eyes they even more densely them narrow), impulsiveness (the actions or acts made under the influence of motives, having been absolutely torn off from the person and uncontrolled), unilateral barren elaborate activity meet (the student of medical school tries to learn some classic language, the pupil of technical training college begins to collect excrements of various animals, birds, etc.).

The formal violations of thinking are characteristic of schizophrenia. They received such name because concern not the content of thoughts, and the most thought process, first of all logical communication between thoughts, and in hard cases even in one phrase. When it reaches an extreme, the speech of the patient becomes the phrases ("verbal salad") which are absolutely broken off, consisting of a chaotic set of scraps. Usually violations are expressed much less sharply: in the form of "sliding" (illogical transition from one thought to another what the patient does not notice), "neologisms" (inventing of new elaborate words, for example "тягофон" instead of "phone") and tendencies to reasoning, fruitless reasonings (for example, "the dog wags a tail when she rejoices, and the cat when becomes angry — if the person had a tail, then when it would twirl by it?") or florid expressions, earlier sick not peculiar ("a vocal feast" — about a variety concert of the singer). Quite often patients can complain of an uncontrollable stream of thoughts – a mentism (thought

crowding), or its sudden breaks - shperrung (thought deprivation, thought obstruction, thought blocking), or on in parallel current two streams of thoughts. The paralogical thinking is characterized by the unilateral, prejudiced direction of ideational activity during which it is taken into consideration only the facts or the casual parties of the phenomena corresponding to the dominating installation. Everything that contradicts it, is rejected. For example, the patient speaks: "I will live in Paris because my name is Ivan Sergeyevich since Ivan Sergeyevich Turgenev lived in Paris"." Pushkin is the poor person, an aggressor since the word "Pushkin" came from the word of a gun. The autistic thinking is guided by desires and imaginations without conditions and requirements of reality, being an antipode of realistic thinking. (For example, the patient calls the wife the neighbor with whom he practically does not communicate; considers that it is possible to live in the 21st and 22nd centuries at the same time). It is the cornerstone of an autism - losses of contacts with people around, leaving in an inner world, estrangement, closures. Touches with former friends and acquaintances are lost, and new do not get.

At schizophrenia almost all productive syndromes (neurosis-like, affective, hallucinative (mainly verbal hallucinosis), crazy (paranoiac, paranoica, paraphrenic), catatonic, hebephrenic), except for a stupefaction, except oneiric are observed. They have an originality, an atipizm about which it will be told further. Psychoorganic, Korsakov, epileptiform syndromes and an organic dementia are not characteristic of schizophrenia.

During schizophrenia allocate three stages: initial, demonstrative and terminating.

The initial stage is an incipient state of a disease of which not rough main displays of an illness therefore it is difficult to make the exact diagnosis are characteristic. Meanwhile, than schizophrenia will be recognized earlier and adequate treatment and psychosocial rehabilitation, that a high probability of the favorable outcome begins.

Three options of the initial period are characteristic: neurosis-like, psychopatholike also began with negative, mainly, the apato-abulic of frustration. The neurosis-like beginning is shown by obsessive, hypochiondrial, asthenic,

depersonalization syndromes. Obsessions differ from neurotic in a invincibility, early accession of rituals, big force of coercion. Patients can perform ridiculous rituals for clocks, without hesitating of strangers. They can even force to carry out rituals of others. Phobias lose an emotional component: speak about fears without nervousness, they happen especially ridiculous (for example, fear of separate letters) or abstruse (phobia of what can become scary, go crazy). Hypochiondrial complaints are shown in unusual, elaborate and even ridiculous form ("bones are scattered", "in a stomach of a gut got off in a lump", "heart clenches", "it is felt how blood from auricles is transfused in ventricles"). Often there are painful senesthopathias — obstinate, burdensome morbid feelings in different parts of a body. The asthenia differs in monotony, amplifies at mental work. Rest and the facilitated mode do not reduce it. A depersonalisation is confirmed most often by complaints to change of itself who is difficult for putting into words ("not such as earlier", "became as the automatic machine", "forked"). The derealization acts in statements about "a hidden wall" among themselves and world around, everything seems "as through glass", "everything somehow strange changed", but in what this change, in words cannot express.

The psychopatholike option of a clinical picture is similar to different types of psychopathies — schizoid, epileptoidny, unstable, hysterical. The syndrome of the accruing shizoidization is similar to a schizoid psychopathy. Gradually a closure, an aversion for relatives, especially to mother amplifies. Because of not concentration and inability to concentrate progress and working capacity fall. Life is filled with pathological hobbies (hobby). Patients collect ridiculous collections (for example, exemplars of excrements of different types of animals). By clocks do extracts of books or make some schemes and plans. But any activity is unproductive — any new knowledge, abilities, is not got skills. Imaginations happen ridiculous or elaborate, can frankly tell about them (represent pictures of death of the world, invasion of aliens, filling of the city with hordes of rats or snakes). Like to argue on "philosophical" subjects ("metaphysical intoxication"), but state thoughts unclear, chaotically, confusedly. Reasonings are under construction on paralogical arguments.

For example, to make people less aggressive, it is necessary to forbid to eat meat as it is eaten by predators.

At looking alike a psychopathy of epileptoidny type, except constant gloom and a closure, cold fanatic cruelty is characteristic (for example, the patient splashed boiled water in a face of mother for the fact that she did not satisfy its any shallow request). Low-motivated or causeless affects of rage suddenly arise and also unexpectedly are interrupted. External accuracy (a careful hairdress the ironed-out clothes) can be combined with untidiness and lack of fastidiousness (lay down in footwear on a sheet, a floor and walls zaplevyvat houses). Sexuality can address on family members, at young men — especially on mother, is shown by sophisticated sadistic perversions. Patients are capable to put to themselves damages, even serious, are dangerous to people around, showing aggression, including sexual. Perfect actions then ignore (for example, having raped the girl in the elevator, right there in the yard of the house it is necessary to sit and watch how they play soccer).

At looking alike the psychopathy of unstable type easily appears in the asocial companies, make hooligan acts, theft, participate in boozes, use drugs. But in these groups remain strangers, passive observers or performers of foreign will. Associates consider them as the strange, slight, but they do not attach it significance. To relatives not only are indifferent, but even cold are hostile, especially to those who love them stronger. Any study and work are thrown. Like to leave for a long time the house, to live in hiding places, cellars, tents.

At looking alike an isteroidny psychopathy of the patient constantly plays the same role ("superman", coquettes, the owner of "refined" manners, unsurpassed talent in any area) without a situation and impression on people around. There are no thin virtuosity inherent in hysterical natures, ability to estimate a situation and to make desirable impression. False affectedness the exaggerated grimaces, an aping and airs and graces are combined with coldness and callousness in relation to relatives.

The beginning from negative manifestations is characterized by decrease in emotions, activities, initiatives, a closure. Patients lose interests, do not get the friends and new. Do not watch the appearance, are careless. Can lay down in outerwear, boots on a bed. Considerably efficiency in study and work decreases. Miss classes,

make truancies at work, aimlessly wander about streets. Teachers and parents connect the changed behavior with awkward age, with the conflicts with peers, one-way love and other circumstances.

The demonstrative stage is a stage of the fissile schizophrenic process at which the expressed disease symptoms are observed. According to a clinical picture on the leading syndrome five main forms of schizophrenia are allocated: prime, hebephrenic, catatonic, paranoica and circular.

Prime form.

In psychiatry, and in medicine in general, such forms at which a clinical picture, character of a current and other signs are typical, classical for this disease are called prime. The prime form is shown by incremental main symptoms of schizophrenia which set is designated as an apatoabulichesky syndrome (or a simplex-syndrome). The illness creeps gradually: the family long does not see changes and when notice, compare what was the patient one or two years ago and what became now. At first interest in everything disappears that interested earlier: to favourite entertainments, a hobby, the companies of friends. In free time patients are busy with nothing: stay at home, loaf about, aimlessly somewhere wander. Still continue to go to study or for work, but do it as if automatically, efficiency quickly falls, to acquire something new are incapable. Become more and more selfcontained, silent. The concerning events cease to cause emotional reaction. Misfortunes do not touch, and joyful events do not find a response. Are indifferent to the family and it is even hostile, especially to those who care for them most. The face becomes expressionless, is only sometimes distorted by rough grimaces. The voice becomes the monotonic ("toneless voice"). Can answer with inappropriate laughter what would force to shudder earlier. Primitive inclinations (gluttony, an impudent onanism) disinhibition. Do not watch clothes, do not wash, do not want to change linen, sleep without undressing. Unexpected causeless aggression in relation to people around is possible.

Violations of thinking at first are characterized by poverty of the speech and sudden stops, "breaks" in the middle of the phrase or "sliding" on an unexpected subject. Patients think out new words (neologisms). Only in far come cases the

speech consists of scraps of phrases. Occasionally incidental crazy statements can meet or there are hallucinations (for example, calls by name) about which the patient can not tell, but it is visible that sometimes he to something listens. The resistant nonsense and hallucinations does not arise.

Hebephrenic form.

Begins at teenage or youthful age. Patients behave as the poor actors playing the got noisy child. Ridiculous silliness, a rough aping, the exaggerated grimaces, a ridiculous laughter do behavior caricature children's. Fun of patients does not infect, and frightens and weighs others ("cold euphoria"). Speak by an unnatural voice — pathetic tone or lisp, at the same time often sophisticated obscenely quarrel, distort words. In the speech primitive rhyming is heard. From time to time motive exaltation breaks out: run, somersault, roll on a floor, resembling beat others, often cruelly, and right there climb to kiss. Are inclined to be bared impudently at strangers, in the face of all frig, seek to seize others by genitals. Are unscrpulous and slovenly. Can urinate and defecate purposely in a bed or in clothes. Gluttony alternates with a food spreading. Crazy statements happen sketchy, and hallucinations — incidental. This form of a disease differs in the most malignant current. Within 1-2 years, and sometimes and several months schizophrenic defect with sharply expressed main symptoms develops. Meets less often than others.

Catatonic form.

Catatonic schizophrenia in the past met often, especially at young age. Now in the developed countries it is noted rather seldom. The expressed cases are shown by alternation of catatonic exaltation and an physical inactivity (stupor) with the complete silence (mutism).

Catatonic exaltation is reduced to in the same way repeating aimless actions and unmotivated impulsive aggression — beat and destroy everything around. Show everything senseless obstinate resistance, do counter to the fact that they are told (negativism). Often break from themselves clothes. Can put themselves damages. Around more often do not react to the events in any way. Exaltation can be combined with a mutism or the speech consists of stereotypic repetition of the same words or phrases (verbigeration, oral stereotypy). Meet "echo symptoms": repetition of

someone else's words (echolalia), mimicry of people around, as if mimicking expressions of their face (ekhomimia), their movements and actions (echopraxia).

The catatonic stupor — an physical inactivity with the complete silence (mutism) can be combined or with the extreme tension of all muscles (a rigid stupor) or with the raised plastic tone — wax flexibility (a cataleptic stupor): hands, legs, the head stiffen for a long time in that pose which somebody gave them, sometimes in the most inconvenient and unnatural. In a condition of a stupor patients do not eat, can resist feeding, and a delivery is carried out through a probe. Urinate and defecate under themselves. The consciousness during a stupor can remain completely, and in the subsequent when the stupor passes, patients explicitly tell about everything occurring around. Such catatonia is called lucid.

At a oneiric catatonia the physical inactivity is combined with oneiroid experiences about which patients tell only subsequently, but at the same time it becomes clear that only separate events reached the patient, and the situation was perceived according to stargaze-like imaginations around (other patients were accepted to aliens, hospital – to some camp etc.). Content of oneiric experiences is quite often scooped from fantastic novels, detective movies or from the occurring stories about awful incidents. On a face of expression of fear and ecstasy replace each other. The oneiric catatonia is more favorable option, than lucid, i.e. flows past periodically, after attacks there is not rough negative symptomatology.

Paranoica form.

It is the most often found form if the disease begins after 20 years. The persecution complex, the relations and influences is characteristic. Less often other types of nonsense — infection, poisoning, a metamorphosis, jealousy, greatness, etc. meet. The persecution complex differs in indeterminacy and a jabber (some to nobody the known mysterious organizations, terrorist groups plan to deal shortly with the patient). Certain specific persecutors are usually called seldom and vaguely or pointed to absolutely casual persons. The nonsense of the relation is especially shown in crowded places (in cars of trains, on concourses and t) or in the habitual companies. It seems that all look at the patient, about him whisper, laugh at him, hint at something.

Other types of nonsense strike with the absurd. Patients declare that, touching door handles, they caught syphilis or AIDS (nonsense of infection) that in a body some animal into who it turned (nonsense of a metamorphosis) was installed that characteristic internals everything decayed (nosomania (hypochondriacal delusion)), etc.

Hallucinations most often happen acoustical, verbal. Pseudohallucinations are especially characteristic. Are most widespread on contents menacing, commenting, antagonistic and imperative. Also calls by name are heard. Olfactory hallucinations are much more rare (usually sick disgusting smells — a corpse, gas pursue, blood, sperms etc.), they can be a cause of failure from food and are considered as a sign of malignant disease. Visual hallucinations are unrepresentative, rather the illusions caused by nonsense meet ("see" the weapon which flashed in someone's hands, taking for it any subject at a persecution complex).

The following stereotype of development of a disease is characteristic of the fissile period of paranoid schizophrenia. The illness demonstrates a paranoiac syndrome or a verbal hallucinosis which are transformed further in paranoid and hallucinatory paranoid. The culmination of the second stage is Kandinskiy-Clerambault syndrome. At the third stage there is to the forefront a fantastic nonsense of greatness. The syndrome becomes paraphrenic. However now, especially at well-timed and adequate treatment, process can stop at a paranoid stage. Besides throughout a disease with different degree of expressiveness (depending on type of disease) the negative symptomatology arises and progresses.

Circular form.

It is shown by depressive and maniacal attacks with an atypical picture. Between them there are light intervals (intermission), is frequent with practical convalescence after the first phases, but with signs of the increasing schizophrenic defect in process of their repetition.

Atypical maniacal attacks are characterized by the fact that at them, except excessively increased mood, excessive activity, aspiration to activity, garrulity, ideas of greatness, the persecution complex is usually developed (the patient the whole organizations, mysterious and criminal pursue). The nonsense of greatness becomes

ridiculous. For example, the patient claims that for several days he grew by 10 cm, his muscles were poured by unknown force, at him "tremendous memory" opened. The nonsense of greatness is inclined to intertwine with the "fissile" nonsense of influence when the patient claims that not it is exposed, and itself opened at itself ability to hypnotize others, to read foreign mind, by effort of will to slow down or accelerate a current of time, to force to fade flowers etc. The nonsense of the relation can get euphoric coloring ("all admire me", "envy", "imitate"). Sometimes there are auditory hallucinations; voices are "learned", give advice, but can threaten or comment on behavior of the patient.

The phenomena of mental automatism are shown by unpleasant flow of thoughts in the head, "jumble in thoughts", feeling that the brain works as the computer or "the transmitter of thoughts". The nonsense of a performance is characteristic: patients consider that all changed clothes around, play the roles charged to them, everywhere "something is created", "there is a filming».

Atypical depressive attacks differ not so much in melancholy and depression, how many alarm and fear. Patients cannot even understand what they are afraid of ("vital fear"), or wait for some awful events, accidents, natural disasters. Easily there is a persecution complex which can be combined with nonsense of self-accusation and the relation ("because of awful behavior will deal shortly with his family", "all look at the patient because nonsense is visible on a face", he is going to be destroyed as he led "a dissolute life", "caught AIDS"). Depressive coloring is got by nonsense of influence ("create emptiness in the head", "deprive of a sexual potentiality"), nonsense of a performance (around disguised secret agents and provokers "to bring" the patient under arrest), a derealization ("all around as lifeless") and a depersonalization ("became as though lifeless"). There can be auditory hallucinations (threats, charges, orders etc.).

The mixed states are especially characteristic of repeated phases. At the same time both depressive, and maniacal symptoms coexist. Patients are excited, irascible, active, seek to butt in everything and to order all, but at the same time complain of invincible boredom, sometimes of melancholy and causeless alarm. Statements and their emotional coloring often do not correspond each other. With a cheerful look can

say that they were infected with a lues (syphilis) or are going to castrate, and with sad expression that the head is overflowed with ingenious thoughts.

Oneiric states develop at height of maniacal more often, is more rare than depressive attacks. Experiences do not differ from described at a oneiric catatonia. During these states patients sit not movably with an air of detachment or lie with the changing expression pleasure, horror on a face. Do not come into contact, from themselves drive or are silent. The events around as if are not noticed. Duration of attacks — from several weeks to several months.

The terminating state comes after the fissile (demonstrative) stage of schizophrenic process, at its adverse (malignant) current. It is shown by the resistant expressed defect which is not giving in to an involution despite the fissile treatment and rehabilitation within several years. Such state still is called a schizophrenic dementia. Its originality distinguishing from other (organic) dementias consists that at the patient former knowledge and experience generally remain, they have no rough mnestic disorders and intelligence, they can state the exact judgments. Patients have not a decrease in level of thinking, but its formal violations, mainly disruptiveness (incoherence) along with associative disintegration. Also rough frustration of the emotional and strong-willed sphere (apathy, an abulia, etc.) and behavior in general are observed (an autism, pretentiousness, a paradoxically, etc.) . Therefore patients cannot productively make use of the knowledge which is available for them and experience and become hard socially deadapted up to helplessness. Such type of a dementia is called apatic-incoherent. Now owing to a schizophrenia pathomorphism (more favorable current in general), its more efficient treatment and rehabilitation terminating states meet seldom. More often the illness comes to the end, depending on type of a current, adequacy of treatment and rehabilitation, either the convalescence (more rare) or which was less expressed (in a varying degree) by defect (more often) which does not conduct to a deep social maladjustment. In such cases speak about residual schizophrenia.

The Soviet psychiatrists (D.E. Melekhov, G.E. Sukhareva, A. V. Snezhnevsky, R. A. Nadzharov) possess the systematics of schizophrenia based not on a clinical picture, and on current types. Three main types are allocated.

The continuous and progreduated type, the most adverse, is characteristic of prime, hebephrenic, catatonic (lucid) and paranoid forms. Without treatment the illness develops steadily and continuously before defect emergence. Remiss usually happen a corollary of treatment and keep until the maintenance therapy is applied. Rate of a course of a disease is various. The malignant option which is usually beginning at teenage and youthful age is adverse (malignant catatonic, hebephrenic, paranoica, prime forms). In these cases there are serious terminating conditions.

The favorable option of this type of a current – slow or low-progreduated schizophrenia. Has two versions – neurosis-like and psychopatholike.

Paroxysmal and progredient (shuboobrazny, from the German schub — shift) the type is characterized by the separate attacks proceeding from 2 — 3 weeks to several months. Attacks alternate with light intervals — remissions in which there are signs of schizophrenic defect and residual symptoms of last attack. Attacks tend to expansion and complication of a productive symptomatology (for example, paranoiac, paranoid, Kandinskiy-Clerambault syndrome, etc.), and also to lengthening. Defect of the person goes deep into remissions. The Shuboorazny type of a current is characteristic of catatonic, paranoid, and circular forms. At it the initial period with sluggish increase negative change of the person is observed rather long (several years).

The recurrent (periodic) type is characterized by bad attacks with a picture of affective, affective and crazy and oneiric and catatonic frustration. At one patients attacks are same (as a cliche), at others - are various. Remissions are long, quality with not rough defect. The initial period short-term (from several weeks to several months), is shown by somatic disorders, affective fluctuations, the phenomena of a somatopsychic depersonalization. This type of a current is peculiar circular and catatonic (oneiric) to forms.

Age features of a clinical picture and current. Children's schizophrenia meets rather seldom. The beginning usually gradual, from baseless and ridiculous scares, motive and speech stereotypies, pathological imaginations. At a demonstrative stage a symptomatology atypical, vestigial, polymorphic that complicates definition of a form of a disease. The current is more often malignant. Defect, except the main

negative symptoms, is combined with a stop of development of mentality at that age stage when the illness was shown. Therefore the onset of the illness in the early childhood leads to a combination of schizophrenic defect and lag of intellectual development – oligophrenic plus ("pfropfen schizophrenia"), and at preadolescent and teenage age — to resistant mental infantility.

Teenage schizophrenia usually proceeds with various psychopatholike violations, "metaphysical intoxication" is characteristic. The dismorfomaniye, anorektichesky and depersonalization syndromes occur among neurosis-like pictures. At the same age the hebephrenia debuts. The proceeding catatonic, paranoica and prime forms of schizophrenia can begin malignant.

"Late" schizophrenia begins after 45 years. The paranoica form with the continuous or paroxysmal current is most often observed. The nonsense usually joins only an immediate environment (neighbors, relatives, colleagues) — "nonsense of a small range". Can meet circular, in attacks the alarming affect, depressive and delusion of persecution, and also a syndrome of Qatar is characteristic. A current in general the favorable - small degree of a progredience and not rough defect of the person.

Maniacal-depressive psychosis.

Maniac-depressive psychosis (maniac-depressive disease, circular psychosis, cyclophrenia) — an endogenic chronic disease which proceeds in the form of phases with affective frustration, light intervals between attacks, i.e. the complete recovery of mental health and lack of changes of the person (intermission), irrespective of quantity of the postponed attacks. The disease can proceed in the form of bipolar phases (maniac-depressive psychosis) and monopolar (monopolar depressive psychosis and monopolar maniacal psychosis).

The term "cyclothymia" was applied for the first time by K. Kalbaum to the weak, weakened illness options.

There is no reliable data about abundance of maniac-depressive psychosis. This results from the fact that psychiatrists are come into the view only by those patients who need hospitalization, and the different frequency of this disease demonstrates diagnostic disagreements and distinctions in comprehension of borders of maniac-

depressive psychosis. Frequency of maniac-depressive psychosis among the population fluctuates within 0,07 — 7,0%. Most often the states which are falling into to this disease are observed at 0,5 — 0,8% of the population. Women get sick with maniac-depressive psychosis more often than man: among sick 60-70% of women, but at the bipolar course of a disease men prevail. The illness can begin at any age, but is the most frequent in mature and late.

Etiology and pathogenesis.

The great value still was attached to a heritable factor by Falre and E. Krepelin. The risk of a disease of maniac-depressive psychosis at sibs and dizygotic twins makes 20-25%, at monozygotic — 66-96%. The hypothesis expresses that communication of coupling of the genes participating in development of affective psychoses with the X-chromosome is possible (M. E. Vartanyan).

Besides, the important role in emergence and a current of MDP is played by psychogenic and exogenetic factors, especially at monopolar depressive type of a current. Therefore the biopsychosocial model of a genesis of alienations and assistance to patients is also applicable to this disease.

The pathogenesis of maniac-depressive psychosis is bound to violation of synoptic transfer in system of neurones of a hypothalamus and other basal departments of a brain which are bound to formation of such features of mentality as wakefulness, the speed of mental reactions, a mood hum noise, affective states. Amine systems of Dofaminum, Noradrenalinum, phenylethylamine and serotonin came under the spotlight.

Alternation of affective psychotic phases and light intervals is characteristic of maniac-depressive psychosis. For an assessment of psychotic attacks usually use the term "phase", understanding as it the psychopathological state limited in time. After a minovaniye of a phase mental health is completely restored. Duration of phases is various — from several days to several years. Average duration — 3 — 6 months. For this disease seasonality of emergence of phases is peculiar. It is known that at some patients of a phase arise in particular months, is more often in the fall and in the spring. Number of phases variously: at part of patients of a phase arise annually, at others only one phase throughout all life is observed.

Besides affective frustration violations in ideational and motive spheres are observed. At maniacal and depressions these violations have counter character. For depressive and the vegetative and somatic frustration testifying to "a synpaticotonic orientation" of vegetative nervous system are characteristic of maniacal states (V. P. Protopopov).

Depressions (phases).

Depressions (phases) are characterized by a triad of alienations: the under mood, delay of thought processes and motive retardation. The under mood, depression, melancholy are the most reference signs of a depressive phase. Expressiveness of emotional violations happens various — from mild degrees of depression and sadness before experience of vital melancholy, to a hopelessness, despair. Experiences of "precordial melancholy" are painful to feelings of a tightening or weight in heart, sometimes to feeling of a peculiar thermalgia. "Moral sufferings" which depth and weight, it is incomparable stronger than physical pain happen usually even more painful.

Emergence of a depressive phase is quite often preceded by sleep disorders, appetite, unpleasant feelings in heart, heartbeat, dryness in a mouth, locks, a delay monthly at women. Such state is inaccurately regarded as a somatopathy — the functional violation of cardiovascular system, etc. In mild cases emotional violations are shown in the suppressed mood which is followed by tendency to doubts, uncertainty in the future, feeling sick, mental and physical fatigue.

In hard cases painful experience of melancholy, incomparable with an everyday grief accrues. No joyful events can bring out of this state. The most severe form of manifestation of affect of melancholy is the state which received the name "explosion of melancholy" – raptus melancholicus which is shown in sudden explosion of despair with exaltation, sobbings, groans, aspiration to put itself damages, suicide attempts.

Rather legible daily fluctuations in expressiveness of depressive experiences are usually observed. Patients test melancholy and alarm early morning clocks, by the evening the state improves a little, patients often say that by the evening "the melancholy as if releases".

Appearance of patients corresponds to their affective experiences: the mimicry and expression of eyes speak about grief and grief, at serious sad conditions of an eye remain dry, a blinking infrequent. The internal third of the century instead of an arch forms an angular fold — Veragut's fold. Eyebrows are shifted, folds on a forehead from continuous reduction of muscles remind a Greek letter an omega, lips dry, densely oblate, corners of a mouth are lowered, dryness in a mouth is noted. Patients sit in a crooked pose, with the hung head, hands pressed to a trunk shifted by knees.

Delay of thought processes is expressed that patients answer questions with a big delay, in monosyllables, a low voice, complain of absence of thoughts or of the same thoughts of characteristic otioseness and desire to die. The attention concentrates hardly, memory on the past does not suffer, fixing of current events is complicated. Any intellectual tension seems to patients insuperable therefore they consider themselves as "idiots", "numskulls". In such state patients do not believe that the similar state can pass, last experience does not help to convince them of the favorable outcome: "Those states were easier". Last, the present and the future is estimated gloomy as a chain of the infinite mistakes and crimes.

Expressiveness of motive retardation is various – from mild degrees to a depressive stupor. The movements are slowed often down, poses are monotonous, patients complain that it is difficult for them to move, difficult to speak.

Patients in a depression do not make plans for the future, have no interests, they often have only one desire — to die. The aspiration to suicide is constantly observed at depressions: in one cases it is fleeting thoughts, in others these thoughts arise periodically, especially early morning clocks when depressive experiences are more expressed. The part of patients in a condition of a depression of thought of suicide is constant and have tendencies with considering of ways of its commission. In such state patients can commit "expanded" suicide: at first they kill the children, aged parents, and then commit suicide.

Violations of thinking at depressive patients can be expressed also in the supervaluable and crazy ideas caused by depressive affect. Ideas of self-accusation, a basis for which are insignificant acts, mistakes which value is overestimated, are most often observed. Patients accuse themselves of murders of relatives, of wastes, of

treason to relatives or the homeland etc. They endure ideas of self-abasement, consider that they are insignificant people that happening to them is a punishment for meanness which they made. Claim that are not worthy to be in hospital, to receive treatment, to eat, drink, sleep on a bed.

At more slight depressions persuasive hypochiondrial fears, persuasive doubts less often — persuasive contrast inclinations are observed.

In some cases when weighting a depression patients complain of absence of any feeling, they say that they became as "chock", as pieces of wood" that they feel nothing and suffer from it. This condition is estimated by patients as heavier: "a depression - it is heavy, but this human feeling, and loss of consciousness is awful".

The fortune was come into by the name "morbid mental loss of consciousness" (anesthesia psychica dolorosa) and usually confirms weight of a depression. At depressive patients it is possible to observe a derealization and a somatopsychic depersonalisation. In the presence of a derealization patients say that the world around is perceived not so legiblly as earlier, it lost brightness of paints, vivacity and vitality, all is perceived as through fog, not washed out glass, a haze. At a somatopsychic depersonalisation patients insufficiently legiblly perceive the body: "I am as if dissolved in environmental, I do not feel the borders". At patients the feeling of satiety is lost, they do not feel thirst, do not test satisfaction from bleeding of a bladder, do not feel that they slept at night though actually slept.

Vegetative and somatic frustration are usually caused by increase of a tone of sympathetic department of vegetative nervous system: are observed tachycardia, increase of arterial pressure, dryness in a mouth, lack of appetite, patients complain of feeling of a spreading in a stomach, intestines, locks, the considerable decrease in body weight — to 10 kg and more is noted that suggests doctors an idea of an oncological disease at the patient and leads to numerous researches. At women during an illness attack menstruation often disappear.

Options of depressions. Depending on a dominance of this or that symptomatology at a depressive phase allocate an alarming and agitated depression at which along with melancholy the alarming exaltation defining a clinical picture takes place (these patients are especially dangerous in respect of commission of suicide

attempts), a hypochiondrial depression at which in a clinical picture various hypochiondrial frustration and vegetative" the latent, masked depressions figure prominently. The masked depression - a depression with a dominance of various motive, sensing and vegetative frustration. The most often masked depressions are shown by somatic frustration, at the same time patients complain of pains in various parts of a body: in heart, a backbone, intestines which have character of senesthopathias. Pains usually have painful character, force patients to see constantly a doctor, to be exposed to numerous researches. Daily fluctuations of intensity of pains attract attention, they are most expressed in the morning, by the evening usually the state improves. Also seasonal nature of somatic complaints is observed in the spring or in the fall of the patient multiply addresses with complaints, then they spontaneously disappear.

Maniacal states (phases).

Endogenic maniacal states are characterized by symptoms opposite to a depression: the increased mood, acceleration of thought processes and emergence of various associations, psychomotor exaltation. Maniacal states can be relatively lungs — hypomanias, average expressiveness — typical maniacal states and heavy — mania with nonsense of greatness, mania with confusion. Development of a maniacal state happens gradually more often. In the beginning patients experience cheerfulness inflow, the mood improves, the feeling of physical and mental wellbeing appears. Environmental it is perceived in iridescent paints, all mental processes proceed easily, with the increased efficiency and weakening of the delays facilitating transition to action. Dream at such patients short, but deep, in the mornings they easily get up, quickly join in habitual activity, cope with all the duties, have no doubts and hesitations in a decision making. The self-rating is usually raised, the mimicry alive, prevails cheerful mood. Unpleasant events do not exert impact on mood. Appetite more often happens is increased, fluctuations of arterial pressure towards hypertensia, tachycardia are noted.

At increase of a maniacal state, first of all, the mood becomes distinct inadequate: unusually cheerful, fine, patients differ in "inexhaustible" energy, they are covered by thirst of activity; however if at the initial stage activity still keeps

efficiency, then on it because of an attention distractibility patients cannot finish any business any more. Associations arise on the surface signs, is accelerated thinking. At a maniacal state interests and abilities which to a disease nobody noticed can be found. Patients begin to write verses, bents to drawing come to light, however with increase of a maniacal state efficiency in this activity becomes more and more random. The behavior of patients becomes stirred up, sexuality amplifies, patients easily strike up acquaintances, enter sexual communications, speak on erotic subjects. Women brightly and brightly put on, excessively use cosmetics, overestimate the external data, tell about the love progress, look usually brisk, cheerful, joyful, say that life is a holiday. In this state the feeling of a step is lost, patients become familiar, loudly speak, joke, loudly laugh, they have no feeling of a distance.

At increase of a maniacal state patients become exited, talk without a stop, voice, as a rule, become hoarse, try to sing, dance, interfere with everything, give various advice. The thinking becomes so accelerated that patients do not manage to introduce at once completely the idea, and cry out only separate words. This state carries the name "gallop of ideas". In such state there is a mass of plans which patients do not manage to state.

From the increased health, activity and efficiency, according to V.A. Gilyarovsky, easily there are crazy ideas of greatness. Most often it is about morbid exaggeration of the talents, beauty, merits and achievements. According to contents these ideas are vital, but do not correspond to the true position of the patient. At a maniacal state there are no ridiculous, absurd crazy ideas. Patients state ideas, as if joking, can easily refuse them. These ideas usually do not exert impact on behavior of patients.

Vegetative frustration, as well as at depressions, are characterized by increase of a tone of sympathetic department of vegetative nervous system. At patients tachycardia, increase of arterial pressure, the considerable loss of body weight are observed, women have no monthly. Patients usually do not show complaints to a somatic state. Allocate several clinical options of a maniacal state: cheerful mania (the German psychiatrist K. Leongard called it pure mania), of which the cheerful joyful mood — euphoria which is combined with fine physical health and revaluation

of opportunities is characteristic; effusive mania at which the increased mood is combined with supervaluable ideas of greatness and aspiration to overactive activity; irascible mania at which the affect is characterized not by euphoria, but irascibility, aspiration to activity, acceleration of thinking. For patients with irascible mania it is extremely difficult to provide care as they constantly have conflicts in office. Because of an distractibility of patients the conflicts quickly disappear, but new right there appear.

The mixed states.

At 20% of patients with maniac-depressive psychosis the mixed states are observed. They can arise during transition from one phase to another, at the same time in a clinical picture symptoms, the characteristic of mania and depressions are combined. For example, the depression is combined with motive exaltation and intellectual braking, a depression – with acceleration of intellectual activity, flow of thoughts and motive retardation. The mania can be combined with motive and intellectual retardation or only with intellectual retardation (barren mania).

Comparative and age features of a course of maniacal depressive psychosis.

Maniac-depressive psychosis at children. The outlined clinically endogenic affective phases of maniac-depressive psychosis do not arise before 12-14 years as a dismaturity of personal structure does not allow affective diseases. T. P. Simpson observed a depressive phase at two-year age. However affective frustration at children differ from the states observed at adults therefore often are not estimated adequately.

Lately the clinical supervision testifying to regularities of formation of affective frustration at children are saved up. Clinical manifestations of affective phases do not contain the typical symptoms observed at adults. At children leaders are the vegetative and somatic symptoms characterizing affective frustration. So, at depressions the sleep disorders and deliveries which are followed by a flaccidity, sluggishness are more often observed. At children backfilling violations, nightmares, fears of darkness, the complaint to unpleasant feelings in a body, a stomach, a breast are noted. Usually appearance changes: patients look pale, tired, lost weight, appetite

to the total disappearance worsens, locks appear. They refuse games, contacts with other children, are whimsical and whining as if without the reason.

At younger school students actually mental component of depressions is more distinct: against vegetative and somatic violations difficulties in tutoring appear, they become sluggish, complain of weakness, become less sociable, gloomy, silent, the shyness extrinsic earlier, shyness often appears. The symptomatology often accrues wavy. It is considered that the average duration of a depressive phase – 8-10 weeks.

Maniacal states at children, despite an atypical of manifestations, are more noticeable, than vivacity and cheerfulness depressive as violations of behavior are usually observed. Peculiar to children during games amplify, they become stirred up and uncontrollable. The child is tireless, does not know when to stop in the activity, cannot proportion the opportunities. Outwardly children look brisk: the person is often hyperemic, eyes shine, the laughter constantly is distributed, the speech is accelerated. Diagnostics is facilitated if disease becomes bipolar.

Maniac-depressive psychosis at teenagers. In the teenage period after 10 — 12 years clinical displays of this disease differ from manifestations at adults a little. At this age of the girl get sick by 3 times more often than boys; and the disease begins with a depressive phase, at the same time all typical signs of phases are found. At teenagers take place retardation in a motility and the speech, decrease of the activity, indecision, slackness, passivity, there is rather conscious experience of melancholy, decrease and lack of interests, depression, grief, boredom or alarm, concern, impossibility to concentrate, of an intellectual dullness. Along with it teenagers have a gloomy and dysphoric mood, revaluation of relationship with relatives and peers and in this regard conflict relationship with suicide thoughts and attempts from behind characteristic low-value. Depressions become more long and more composite, being followed by nonresistant crazy experiences. At maniacal states along with a hyperactivity, the increased health, aspiration to activity, indefatigability and an distractibility psychopatholike forms of behavior are found. These frustration can mask a phase of maniac-depressive psychosis. At patients the psychopatholike behavior is shown not only in violations of school discipline, but in an alcoholization, offenses, aggression. Such patients are rough, free, with the stirred-

up inclinations and tendency to various excesses. Rather legiblly seasonality of phases acts.

Maniac-depressive psychosis at late age. E. Krepelin noted the significant increase in frequency of depressions at late age. The beginning of maniac-depressive psychosis aged after 45 years is noted in 27% of cases and after 60 years — in 8,8% of cases.

In spite of the fact that in literature there is no consensus about influence of age on the course of maniac-depressive psychosis, many researchers note a tendency to complication and lengthening of depressive phases. It is connected with accession of the hypochiondrial experiences reaching in some cases hypochiondrial option of nonsense of Kotar. At involutional age a dominance of the alarming and agitated depressions inclined to a fixing current is observed, cognitive frustration are rather expressed. B this and later age of a phase of maniac-depressive psychosis proceed most hard and most of patients need hospitalization.

Maniacal states at late age meet less often, and complication and weighting of a symptomatology usually is not observed. In some cases the irascible mania with irritability and a conflictness is noted. More often patients are complacent, fussy, unproductive, the disinhibition with hyper sexuality sometimes prevails, the ridiculous megalomaniac crazy ideas reminding nonsense at a general paralysis can be observed.

Developing of maniac-depressive psychosis at late age demonstrates deterioration in the forecast in connection with a fixing current, resistance to therapy and inexact escaping of a disease state.

TEST TASKS
(for self-preparation)

Choose one correct answer

1. CHANGES OF EMOTIONALITY AND WILL, CANCELLATION OF SENSATION, INTERESTS, MOTIVES

1) anhedonia

2) abulia

3) defect

4) hypesthesia

2. IRREVERSIBLE DISINTEGRATION OF THINKING, THE EMOTIONAL STUPOR WITH IMPOSSIBILITY OF SOCIAL ADAPTATION AS A RESULT OF SCHIZOPHRENIC PROCESS

1) terminating state

2) schizophrenic defect

3) demonstrative stage of schizophrenia

4) social disadaptation

3. SLUGGISHLY ACCRUING CHARACTER DEVIATIONS: OBSTINACY, MALIGNANCY, AGGRESSION, INABILITY TO STRONG-WILLED TENSION OR THE CLOSURE, SHYNESS, "ODDITY" WHICH JOIN EMOTIONAL IMPOVERISHMENT AND CHANGES OF THINKING

1) apatic-abulic defect

2) pseudo-organic defect

3) asthenic defect

4) psychopatholike defect

4. NEUROTIC, HYSTERICAL, HYPOCHIONDRIAL, OBSESSIVE SYMPTOMS AGAINST VERY SLUGGISHLY INCREASING DEFECT

1) apatic-abulic defect

2) pseudo-organic defect

3) neurosis-like defect

4) psychopatholike defect

5. THE SCHIZOPHRENIA PROCEEDING WITH SLUGGISHLY INCREASING APATHY, DECREASE IN THE INITIATIVE, INTELLECTUAL

VIVACITY WITHOUT THE EXPRESSED CRAZY, CATATONIC AFFECTIVE SYMPTOMS

1) catatonic form

2) paranoica form

3) prime form

4) circular form

6. CRAZY IDEAS (PROSECUTIONS, INFLUENCES, JEALOUSY, ETC.). WITH ACCESSION OF THE SYNDROME OF KANDINSKY, HALLUCINATIONS

1) catatonic form

2) paranoica form

3) prime form

4) circular form

7. REPEATED CONDITIONS OF THE STUPOR WITH NEGATIVISM, WAX FLEXIBILITY, THE MUSCULAR STRAIN OR THE CONDITION OF EXALTATION WITH THE DISINTERGRATION OF THOUGHT, THE ECHOLALIA, STEREOTYPIES

1) catatonic form

2) paranoica form

3) prime form

4) circular form

8. THE CHRONIC CURRENT WITH GRADUAL INCREASE OF DEFECT AND DEVELOPMENT (COMPLICATING) OF PRODUCTIVE (PSYCHOTIC) SYMPTOMS

1) shubobrazny type

2) periodic type

3) flaccid type

4) continuous type

9. REPEATED SAME PSYCHOTIC (CATATONIC, AFFECTIVE AND OTHERS) ATTACKS, NOT RASPING DEFECT IN INTERVALS BETWEEN THEM

1) shubobrazny type

2) periodic type

3) flaccid type

4) continuous type

Lecture No. 8

Reactive states, psychogenias, psychopathies

Concept "psychopathies", "reactive state". Psychopathies, accentuated character, pathocharacter development. Classification of psychopathies. Medium and social adaptation of psychopaths. Concept "reactive state". Psychotic and not psychotic forms of reactive states. Reactive psychoses: affective and shock, depressive, paranoica, hysterical. Neurosises and conditions for their emergence. Asthenic neurosis, neurosis of obsessional states, hysterical, depressive and hypochiondrial neurosises.

The first part of lecture will be devoted to disorders of the person or psychopathies. But before we will give definition to concept the accentuated person which was entered by Carl Leongard. Understand option of standard personal development in which structure there is an accentuation any one or several lines of the person - temperament or character as the accentuated person. The accentuated person is adapted in social medium, the most pointed lines of the person at the right application which is especially caused by harmonious education can promote adaptation of the person. For example, the person, accentuated on hysterical type, finds herself in such professions where it is required implications of virtuosity, emotionality. The psychasthenic accentuated person well feels in the situations demanding a pedantry, scrupulousness of activity in which everything is planned and is predictable. Concerning the accentuated person Carl Leongard also applied expression that accentuated persons are the best part of mankind. The pointed lines have also the appendix, opposite in respect of social adaptation. It is about the so-called "weak" place of an accentuant. For example, for a hysterical accentuant the "weak" place is the situation of its ignoring, for a psychasthenic – a situation of the excessive responsibility which is especially demanding implication of leader and organizing abilities. More detailed statement of keeping of the accentuated person with digressions to the description of the famous literary heroes is stated in the fine monograph of C. Leongard "Accentuated persons", and the separate types of the

person having already disadaptation signs, that is a clinical typology, we will state when treating pathological options of the person – psychopathies.

The concept ***"psychopathies"*** is characterized by ***P. B. Gannushkin's triad – O. V. Kerbikova. It includes criteria of totality of psychopathic lines, their stability, and criterion of a social disadaptation*** which accompanies the psychopathic person throughout almost all life. The criterion of totality of psychopathic lines reflects disorders of all structure of the person in general, that is all structures and properties of the person suffer. At which unlike accentuation separate lines of the person are deviating (negative). The criterion of stability reflects implications of psychopathic lines throughout all human life. Fluctuations of psychopathic implications both towards their ascending, and towards decrease are possible, i.e. this state remaining stable isn't stiffened. And these pathological lines lead to a social disadaptation of the person. When you collect the anamnesis of life of the psychopathic person, you can pay at once attention to constant difficulties of her adaptation: at school, at the choice of work or on production, in a family. At the same time mental capacities don't suffer in an expressed way.

The parentage (it isn't quite correct to speak about a psychopathy etiology as these states don't correspond completely to criteria of illness – nosological unit – there are no criteria of a pathogenesis, current, an outcome) psychopathies allows to classify all their variety on three main groups: "nuclear", regional and organic. Psychopathy not illness, but pathological state.

At a "nuclear" psychopathy which still call genuinical or constitutional the leading causal factor is genetic predisposition. Observing the "nuclear" psychopath and knowing his relatives, it is possible to note their characterologic similarity. In this case expression "Like father like son" is applicable. This group of psychopathies is shown practically since the childhood, proceeds hard, is difficult for correctional therapy.

The following group of psychopathies by origin – regional or acquired (acquired) – was allocated by O. V. Kerbikov. This group of psychopathies is defined by an adverse effect of medium, first of all, of the wrong education. The wrong education assists fixing the dissotsialnykh of lines in character of the person. In

particular, excessive guardianship, a hyper patronage of children from parents matters. The indulging hyper patronage with a connivance to whims leads to formation at the child of feeling of permissiveness (education on the "idol of a family" type) that is fraught with development of hysterical lines of the person, the dominating hyper patronage with suppression of independence leads to fixing of lines of timidity, uneasiness, indecision – development of the psychasthenic person. Deprivation of emotional support – an orientation on ascetic education (Spartan) – schizoid lines; the hostile relation (education as "Cinderella") – to a social otgorozhennost, mistrust to people around, the aggression wearing in a warning way - protective character – the asthenic person. Neglect – feeling of permissiveness, asociality of behavior, so-called, to formation of the person through "education by the street", "who physically strong, that is also right" - explosive (erethitic) type of the person.

The group of psychopathies in which parentage the leading factor is the organic nature of damage under the influence of the external influence injuring a brain or interfering its development in the fetal period and in the early childhood is called organic psychopathies. The largest expert in the field of children's psychiatry much dealing with issues of psychopathies G.E. Sukhareva defines this group as anomalies of development in connection with damage of a nervous system at early stages of its ontogenesis. Damage it can be caused by an infection, intoxication, a fetal or birth trauma.

In clinical practice the combination of all three listed factors quite often meets: genetic predisposition, wrong education and organic harmfulness.

Further the illustration of the psychopathic person from lecture of professor Yu.E. Rakhalsky is given.

Our patient who is 32 years old now early was deserted. There is no exact information about his parents. According to the patient, the father killed mother and was placed in an insane hospital where there were several years. Since the childhood of the patient I found deviations in the behavior. Still the child it was whimsical, sensitive, stubborn, quick-tempered. Predilection to boasting and a lying was early

shown. He said to children who studied at other school that he works as the teacher. I tried to represent the teacher at the school: I got the cool magazine, I demanded that pupils submitted to it. He was brought up in orphanage, I was extremely undisciplined, many times ran away and was on the tramp. The doctrine troubled it, nevertheless it ended 7 classes. At the age of 14 years it was for the first time placed in an insane hospital in Ulyanovsk. According to an extract from a case history, he was whining, said that he doesn't want to live. At the same time, on trifles I quarreled with other patients, it was very obsessional, I tried to start with all conversation. If somebody objected it or tried to constrain it, he was aggressive, loudly swore and could even start a fight. After a while after hospitalization it noted attacks which were regarded by doctors as epileptic. Later we learn what attacks were.

His further life is full adventures. He visited the most different insane hospitals: in Ufa, Chelyabinsk, Magnitogorsk, Zlatoust, Bitter (nowadays Nizhny Novgorod), Perm, Kazan. In intervals he was in jails, was on the tramp. Sometimes he went to work, but more than three months on one place didn't remain. He abused alcohol, did himself injections opium of the containing drugs. It got to prison for thefts, fraud, quite often giving itself(himself) for another. Its predilection to any deception was found also in insane hospitals. He could repeat attacks which in the Ulyanovsk hospital doctors considered epileptic as he admitted itself later at will, imitating epileptics whom was much in hospital. To imitate and reincarnate he was a master. At one time he went from the city to the city, visited various institutions, giving himself for the deaf-mute and receiving benefits there. He could pretend a deaf-mute so skillfully that within several weeks he worked in artel of deaf-mutes until made fine theft and didn't disappear.

The constant violator of the law, the tease, the fighter, the swindler, the liar, the fan to drink, he especially willingly played a role of the peace officer. During those short periods when it worked somewhere, he entered a team (volunteer society from citizens on protection of a law and order, widespread in the USSR) on fight against hooliganism: happened that he some time was considered as the quite good combatant. But in once at the station he began to interfere with actions of militiamen, behaved aggressively, shouted, threatened to deal shortly with all, then fell and

fought in cramps. Another time, demanding that it was given the chance to work as the combatant, I began to altercate with police officers, loudly I shouted, then I began to behave ridiculously, I commanded, I demanded that all submitted to it as it – "the genius of the people". I tried to strip to the skin, I danced, I sang. As it is written in the statement which is drawn up then, he swallowed of some tablets. Its exaltation came to an end in a convulsive attack.

As it was already told, it many times was located in an insane hospital, mainly for forensic-psychiatric examination. In hospitals he was is cheerful, recovered, talkative, importunate, boastful, is irritable, spiteful, made a different claim. He refused nutrition, hid under a bed, covered the face with a pillow. He wrote indictments on hospital attendants who held it, signing them "the Genius of the Soviet Union". It became perceptible that it was very inspired, inclined to posing, its judgments were naive. It it remains till present. It was placed in our hospital after the next collision with the law under especially curious circumstances. In the enterprises where he addressed, he wasn't employed. Then he appealed to court (under laws of the USSR the citizen surely has to be to work and if it wasn't, could make responsible for parasitism). It so bothered employees of court that they eventually took it the courier in the establishment. He worked not bad and even promoted after a while – he was made the courier secretary. He as though was fond of new activity, bought legal brochures, but soon its adventurous bents were shown and here. It was presented to the brother of one of the condemned people as the investigator. Promising to help, he took a large sum of money from it and went "to strive" to Moscow. In hotel it gave itself(himself) for the judge. He received from the person deceived by it still money by mail, then caused it to Moscow, took from it several large notes, allegedly for transfer to officials. On this money he drank several days, then went to prosecutor's office, returned the rest of money and told about all incident. We will talk to it.

"Hello Pyotr Grigoryevich!" - "Hello". – "I you didn't see for a long time, what happened you new?" - "And that can happen a new me - I sit like a bird in a cage like a young eagle in prison crude". – "Have we here in the dungeon?" - "Yes it isn't better, and me all the same where to perish – in prison or in a madhouse. What

advantage in talk on it. I am healthy, I can walk the streets as well as you". – "However, it does not get anything good when you see yourself on the loose". – "And what did I make – I wanted to joke. I inflated couple of fools – they should be learned. If I want, I can be a judge – I studied this business, I have books" ... - «What was you studying – criminal law, criminalistics? According to what books?" - "Books such what it is necessary".-"Who their author? " - "Ivanov". – "What do you know about concept of fault of our legislation?" - "It is guilty, so answer". – «Tell me, do you have attacks?" - "Happen when I worry. Five healthy men on me rush – to everyone there will be an attack. – "It happened when you were detained at the station?" - "Yes". – «Did you although have attacks in hospital?" - "It used to be I made them myself. Do you want me make an attack?». (falls, randomly fights, then rises panting). – "Means, at the station you didn't represent an attack". – "No, I unconscious was, without memory". – "Thanks for conversation. Good-bye».

We got acquainted with the person in whom since the childhood sharply expressed character deviations are found. These deviations are so appreciable that all life of the patient passes in jails, in hospitals. If it remains out of walls of these two establishments, he can't adapt in the regular way to demands of environment and quickly enters collision with the law. His powers of thinking are raspingly not changed, but conversation with it shows superficiality, lightness of its judgments. Its main lines – instability of inclinations, predilection to deception, a lying. He reproduced a surdomutism, attacks lied. Undoubtedly, these actions had character of conscious deception. However, it is possible to believe our patient that at the time of nervousness he – already besides his desire – had attacks, conditions of exaltation with ridiculous statements. Then something else came into action, other than conscious aspiration to deception, namely: unconscious hysterical mechanisms as "habitual" protective reaction. It grants to us the right to carry our patient to a hysterical psychopathy. Besides, are available for this patient line and unstable type of a psychopathy. The main vital credo of persons with unstable type of a psychopathy are life in the afternoon, predilection to idleness, absence of own opinion, its dependence and behavior from the most significant, is more often in the

asocial plan, the person. They are inclined to deception, thefts, easy for ways of receiving material values. Such persons most early, already at teenage age, get to the asocial companies, making criminal actions. On an etiology in given by a case it is possible to speak about a "nuclear" psychopathy (heredity on the fatherly line, emergence of psychopathic lines in the early childhood, difficulty of a kurabelnost).

We will consider the following **type of a psychopathy – asthenic**. The main maintenance of an asthenic psychopathy is predilection to fatigue (asthenia), an impressionability, a hyperreactivity in relation to physical and mental impacts. These people the shy, timid, not able to protect interests. psychasthenic whose characterologic maintenance we already partially concerned at analysis of concept of accentuation are close to asthenic psychopaths. At a psychasthenic psychopathy indecision, uncertainty in itself, constant feeling of own low-value is especially expressed. As it was noticed by I.P. Pavlov, at them the relative delicacy of a subcortex which is shown in poverty, uncertainty of emotions and inclinations takes place. The second alarm system dominates over immediate, figurative perception of reality through the first alarm system at them. These are people excessively rational, inclined in large quantities time to come back to the same reflections concerning the acts, impressions – to what psychiatrists call "a mental chewing gum". Such psychopaths part have obsessional phenomena.

The listed types of psychopathies (hysterical, asthenic, psychasthenic, unstable) a number of psychiatrists fall intoed to weak type, based on I.P. Pavlov's psychophysiology. Division into weak and strong types is based on the features relating not to character, and to its biological basis – to temperament.

The following type of psychopathies relating already to the strong type – excitable or impulsive or explosive. ***Excitable psychopaths*** are characterized by weakness of braking at the affective reactions expressed the sthenic. They do not suffer objections and easily come to a condition of anger, rage. It is close according to clinical contents to excitable psychopaths – ***epileptoid type of a psychopathy***. They are also inclined to an affect discharge in the form of aggression, irascibility, but unlike excitable psychopaths this discharge is preceded by the particular period of "accumulation" of affect therefore an epileptoid psychopathy still call inert and

impulsive. The epileptoid personality can build up the interpersonal relationship differentially: with people on whom they depend - are sugary, obsequious, compliant, concerning weak type of the person they become despots. But in case of offense from any person, it is not dependent on his status, the epileptoid psychopath surely will react sooner or later with affective explosion, at the same time, quite often at the most unexpected moment for the victim. Rancor one more characterologic feature of an epileptoid.

Further we will consider ***paranoiac type of a psychopathy***. The structure of a paranoiac psychopathy is defined by a triad of signs: the overestimated self-conceit (grandness), suspiciousness and continuous expectation of prosecution. These people are characterized by tendency to formation of the supervaluable ideas which for a long time are getting stuck in their consciousness. They are characterized by arrogance, conviction in characteristic infallibility and correctness. The heightened sense of characteristic advantage is combined at them with hypersensitive to failures which reasons they always project in surrounding – accuse of a biased assessment, the excessive bias having to them personal hostility.

The concept of ***a schizoid psychopathy*** unites a wide range of heterogeneous characterologic features. According to E. Blyoyler, the schizoid personality including a combination of polar characterologic properties "consists of a set of segments". The shy, timid, finely feeling natures, resist indifferent and emotionally blunt here. E. Krechmer spoke about the schizo as about the person representing "an alloy of a tree and glass", emphasizing extreme sensitivity to ignoring of his characteristic requirements, desires, interests and the absolute indifference to others experiences, sorrows, etc. Along with dry, petty, avaricious, venomous pedants, gloomy odd fellows and dreamers released from life persons of stern temper, the severe, business, persistent, obstinate purposes in achievement, rigid in the aspirations and inclinations treat group of schizos. At all variety of personal features of schizos unite the phenomena of a social closure (a social autism), a discomfort in the field of the human relations, a frontage to the sphere of internal experiences, often with different imaginations (introversion), poverty of emotional communications with people around, empathy (ability to empathy).

The special group is made by psychopaths with changes of a fundamental component of mood, psychopaths who based on the ratio of basic processes fall into to various options of the strong type more often, but they can have also properties of weak, melancholic type. This is the hypertemic person differing in the excited mood – cheerful, relative frame, fissile people. Not all from them are prime and easy in communication, many differ in the raised self-rating, tendency to interfere with all events, to impose the will, aspiration by all means to achieve the, entering the continuous conflicts with people around.

Constantly the under mood is characteristic of hypothymic or as they still them are called, constitutional depressive. All of them see black, life does not give them routine pleasures and pleasure.

The listed types of psychopathies, though are the most recognized, do not settle all pictures which meet in life. More often we observe a combination of several lines of different types – "tesselated" psychopathies. Hystero-unstable, hystero-epileptoid, shizo-epileptoid types of psychopathies can be examples.

In the field of studying of a psychopathy the special merit belongs to the Russian psychiatrist P. B. Gannushkin (1875-1933). P. B. Gannushkin not only with larger skill described and systematized features of character and behavior of psychopaths, the fact that he called a statics of psychopathies, but also revealed their dynamics – laws of development of psychopathies, changes which happen at the psychopath according to biological changes and to changes in social conditions. As highlights of dynamics of psychopathies P. B. Gannushkin allocate: 1) phase or episode; 2) reaction; 3) development. The phase is understood as the changes of a mental state arising quite often without apparent dependence on external influences. If these changes last not for long – several days – say about an episode. During a phase there are mainly shifts of mood towards mild depression or a dysphoria, or – is more rare – high spirits; at psychopaths of asthenic and psychasthenic type of a phase can be shown by persuasive states, at schizos increase of an autization or isolation. Distinguish decompensation phases when there is an increase, a sharpening of psychopathic lines, and compensations – decrease, smoothing, mitigation of psychopathic manifestations.

Reactions (psychogenias, reactive states) arise under the influence of adverse mental effects, mental injuries, not only at psychopaths, but also at healthy. Differences of psychopaths from healthy in this regard consist, first, that readiness for emergence of reactive states at them is much higher and these states appear at them at such situations which for other people remain nonpathogenic, i.e. are quite overcome without any mental changes. Secondly, in the picture of psychogenic reaction at psychopaths properties, characteristic of them, and the person's tendencies are usually expressed. So, the hysterical psychopath will react to the same mental trauma hysterical symptoms – attacks, paralyzes, a mutism, etc.; excitable – long irascible exaltation, uncontrollable aggression, гипотимик – a depression. The third moment of dynamics of psychopathies according to P.B. To Gannushkin – ***pathological development (abnormal development)*** – means long, rather permanent disturbances under the influence of an adverse situation or repeated mental injuries. It affects in one cases emergence of new deviations of character and an appreciable excavation former, in other cases formation of syndromes – hypochiondrial, obsessional, paranoiac which remain for years.

The concept **"reactive state"** means psychologically caused (psychogenic) change of the mental status. ***Criteria of reactive states*** were designated by Karl Jaspers:

1. Emergence of alienations after a mental trauma. 2. Dependence of disease at most (the personal importance and duration) the injuring situation. After a while after the mental trauma ceases to work (a disactualization of experiences), the reactive state is weakened and completely leveled. 3. Content of psychopathologic experiences follows from character of a mental trauma, between them there is psychologically clear communication, that is "sounding" of experiences in complaints, behavior of the patient takes place. For example, experiences of the patient with the situational depression arising after death of the loved one are filled with memories of the dead, charges of of insufficient attention to this person, the patient is excruciated by these memoirs.

The injuring experiences are diverse, it is difficult to systematize them. First of all, they can be parted on acute and chronic. The acute, expressed, rather short-term

experiences caused by quickly caused influences, sudden shocks of the accidents proceeding quite often with threat of life are called affective and shock reactions. They can be observed in two options: in the form of exaltation (hyperkinetic reaction) or in the form of a stupor (hypokinetic reaction). Observing video filming of natural disasters and accidents which witnesses we even more often are recently, listening to stories of eyewitnesses of events, life-endangering, we notice that one people at this moment begin to rush about, make impulsive actions, being salvaged, for example, from the approaching fire or a huge wave, quite often not only without moving away from danger, and and moving towards to it (panic state). Others, on the contrary, freeze, can't move. In these situations it is about phylogenetic the caused adaptive (pseudo-adaptive) including of protective mechanisms. Affective and shock reactions always proceed to some narrowing of consciousness (sensitivity reduction of the threshold, change perception of time, a frequent partial, or full amnesia of events). For this reason, people at this moment, being salvaged from the fire, jump out of a window from height of the 20th floor or stop "as driven" before the approaching train. Affective and shock reactions are, as a rule, short on time and last of several minutes, till several hours.

Reactive psychoses and neuroses also belong to reactive states. The main differential sign of psychotic and neurotic level of disorder is, first of all, safety of critical evaluation, comprehension of morbidity of own disorders. Respectively it is shown also in behavior of patients. At the neurotic level of disorders the patient activly looks for the help.

We will consider the main reactive psychoses. Situational depression, a reactive paranoid, hysterical psychoses concern to them, besides affective and shock reactions.

Situational depression as it was already specified, most often appears as a result of death of the close family or loss of property. Its difference with the usual experiences natural in similar situations, consists in the larger duration and depth of a depression. At patients thoughts of the comprehended misfortune, a resentment or shame, pity to themselves, despair, unwillingness to accept happened (denial) dominate. This state is frequent is followed by loss of a dream, appetite, weakness,

absent-mindedness, indifference to everything that doesn't belong to the happened grief.

For ***a reactive paranoid*** the defining moment is existence of some threat to wellbeing of the person, long mistrust to it. At the same time such features of character of the diseased as uncertainty, indecision, uneasiness or, on the contrary, excessive self-confidence, conviction in the correctness, jamming on the separate experiences leading to supervaluable ideas are important. People alarming, uncertain, inspired have ideas of the relation and crazy interpretation surrounding, following from a real situation. For such people, as well as for the people living in the conditions of mental isolation owing to deafness or a blindness, rather small mental conflict for emergence of a paranoid.

The acute reactive paranoid is characterized by fast development of a persecution complex. Begins to seem to the patient, and then there is a conviction that he is watched by some persons that he in the center of attention that people against it arrange, he has to be robbed to kill. There is a pavor, it causes the wrong acts, aspiration to avoid persecutors or to decontaminate them. The current is incontinuous; the reason of similar states, along with a mental trauma, is somatic trouble (an asthenia owing to a long sleep deprivation, malnutrition, a physical disease).

The acute reactive paranoid arises, in particular, after patients get to a situation, unusual for themselves where they are surrounded by foreign people speaking on unclear to the patient tongue and also in prison conditions at persons under investigation and convicts. In many cases of an acute reactive paranoid illusory perceptions and auditory hallucinations appear.

Psychogenic paranoiac (it call also paranoic) the delirium is in many respects caused by such properties of the person as a stenic, self-confidence, commitment, larger activity at protection of the rights. He most often is at the person to the raised self-rating, mistrustful and suspicious, dissatisfied with the situation, but differing in naive, narrow, unilateral thinking. These properties of the person contribute to supervaluable ideas. Any failure, or a series of failures frame belief at the patient that he the victim of injustice – it experience becomes the basis for paranoiac reaction or even for development further of paranoia – the chronic delirium defining all life of

the patient. One patients have a pathological barratry, at others crazy ideas of invention. A kind of a reactive paranoid is the induced delirium which arises at persons dependent on the loved one, stating crazy ideas. Owing to suggestibility (induction) at the induced delirium of people begins to part the crazy concept of the person, significant for itself and even to join in it at the behavioural level. For example, mother of the patient with a delirium tremens of jealousy "helps" the son, watching the daughter-in-law, "gathers" evidence of its incorrectness. Separation of the inductor and induced quickly enough leads to a disactualization of crazy experiences.

Treat hysterical reactive psychoses: hysterical twilight state, puerilism, pseudodementia, Ganzer's syndrome. All these conditions of hysterical type can easily pass one into another, replace each other. All hysterical psychoses are united that they arise in the presence of an environment, most often in the situations wounding dignity at insufficient attention to the existing problem of people around and at persons whose main line is a dismaturity, first of all the emotional sphere. The least mature mechanisms of psychological protection as denial and regression on early stages of development are the cornerstone of hysterical psychoses. For example, at a puerilism in a psychogenia situation adult patients begin to behave as children: speech intonation ("baby talk") changes, they begin to creep, play dolls. to address people around as to kindergarten teachers, to sit down on knees, etc. At Ganzer's syndrome helplessness in answers to simple questions, disability it is correct to call parts of a body, to distinguish the right and left side it is combined with a childishness and a disorientation. Answers, though wrong, demonstrate that the patient understands sense of the asked question (a twilight state with a мимоговорение). Hallucinations can be observed. For the first time the syndrome is described by S. Ganzer (1898) in a situation of judicial proceedings.

At extreme regress there can be a ***running wild syndrome*** when the patient unconsciously begins to behave as an animal (most often, a cat or a dog). We observed the running wild syndrome at the girl of 15 years which arose owing to rape when she after mother's question from where it has blood on jeans, fell on hunkers the beginnings to it to jump, at the same time making the sounds reminding cat's

miaow. After hospitalization within the first minutes she crept on an office, curved a back, hissed in attempts to get closer to her, that is "reincarnated" in a cat.

Sometimes the patient "reincarnates" in the half-witted person (***pseudodementia***), not knowing, how many at him fingers on the hands ("to children and half-witted a lot of things says goodbye") which are allegedly not comprehending even the most prime situations with a constant mimicry of bewilderment, misunderstanding.

At hysterical psychoses patients as if remove from themselves undesirable, disturbing them (negation). For example, the schoolgirl of the 7th class after the teacher seized her in examination writing off, had a hysterical twilight state with immersion in an imaginary situation in which it "played" a role of the approximate, capable girl composing verses, able to speak many languages. In case of the latter mother of the child who died on the fire "transferred" herself to a situation which was before the fire when her child was living, and several days carried the teapot wrapped in a blanket on hands, claiming that it is her son. Remember "the wife of the junior researcher Guskov" in the famous comedy of E. Ryazanov "Garage" when it at refusal in receiving garage "reincarnated" in the hostess of the house with false recognitions.

The following group of psychogenic diseases are neuroses.

In the modern domestic literature the etiopathogenesis of neurosises is considered, first of all, from the point of view of the pathogenetic concept of V. N. Myasishchev formulated in 1960 on the basis of psychology of the relations.

According to the pathogenetic concept, V. N. Myasishchev (1960) considered neurosis as violation of system of especially significant relations of the person having the expressed emotional and motivational and behavioural components. One of the most important types of violations of system of the relations of patients with neurosises is also the intrapersonal conflict. Substance of ***the neurotic conflict*** is the expressed inconsistency of the significant relations, and it becomes pathogenic and gains nature of the neurotic conflict only in case this conflict cannot be designly resolved because of its poor understanding. Thus, neurosis, by V.N's definition. Myasishcheva, the psychogenic disease which cornerstone is unsuccessfully is

nonrational and the contradiction which is barrenly resolved by the person between it and the parties of a real, significant for it, causing painfully burdensome experiences with inability to find a rational and productive way out that involves mental and physiological disorganization of the person.

V. N. Myasishchev's pupil B. D. Karvasarsky defines neurosis as "psychogenic (as a rule, conflictogenic) the psychological frustration resulting from violation of especially significant biotic relations of the person, which is shown in specific clinical phenomena in the absence of the psychotic phenomena».

Neurosis is characterized, first, by a reversibility of pathological violations, irrespective of its duration that corresponds to comprehension of neurosis I.P. Pavlov as mental disturbance disorder which can proceed days, weeks, months and even years; secondly, the psychogenic nature of a disease which, according to V. N. Myasishchev, is defined by existence of substantial communication between a clinical picture of neurosis, features of system of the relations and a pathogenic conflict situation of the patient; in the third, the specificity of clinical manifestations consisting in dominance emotional and affective and the somatic-vegetative of manifestations.

Significance of the conflict in a genesis of neurosis is designated also in some other definitions: neurosis - the psychogenic disease arising against features of the person and a failure of mental protection with formation of the neurotic conflict, which is shown the functional violations in emotional, vegetative and somatic spheres (Ayrapetyants M. G., Vane A.M., 1982); neurosis – the psychological frustration of not psychotic register caused by frustration based on the autopsychic conflict (Voitenko R. M., 2002).

Three main types of the intrapersonal psychological conflicts corresponding to three main forms of the neurosises allocated in the Russian psychiatry are designated: hysterical – at hysterical neurosis; psychasthenic - at obsessive-phobic neurosis; neurotic – at a neurasthenia. Noting features of the conflict of hysterical type, it is easy to be convinced that excessively overestimated person's claims in combination with underestimation of actual opportunities create an absolute obstacle in realization of desirable results in the outside world. ***The hysterical intrapersonal conflict*** is

defined, first of all, by excessively overestimated person's claims which always are combined with underestimation or the complete ignoring of objective actual conditions or requirements of people around.

Features of ***the conflict of psychasthenic type*** are bound to contradictory internal tendencies and requirements, fight between desire and a debt, between the moral principles and personal attachments. The anticipation of the psychoinjuring situation is an immediate cause of emergence of persuasive fears. Subjective prediction of threat becomes for them a source of mental tension and alarm which fabulization reduces the level of indeterminacy and carries out function of psychological protection.

The neurotic type of the intrapersonal conflict is formed most often in conditions when the unhealthy aspiration to personal success without actual accounting of forces and opportunities is constantly stimulated that is promoted by great demands placed by the increasing rate and tension of the modern life. The feeling of overwork, a lack of energy, smaller efficiency of work, the characteristic of patients with a neurasthenia, represents result of an expenditure of energy on creation of various neurotic mechanisms. At the same time, all asthenic states at neurosises, and first of all at a neurasthenia, serve as a peculiar protection (tyre-tread / патопротекторной) from possible involvement in situations, the bound to tension and alarm.

In domestic (Russian) psychiatry allocate: neurasthenia, hysterical neurosis, neurosis of persuasive states, depressive neurosis (neurotic depression), hypochondriacal neurosis. Many authors consider depressive and hypochondriacal neurosises as a stage of a fixing current of the main forms of neurosis (a neurasthenia, hysterical neurosis, neurosis of persuasive states).

Let's consider the main clinical features of neurosises.

The main manifestation of a ***neurasthenia*** is the kind of an asthenic syndrome – ***a neurotic syndrome***. One of classical complaints of patients is the dull pulling together ache on a head circle ("as if the hard hoop is put on"), a so-called "helmet of the neurasthenic". At a neurasthenia in an onset of the illness symptoms of irritable weakness and vegetative symptoms are observed (heartbeat, the increased sweating, violation of appetite and a dream, unpleasant feelings in a stomach or heart, a tinnitus

(ear noise) etc.) which easily arise and quickly disappear. Then there are an irritability and tearfulness, an intolerance of bright sounds and light, difficulty when performing the work demanding precise shallow movements. In a situation of activity which is psychogenic (for example, running in short deadlines of undesirable work) the expressed emaciation (asthenia), patients, besides a headache is shown, note difficulties of reminder, judgment of tasks. At the same time research by psychological techniques out of a situation (in clinic) mechanisms of memory, thinking of any violations is not found. Also any deviations of an organic genesis in a brain at instrumental methods of inspection (EEG, MRT) do not come to light. Concerning the specified somatic complaints of patients quite often hospitalize in therapeutic office of a hospital. Rest, the calming therapy and the exact psychotherapeutic approach to patients in such state, as a rule, lead to mitigation, and in some cases and to disappearance of symptoms. At an acrimony, tearfulness, a touchiness it is not recommended to give advice like "to get it together", "to hold the emotions". These councils can worsen contact with the patient and complicate further treatment. It is necessary to remember that the patient cannot implement such recommendations owing to a disease state which reason the unconscious irrepressible conflict (conflict) caused by psychogenic influence is.

Larger difficulties at the doctor arise in differential diagnostics in the presence at the patient of ***the hysterical neurosis*** which is shown hysterical conversion and/or somatoform disorders. Ancient Greek doctors connected emergence at women of hysteria with dysfunction of a uterus (hysteria; from Greek Hystera – a uterus). They considered a uterus as independent body and connected emergence of hysterical symptoms with movement of a uterus on the woman's body. Hysterical neurosis is the neurosis which is shown polymorphic functional mental, somatic and neurologic frustration which is characterized by big suggestibility and autosuggestibility of patients, aspiration through an illness to draw attention of people around. As we already specified by the reason of hysterical neurosis, besides a psychogenic situation, the hysterical intrapersonal conflict is. The variety and variability of hysterical frustration is explained by it.

The classical clinical picture of hysterical neurosis is presented by so-called conversion frustration. The concept "conversion" came from psychoanalysis of S. Freud who believed that through conversion the patient has permission (weakening of tension) of the intrapersonal conflict by emergence of somatic symptoms. Hysterical paralyzes and a paresis as "stockings" and "gloves" belong to conversion symptoms (an anesthesia of legs or hands not corresponding to an anatomic innervation). The complete physical inactivity (akinesia) which is arising psychogenically and having the hysterical intrapersonal conflict in a basis is called a hysterical astasia-abasia. One more display of hysterical neurosis is the hysterics: the patient (meets at women more often) in the presence of someone falls and spasms begin, at the same time unlike the developed epileptic seizure there is no staging of an attack (tonic, clonic). The classical hysterics is presented by a so-called hysterical arch (hogging of a backbone to an arch with fixing of a body in a nape and heels) and random motions of extremities with rhythmical reduction relaxation of muscles. The patient at a hysterics practically never mutilates himself, "chooses" (unconsciously) convenient room and the place of falling. The following conversion frustration are hysterical deafness and a blindness. At these touch violations there is a particular selectivity of a blindness or deafness. For example, arises concerning a particular situation: the patient does not see the husband who reported about treason and does not hear, at the same time moves along the corridor, bypassing obstacles, answers questions of the doctor.

The classical picture of hysterical (conversion) neurosis now in comparison with the beginning of the 20th century, meets less often. We observed hysterics at the patient who the long time could not become pregnant. On the manifestations the attack reminded childbirth: began most often in a bed, was followed by shouts which were heard on all office. At the same time the patient as if travailled: parted legs, bear down, convulsive reductions of muscles of a abdominal. Out of attacks her gait reminded the movements of the pregnant woman on late term (waddle). She put on an olympic sweatshirt of the husband, thrust hands into pockets, delaying an sweatshirt from pulling downward and forward, imitation of a stomach of the pregnant woman. Hysteria symptoms usually remind displays of the most various diseases therefore E. Krechmer called it "the great simulator". All of them remind somatic and neurologic

diseases. Always it is necessary to remember that in each hysterical symptom there is an element of "the conditional gratefulness and desirability", i.e. hysterical reaction always has character of protective morbid reaction of an organism which joins, protecting the patient from psychologically intolerable situation. Patients with hysterical frustration do not feign in the true comprehension of this term (there is no element of a conscious intentionality). Conversion frustration result from an ***unconscious*** contradiction (the intrapersonal psychological conflict). For this reason patients very often before psychotherapeutic treatment (the leading method of therapy of neurosises) do not realize relationship of cause and effect between displays of an illness and a psychogenic situation and quite often consider that their symptoms are unique, and are displays of a serious somatoneurologic illness. Therefore such patient never should say that he is not sick that he "has to get it together and everything will pass", at the same time, as a rule, the symptomatology accrues. The doctor has to explain to the patient that his frustration - result of an strain of nervous system that bodies are only spokesmen of that nervous illness which is available and who needs to be treated.

Now the picture of hysterical neurosis, especially at the fixing course of a disease, is even more often presented by somatoform and depressive symptoms. It is a consequence, a so-called pathomorphism of a disease when clinical manifestations "look" as social accepted. For example, from the point of view of the patient with hysterical neurosis society and people around will quicker accept a serious illness if it is shown not by alienations, and, for example, diseases of internals. And doctors even more often face in the practice so-called "somatic masks" of hysteria which are presented by cardial, gastro-intestinal, neurologic symptoms. Therefore patients with somatoform disorder at the beginning of the clinical way address doctors-internus (therapeutist) : to therapists, cardiologists, neurologists, etc. And in case of suspicion on a hysterical genesis of symptoms it is always necessary to find out when collecting the anamnesis existence of stressful situations, significant for the patient, and to pay attention to temporary communication between the beginning of a disease and a stressful situation.

Persons with special traits of character (inclined to fixing on the negative emotions) in the long-livedly, subjectively not the solvable psychoinjuring situation can have a suppressed mood which becomes gradual constant and accepts morbid character. Such frustration are called ***a neurotic depression (depressive neurosis)***. As well as at other neurosises, at a neurotic depression vegetative-somatic disorders (a stage of somatic complaints) and vegetovascular dysfunction are observed in the beginning. With these frustration patients address the therapist. Unpleasant feelings in a stomach, intestines, pains, spasms, compression in heart, etc. are characteristic of this period. At inspection find persistent hypotonia and a spastic colitis. If at other neurosises (a neurasthenia and hysterical) vegetovascular and emotional lability and variability of a symptomatology are noted, then at a neurotic depression vegetovascular and emotional violations are resistant and monotonous. Patients have no emotional lability. Patients are a little suppressed, sluggish. In the favorable situation (is more often at work) feel more vigorously, depression amplifies in the injuring situation. As a rule, hypochondriacal fixing on somatic frustration is not observed.

Emergence of resistant somatic complaints that it is often observed at fixing the course of neurosis, with gradual fixing on somatic trouble testifies to a clinical picture of ***hypochondriacal neurosis***. At the same time objective research techniques do not confirm any organic changes from systems of internals. In this case there is a fixing of the conditional gratefulness of an illness, the patient resolves unconscious contradictions (the hysterical type of the intra personal conflict most often is the cornerstone) through a somatization, thereby removing some part of tension and realizing the desires and aspirations through an illness (somatized or somatoform symptoms).

Compulsion neurosis (obsessive-phobic neurosis) – a form of neurosis which specific symptoms are persuasive fears (phobias), representations, memoirs, doubts (thought) and action (rituals, tics). At the first stages of a disease there are phobias (fears), then persuasive compulsive frustration (in particular, contrast inclinations) and later – other persuasive states. In an onset of the illness of a phobia arise at immediate collision with the injuring situation, for example at a trip to the subway

where there was a fear. Then phobias arise already at expectation of a meeting with the injuring situation, i.e. at expectation of a trip to the subway. And at last, the fear arises at only one idea of a possibility of this situation. Typical for development the phobic disorders is expansion of the situations causing fear: in the beginning the patient feels fear to go to the subway, then in an electric train, the tram, etc.

Various protective actions – rituals - usually join persuasive fears. At the initial stage rituals have character of direct protection which is expressed in avoiding of the injuring situation with the subsequent complication of protective actions. Rituals have no symbolical character, and are always concrete. Patients keep the critical attitude towards persuasive fears. Only at fear height, for the short period the critical relation can be lost. As we already specified obsessive-phobic neurosis the psychasthenic conflict is the cornerstone (the conflict between desires and impossibility of its realization owing to collision with conscience, moral and ethical bans). For example, emergence at the young young man who is brought up by the rigid, directive father of persuasive desire to wash hands and misophobias (fear of pollution), can be explained with unconscious desire of death to the father. Collision of this desire with education, morals, ("untidiness" of desire, impurity of thought), leads to emergence in the conscious cognitive sphere of thoughts and fears concerning characteristic impurity which can lead to infection with a serious illness and characteristic death. There is a constant requirement of washing of hands, bodies that in the symbolical form "wash away from itself dirty desires».

TEST TASKS
(for self-preparation)

Choose one correct answer

1. COMPLEX OF THE EXPRESSED DEVIATIONS IN CHARACTER OF THE PERSON PREVENTING ADAPTATION IN SOCIETY CONCERNING ALL WAREHOUSE OF THE PERSON, BUT NOT SEPARATE LINES AND POSSESSING RELATIVELY STABILITY (THE SMALL REVERSIBILITY)

1) psychopathy

2) character accentuation

3) social disadaptation

4) psychopathic phase

2. PSYCHOGENICALLY CAUSED REVERSIBLE DISEASE STATE, NOT BREAKING COGNITIVE ACTIVITY, BUT COMPLICATING ADAPTATION TO LIVING CONDITIONS AT PRESERVATION OF THE EXACT CRITICAL EVALUATION OF MORBID MANIFESTATIONS

1) psychopathy

2) character accentuation

3) psychosis

4) neurosis

3. THE EXPRESSED AND STABLE DEVIATIONS IN CHARACTER OF THE PERSON STIRRING THE ADAPTATIONS IN SOCIETY ARISING UNDER THE INFLUENCE OF ADVERSE EFFECTS OF THE ENVIRONMENT

1) psychopathy

2) neurotic development of the person

3) pathocharakter development

4) neurosis

4. EMOTIONAL EXCITABILITY, IRASCIBILITY, READINESS FOR IRASCIBLE AND AGGRESSIVE REACTIONS IN SLIGHT OCCASIONS, THE CONFLICTNESS AND UNSOCIABILITY

1) excitable psychopathy

2) epileptoid psychopathy

3) pathocharakter development

4) schizoid psychopathy

5. IMPRESSIONABILITY, SHYNESS, SHYNESS, THE UNDER SELF-RATING, TENDENCY TO DOUBTS, INDECISION, UNEASINESS,

SUSPICIOUSNESS, IT IS FREQUENT ALONG WITH PEDANTRY AND IMPORTUNITY

1) excitable psychopathy
2) epileptoid psychopathy
3) pathocharakter development
4) psychasthenic psychopathy

6. EGOCENTRICITY, SUGGESTIBILITY, ASPIRATION TO BE IN FULL VIEW OF ALL, ROUGH MANIFESTATION OF EMOTIONS, DEMONSTRATIVENESS AND THEATRICALITY OF BEHAVIOR, TENDENCY TO FICTIONS

1) excitable psychopathy
2) hysterical psychopathy
3) unstable psychopathy
4) psychasthenic psychopathy

7. THE SUPPRESSED MOOD CAUSED BY THE MENTAL TRAUMA WHICH MELANCHOLY CIRCUMSTANCES OF THE MENTAL TRAUMA ARE REFLECTED IN CONTENTS

1) asthenic psychopathy
2) endogenic depression
3) depressive neurosis
4) situational depression

8. THE CONDITION OF THE STUPOR OR RANDOM MOTIVE EXALTATION WHICH IS PSYCHOGENICALLY CAUSED, QUICKLY FOLLOWED BY THE CLOUDINESS OF CONSCIOUSNESS

1) excitable psychopathy
2) affective and shock reaction
3) situational depression
4) twilight (clouded) frustration of consciousness

LECTURE NO. 9

Psychiatry of late age (psychogeriatrics)

Social value of the help to elderly. Gerontology and geriatrics. A periodization of late age in a gerontopsychiatry. Basic groups of alienations. Old age psychogenias. Atherosclerotic and hypertonic violations of mentality. Standard syndromes - a psychasthenia (encephalasthenia), a dementia, psychoses. Senile dementia. Alzheimer's disease. Peak illness.

The expressed demographic shift of the population towards its consenescence is observed in the developed countries within the last 25-30 years. This shift is caused as increase in average life expectancy in the countries of Europe and America, Japan, and decrease in birth rate including in Russia. In this regard indexes of abundance of alienations in the senior age contingents of the population also grew. According to domestic and foreign authors, from 10 to 25% of all persons are more senior than 60 — 65 years suffer from mental violations of various weight. The alienations revealed at persons of late age are non-uniform in clinical and in the aetiopathogenesis relation. They can be distributed on two groups. The alienations developing in earlier age periods and proceeding or repeatedly arising after the beginning of an aging and also the mental diseases which for the first time arose at late age, but not specific to it, capable to develop in various periods of life belong to the first group. This group includes the majority of clinico-nosologic forms of mental pathology: the schizophrenia, maniac-depressive psychosis, epilepsy, psychogenic diseases, alienations caused by somatic diseases, infections, craniocerebral injuries, an alcoholism, drug addiction. The second group is made by alienations, mainly or always arising at late age and directly or indirectly the bound to an aging. The second group includes the functional alienations of late age, senile and presenile dementias and mental violations caused by cerebral and vascular pathology — a brain atherosclerosis and an idiopathic hypertensia.

The complex of factors, the bound to an aging, has significant effect on clinical manifestations and dynamics of mental diseases of the first group and plays the leading role in an etiology and a pathogenesis of alienations of the second group.

Among these factors the following is most essential: the neuroendocrinal shifts caused by a climax; the various functional and structural changes of all systems and bodies caused by an aging; accumulation of somatic diseases and age illnesses; a special social and psychological situation in which there is an aging person (the termination of work, narrowing of social communications, loneliness as a result of death of relatives, impossibility of satisfaction of many interests and requirements, difficulties of self-service owing to age illnesses, senile feebleness); psychological aging, the character changes coming during an involution (decrease in an emotional hum noise, impoverishment of interests and shift them to the sphere of physical and material welfare, alarming suspiciousness, conservatism, distrustfulness, poor activity, inertness of mental processes, easing of mobility intellectual mnestic functions).

High abundance of alienations in the senior age contingents of the population, an aetiopathogenesis and clinical originality of alienations of a presenium (from 45 years) and an old age (65 years are more senior), features of therapy mentally sick of the senior age groups promoted selection in the middle of XX - го centuries of the special section of psychiatry — gerontological psychiatry. So far the gerontological psychiatry considerably developed both in scientific, and in the organizational relation. Various forms of specialized mental health services to patients of late age are created: gerontological offices in insane hospitals, gerontological offices at psychoneurologic dispensaries, houses boarding schools for the persons of late age suffering from abalienations (mental disorders).

The majority of alienations at late (elderly) age are caused by organic pathology which is shown as a productive psychopathological symptomatology of various level – neurotic and psychotic, and increase intellectual мнестического deficiency, up to a weak-mindedness syndrome. Specifics of work of the psychiatrist with organic mental violations consist in need of an exit out of limits actually of psychiatry — in a neurologic syndromology; competence of the psychiatrist of a discernment of somatic frustration, typical for late age, is necessary.

Carry presenile psychoses (melancholy, a paranoid) to the functional alienations of late age. The presenile (involutional) paranoid is characterized by nonsense of

damage, poisoning, the relation, etc. of "a small range", rather systematized, with a tendency to a progredience and rather sharp beginning. Presenile melancholy is described as an affective state with a depression, alarm which can be followed by motive concern and agitation; it is characterized by progressing of actually depressive and related crazy symptoms. Intellectual mnestic violations are not characteristic of involutional states. Their selection in self-contained nosological forms is doubtful. The clinical supervision and criteria which are been the basis for nosological differentiations in essence to the were too narrow and insufficiently essential (E.Ya. Shternberg). Negation of independence of the functional psychoses of age of an involution gained the greatest distribution in the modern German psychiatry.

Alienations at vascular damage of a brain.

From the didactic purposes we will speak about vascular process, without subdividing it into an idiopathic hypertensia and an atherosclerosis of brain vessels as these diseases are quite often combined with each other and psychopathological manifestations at them in the majority are similar.

Initial stage. Vascular damage of a brain can be shown in the beginning only by hardly noticeable symptoms which are often looked through. Aiming research by the most prime psycho-pathological tests of memory, attention, ingenuity, can show that adaptation of the patient — not the sign of the complete health, and is reached by experience, habitual, waste working methods and communication with people. Deviations can be inaccurately explained with senile age, an alcoholism, other exogeneities.

The most frequent precursory symptom of an atherosclerosis — initial and its mild forms — is the psychasthenia (encephalasthenia), an organic asthenia. At an atherosclerotic asthenia the main lines — the increased fatigue and irritability which is shown, first of all, tearfulness in an insignificant occasion (faintheartedness). Nonuniformity of manifestation of fatigue, dependence on interest in work, on the previous rest, a hyperesthesia to external irritants are expressed here less, than at asthenic neurosis. At many patients decrease in speed of reactions, mainly, speech is observed ("a mental hearing loss" of Alzheimer). Memory is much lower than age level, fluctuates — are not reproduced the close, old events. The possibility of

reminiscence depends on the subject nomination — at a reminder of names of participants of events, names of places of the patient reproduces also events. The impossibility to use more perfect paths of adaptation peculiar to young people promotes formation of such lines as a pedantry, conservatism, restriction of interests and aspirations.

Depending on premorbid properties (for example, alarming suspiciousness), from the influences injuring mentality there are more composite syndromes — astheno - hypochiondrial, astheno-depressive. At an atherosclerotic psychasthenia the obsessivno-fobichesky syndrome is shown by persuasive doubts in a regularity of the actions, persuasive reminiscence of names, terms, literary characters (that it is possible to explain with aspiration to compensation of dysmnesias), fears, most often, a cardiophobia.

Psychopatholike reference states at a cerebral atherosclerosis represent a point of the negative premorbidal lines (alarming and hypochondriac, asthenic and psychasthenic, rigid and explosive) and smoothing compensating them positive. It happens against the common mental astenisation, to dysmnesias, the accruing intellectual decrease.

Actually psychotic violations of a cerebral and atherosclerotic genesis (Yu.E. Rakhalsky, V. M. Banshchikov) – vascular psychoses – arise as facultative frustration along with two "axial", main syndromes of cerebral and atherosclerotic mental violations – a psychasthenia and psychoorganic. More often psychoses are observed at a stage, the intermediate between initial displays of cerebral atherosclerosis and a dementia as the dementia can "reduce" the psychotic phenomena, to reduce expressiveness of a productive symptomatology. The most frequent psychotic forms of mental violations at a cerebral atherosclerosis are frustration of consciousness, affective syndromes (depression), hallucinative and crazy states. Violations of consciousness at a vascular disease of a brain meet more often in a look the nonproductive (postapoplectic) forms, from productive forms of detuned consciousness the delirium and twilight frustration of consciousness are the most widespread. Except for violations of consciousness, depressive and hallucinatory states, infrequent – maniacal, catatonic syndromes are the most frequent. The course

of vascular psychoses can be sharp (till 2 months), fixing (from 2 to 4 months), relapsing (remittent) and the continuous (chronic).

The depressive syndrome of a vascular genesis is characterized by a combination of depressive affect to all-cerebral vascular disorders, to some expressiveness of a cerebral-asthenic symptomatology and, in later stages, with the dementia phenomena. The leading psychopathological symptom is frustration of mood, vital melancholy. However a number of the reference displays of an endogenic depression is absent. Usually psychomotor retardation and typical daily mood swings with deterioration is not observed in the morning. Manifestations of melancholy are deprived, as a rule, sensual expressiveness, they are rather monotonous and monotonous. Patients state ideas of characteristic insolvency, an otioseness (inutility) , uselessness, absence of sense of existence. Quite often hypochondriacal statements join these ideas. Obstinate fixing on the jet and situational moments which are usually provoking developing of a depression at a cerebral atherosclerosis is very often observed. To distinguish actually the depression of a vascular genesis from a jet state at a cerebral atherosclerosis in such cases happens very difficult. To help it is correct sometimes make the diagnosis more expressed discrepancy between insignificance of a psychogenic occasion and force of depressive reaction in case of the "true" atherosclerotic depression, and also rather larger, perhaps, sounding of reaction torques throughout all disease can at a jet state. Duration of a psychotic state cannot characterize as, jet states at a cerebral atherosclerosis differ in big duration, and the "true" depressions of a vascular genesis, on the contrary, can abortally (abortive) proceed sometimes. The so-called grumbling or grumbling depression is more often observed. Patients with everything are dissatisfied, in everything see the poor party, are fixed on the negative moments in an environmental situation, in people, in to themselves. Each event, each change in environmental becomes for them a reason for new discontent and grumbling, for further decrease in mood. Quite often patients date the melancholy for specific external events, "motivate" it, explain decrease in mood with reaction to mnestic violations, to lack of "speed of a reason". Tearfulness is expressed and inseparable from atherosclerotic faintheartedness. As well as at an astheno-depressive syndrome, the melancholy, the poor mood usually amplify by the

evening together with the phenomena of cerebral-asthenic character – an emaciation, fatigue, headaches, etc. Though the depression keeps with firmness, intensity of displays of a depression considerably fluctuates, sometimes within one days that gives to a symptomatology the "flickering" character, characteristic of a cerebral atherosclerosis. The expressed dependence between depressive symptoms and various somatic, first of all cardiovascular, violations is noted. Accession or deterioration in a current them can make depressive frustration more fixing, malignant, or alter a psychosis picture more considerably, most often towards violation of consciousness. Almost always to some extent there is an alarming coloring of a symptomatology in a look or constant mild uneasiness, or incidental alarming attacks which can be followed by motive concern, agitation, sometimes alarming monotonous lamentations. The vascular depression can accept remittent character that forces to think of larger expressiveness of cerebral and atherosclerotic process and comparative less favorable type of its current. Repeated depressive attacks become, as a rule, more fixing and intensive. Lack of daily fluctuations, typical for an endogenic depression, Protopopov's triad, the relative lability of depressive affect ("fibrillation"), its communication with an asthenic and cerebral and vascular symptomatology represent a sufficient support for the differential diagnosis from depressive phases of maniac-depressive psychosis.

The syndrome of a hallucinosis of a vascular origin meets more often in the form of the true auditory hallucinations, is more rare - olfactory or tactile which arise and amplify usually in evening or night time. The current can be both sharp, and chronic.

The paranoiac syndrome in the form of nonsense of jealousy of a vascular genesis arises against the cerebral-asthenic of the phenomena and a psychoorganic syndrome, or more or less expressed dementia signs. Falling of a sexual potentiality with fixing on it patients is quite often noted. At registration of nonsense of jealousy premorbidal features of the person of the patient, in particular, the increased suspiciousness, jealousy (paranoiac lines of the person) are of great importance. Matters as well the previous alcoholism (V.A. Gilyarovsky). When the nonsense of jealousy arises against the expressed dementia phenomena, crazy ideas have ridiculous character (for example, the 70-year-old patient claims that his 68-year-old

wife "lives" with the 17-year-old young man, and is going to divorce her or has continuous sexual contact with a stallion in a stable). The nonsense in these cases is fragmentary, does not form complete system. Rather fast improvement of a state and at the same time larger tendency to recurrence are characteristic of nonsense of jealousy of a vascular genesis that should be put in particular communication with the fluctuating, "flickering" nature of vascular process. Lack of systematization, development and expansion of nonsense is characteristic of a paranoiac syndrome of a vascular origin (unlike that at schizophrenia).

Acute paranoia vascular psychoses are characterized by suddenness of emergence, rapid development of a symptomatology, and in case of the favorable current – a fast exit of the patient from a psychotic state. In a clinical picture the affect of fear, alarm and acute sensual delirium - the relations, prosecutions, poisonings, etc. prevails. Quite often developing of psychosis is preceded by a psychogenia which originally can enter a nonsense plot. Crazy ideas are sensually concrete, nonresistant, very frequent verbal illusions and the true auditory hallucinations. Under influence of fear and crazy ideas patients can make ridiculous and dangerous acts. At height of psychosis or at the very beginning of it "the exogenetic raid" - a peculiar change of consciousness in the form of poor orientation, inexact coverage of a situation, a somnolence or mild degree of an obnubilation is often observed. At height of psychosis also the nonsense of influence can appear (quite seldom). However the brevity of nonsense of influence, its instability, acuteness of anxiety and fear, the loudspeaker of a clinical picture allow to carry out the differential diagnosis with late schizophrenia. Psychosis can sometimes last about several weeks with its transition to a chronic or relapsing current. The acute hallucinatory paranoid states proceeding more malignant are characteristic of later stages of cerebral and atherosclerotic process. States are characterized by the verbal and visual hallucinosis and nonsense determined by the maintenance of hallucinations. The "hallucinative" nonsense most often has character of a persecution complex, charge, damage, also erotic nonsense is observed. This psychotic symptomatology represents, apparently, expression of peculiar vascular and brain crises.

Chronic hallucinatory paranoid psychoses are characterized by gradual registration of crazy ideas of prosecution with a verbal hallucinosis of various degree of expressiveness. Crazy ideas carry rather low-developed, monotonic and monotonous, "small-scale" character. The hypochondriacal nonsense with an acoustical and tactile hallucinosis – "dermatozoic delusion" (Ackbom) belongs to quite infrequent forms. Patients claim that they feel and see how on their skin various shallow parasites teem, "fungi, louses, worms". Development of similar nonsense the numerous unpleasant feelings, paresthesias resulting from vascular defeat can sometimes precede.

It is necessary to differentiate hallucinatory paranoid conditions of a vascular genesis with late schizophrenia. Hallucinations at vascular psychoses have scenic character; hypnagogic hallucinations are quite often noted. Hallucinations usually arise and amplify at night; acoustical pseudohallucinations almost do not meet. The true auditory hallucinations and verbal illusions at vascular paranoids are observed considerably more often than at schizophrenia. At vascular paranoids delire it is routine more poorly, than at schizophrenia; are absent symbolics, neologisms, the phenomena of psychic automatism are expressed poorly or are absent, ideational automatisms are not observed, and sensory (senestopathic) automatism are monotonous and concrete. At a paranoic form of the schizophrenia beginning at advanced age, ideational automatism though in a vestigial look, meet quite often, and touch – quite often happen plentiful, diverse and differ in absurd, irreality of contents. At the initial stage of a disease at vascular paranoids affective frustration are usually brightly expressed (an alarming depression with fear). There is an asthenic affect with "asthenic delirious activity" (E.Ya. Shternberg) later, aspiration of the patient to leave persecutors, but not to struggle with them. At schizophrenia affect more dim remains crazy activity also longer. Essential differential-diagnostic sign are features of change of the person. At patients with schizophrenia (even complicated by a cerebral atherosclerosis) a schizophrenic autism, inaccessibility, negativism, airs and graces, oddity, aspiration to a dissimulation and special schizophrenic emotionality remains. Vascular patients have changes of the person on organic type. Vascular psychoses proceed against cerebral asthenic and psychoorganic syndromes. At paranoic

schizophrenia the progredience of a current is expressed in the form of complication of a syndrome. At vascular psychoses the delirium does not expand, is not systematized, and stabilized for some time, and then gradually fades, in process of increase of dementia . At any stage of development hallucinatory disorder can be replaced by psychopathological symptoms (syndromes) demonstrating, most often, disorders of brain blood circulation: syndromes of frustration of consciousness, Korsakovsky syndrome; more and more the tendency to dementia is found. Thus, during vascular psychoses, as a rule, there are alienations which are not belonging to a circle of schizophrenic.

There is a lacunar atherosclerotic type of a dementia later: at the relative safety of "core" of the person tendency to a tangentiality with a justification of the insolvency, aspiration to compensation of its (pseudo-compensation) at the relative mental vivacity and activity of patients is noted.

Demonstrative stage. Common for atherosclerotic weak-mindedness is larger safety, than at other dementias, moral ethical aspects of the person, faintheartedness, "fibrillation" of symptoms with frequent development of an akineticorigid neurologic syndrome. Signs of amnestic option of dementia — the expressed defeat of memory as a korsakovsky syndrome in a terminating stage quite often passes into an asemia dementia.

The pseudo-senile option is characterized by emotional impoverishment, a spiteful and grumbling hum noise of mood, the progressing amnesia with shift of a situation in the past, crazy ideas of damage. It represents in most cases a combination of atherosclerotic and senile processes. Weighable diagnostic signs of a vascular origin of "a senile syndrome" are asthenic-depressive shift of mood contrary to euphoria or emotional callousness at a senile atrophy, the considerable fluctuations in intensity of psychopathological symptoms, an akineticorigid syndrome and other focal neurologic frustration.

Asemia (pseudo Alzheimer's) type of atherosclerotic dementia — infrequent. The Afazo-aprakto-agnostichesky syndrome usually arises owing to clinically hardly noticeable circulatory disturbances in the left-hand temporal and parietal shares. A neurosis-like symptomatology at the beginning of a course of a disease, the asthenic

or astheno-depressive hum noise of clinical manifestations, "fibrillation" of symptoms of weak-mindedness can speak well for vascular defeat. And here the combination of Alzheimer's disease or a senile dementia with atherosclerotic defeat of vessels of a brain is quite often possible.

The Asemichesky type of a dementia at "clear" vascular process is, as a rule, shown by the isolated violation (but not systemic, as at its combination to Alzheimer's disease) the highest cortical functions, most often speech including symptoms of a motor aphasia, extrinsic for the combined vascular and atrophic pathology. Besides, regression character of a current the afaticheskikh of frustration contradicting the combined processes is possible.

The pseudoparalytic option of atherosclerotic weak-mindedness is caused by vascular defeat in frontal lobes and is characterized euphorically - noncritical behavior. Quite often repeated strokes which lead to death join. It is necessary to exclude a general paralysis and a tumor of frontal lobes of a brain at this option.

Terminating stage. The dementia at an atherosclerosis of vessels of a brain quite often at this stage is complicated by strokes with development of gross neurologic violations if the postinsultny state (coma) does not come to an end with death. In cases of a bezinsultny current it is possible to note smaller expressiveness of physical displays of marasmus, a distinct akineto-rigid syndrome, some oddments "abilities to perception of the speech, to pronouncing separate words or prime phrases unlike a terminating stage of Alzheimer's disease. Various options atherosclerotic dementias lose the main differences, it becomes globarny.

Senile dementia of altsgeymerovsky type.

Initial stage. The beginning of a senile dementia of altsgeymerovsky type is shown by particular degree of a roughening or leveling of personal lines, decrease in criticism to the behavior and judgments, to the improper acts. The most typical symptoms of an initial stage of a senile atrophy are the person's roughening with a capriciousness, an aversion for the family, neighbors, distrustfulness, avarice, cynicism (the person's psikhopatization) or there is a leveling of personal lines with a flaccidity, indifference to environmental, health, to clothes, an order in the house, a divergence. At the same time procreation of rather recent events is broken in the

beginning. Loss of criticality with separate ridiculous acts, does not correspond still to not rough frustration of thinking. Remember Mendel Krik with his rough noncritical behavior in a family in "The Odessa stories" of Babel. After the particular period of a psikhopatization there was a leveling of the person.

The initial stage of a senile dementia can be rather long-lived, especially when in initial symptoms dysmnesias with the relative safety of criticism and smaller expressiveness of personal changes prevail. Patients within 1-2 years keep exterior forms of behavior, try to participate in household chores, but lose things, money, confuse and forget names of relatives, recent events. Memoirs of the old past quicken. There are disorientation episodes in unfamiliar and unfamiliar places. Accession of a somatopathy, change of a habitual stereotype — moving to the new place — result in amnestichesky "confusion" with a disorientation in the place, time, concern, not recognition of relatives and chance recognitions. Early enough crazy ideas of damage join initial symptoms (Plyushkin in "Dead douches" of Gogol). In certain cases the syndrome develops at an initial stage crazy (paranoiac, paranoica, paraphrenic).

Demonstrative stage of a senile dementia of altsgeymerovsky type. The most frequent prime form of a senile atrophy at a demonstrative stage is characterized by poverty and roughness of emotions, the progressing amnesia with rather superficial shift of a situation in the past, fragmentary confabulations, mainly, ekmnestichesky (falling into to the remote past) and to a lesser extent mnemonic (the forgotten events of the present are replaced with events of routine activity of the recent past); the lexicon due to loss of nouns, adjectives, the unions, the especially lengthiest and compound words grows scanty. Fussiness, with inversion of a dream, a symptom of "collecting" is noted at night, crazy ideas of damage are expressed. Sometimes there are conditions of confusion with short-term, more often, night episodes of visual illusions, hallucinations. Such states are quite often bound to complication of dementias a somatopathy.

In other cases, with a dominance at an initial stage the amnesticheskikh of frustration in the form of the progressing amnesia and violation of procreation of the real events, confabulations are brightly expressed mnemonic and ekmnestichesky (falling into to the remote past). There are conditions of so-called senile "delirium"

with deep shift of a situation in the past, chance recognitions, emotional vivacity with a dominance of eyforichno-complacent affect. Quite often patients show aspiration to any activity which does not correspond to a situation and has character of fussiness ("business fussiness"). Somatogenias (changes of arterial pressure, pneumonia) sometimes cause fluctuations of a state with change of an emotional hum noise from complacent and euphoric to apato-dysphoric or subdepressive, with inaccurate orientation (patients understand that they are in hospital, but character, locations do not know it).

Terminating stage. At a senile dementia of altsgeymerovsky type speech reactions are considerably reduced, questions are often left without answer. Verbal and literal paraphasias become frequent. Actions, even habitual, patients carry out clumsily, do not understand the instruction turned to them. Cease to move self-contained.

Alzheimer's disease.

Initial stage. In typical cases of Alzheimer's disease the amnestichesky syndrome (korsakovopodobny), with a space and temporary disorientation develops in the beginning. Together with it there are not rough, asemichesky frustration (speeches, letters, a praksisa) — classical option. At Alzheimer's disease the special type lacunar dementias with the relative safety of criticism, mimic and emotional reactions and at the same time rough intellectual мнестической insolvency is formed. Afazo-aprakto-agnosticheskny the syndrome in an onset of the illness is expressed clinically by loss of the composite practical skills (patients as if "forget" how to cook food, to wash the dishes, etc.) impossibility to call many objects which are especially seldom used in life, mistakes in the letter ("forget" as this or that letter is written) reading, the account. Already in this stage verbal paraphasias often meet (replacement of one word with another, remotely similar in sense) and logoclonisms (a spotykaniye on the first syllables of the pronounced word), in the speech prevail impersonal sentences because of loss from a lexicon of nouns.

Alzheimer's disease at **a demonstrative stage** is characterized by the almost complete loss of traces of the past already without compensation of amnestichesky defect confabulations, the complete disorientation, especially space, reaching an

agnosia (patients come across objects in search of escaping of an office), an ideatorny apraxia (the plan of action at prime skills is surprised — washing of hands, clothing, an undressing), the fussiness peculiar also such patient is followed by the stereotypic movements (patients constantly finger clothes, try to tie clothes in knot, go, having clamped a clothes lump at a belt or at a collar). Disintegration (impossibility) of the letter, reading, the account is observed; amnestic, with impossibility of the nomination (name) even of the most common objects in life, touch (misunderstanding by the patient of the speech turned to it – defeat of speech hearing – a back third of the top temporal crinkle, Vernike's center – at frequent safety of hearing in general) aphasias. There are not only verbal paraphasias as reflection, mainly, of an amnestic aphasia (an average temporal crinkle of a dominant share), and also literal paraphasias, logoklonic stutter at the beginning of words are frequent. Roughly the phrase speech in which replaceable words (particles "so prevail suffers... here... it"), pronouns, verbs.

At **a terminating stage** at Alzheimer's disease there is the complete disintegration — both physical, and mental: the aphasia becomes total, speech contact with patients is impossible, they senselessly repeat only separate syllables; the apraxia is universal — patients cannot self-contained eat, go, sit down. There are motor automatism: violent laughter, crying, iterations (stereotypic actions in the form of "washing of linen", a scuffing of palms the friend about the friend, hips, etc.). Further flexion contractures and a pose of an embryo are characteristic.

For demonstration of Alzheimer's disease we give the following clinical supervision.

The patient is 73 years old. From 67 years ceased to cope with work of the veterinarian, worked as the watchman. Became forgetful, could not remember where put things. Recognized acquaintances hardly, forgot their surnames. Became irritable. In 70 years not always found the house necessary to it, the street, violations of the speech appeared: sometimes pronounced obscure words, answered not on - to an entity. Since the same time not always correctly put on, confused "face" and a wrong side. For the first time came to an insane hospital in 70 years. Easily entered conversation, it was good-natured, kind. The movements are free, active, expressively

gesticulated. The mimicry is diverse, adequate. Weakness of judgments, concreteness of thinking came to light. It was verbose, during conversation sometimes operated with the composite abstract concepts, but could not pick up sometimes in conversation a proper word, especially names of objects, in the past well familiar to the patient. Stumbled on the first syllables, sometimes could not pronounce the word at all. Falloff of memory on the present and the past was noted (did not know the current number, month, could not remember in what it hospital where it is, to report some most outstanding events, to detail them on time). To memory violations the relative criticism remained. In 7 months it is delivered in a hospital by ambulance car from a bath where sat from morning to late evening. In a hospital the expressed disorientation in the place, in the current time is noted. It was fussy, the concrete orientation of judgments, an amnestic aphasia, an apraxia, jump of handwriting, a spelling error of words came to light. Rough decrease in memory on current events and on the past. The following receipt in 73 years. It is delivered by the foreign woman who found it aimlessly vagabonding down the street with a ware grid on the head.

***Mental status**. The examinee came into an office by means of medical personnel, in response to a greeting greeted. Easily enters conversation with the doctor, expressly politely exchanges bows, begins to thank the doctor for care. The mimicry is adequate, various, vividly gesticulates. Appearance is slovenly. Sitting on a chair constantly something does by hands: it is gathered, irons head hair, tries to keep step with environmental objects, makes the same movements on type of "washing of linen". It is disoriented in the place, the current time. The mood is complacent, sometimes becomes spiteful. Does not find crazy ideas. The thinking is inconsistent, extremely primitive. It is verbose, the speech is rich with intonations, the lexicon small, but sometimes uses also words of a foreign origin: "opposition", "recitation", "prevails", etc. In certain cases passes to a monologue which represents a mere verbiage and does not stop until the patient is interrupted by the interlocutor. The phrase speech is complicated; statements are florid, senseless, incomplete, nouns are absent; on a question whether there was it on appointment yesterday (to the patient the granddaughter came), answered: "I yesterday at... at... joined to female with... coc...*

to estate". The logoclonism is expressed. Distorts words: meat – "моco". The speech turned to it understands badly, often answers not in respect of a question. Could not call the shown objects (the handle, a button, a pacifier), tried to explain their value, but unsuccessfully. It is difficult to fix the patient's look on this or that subject even if the patient holds it in hand. In response to a request to light a match helplessly plays with a box, having got a match, the box drives it on inside. Cannot put on, wash without the aid of personnel. The letter of the patient represents separate lines, zigzags. The partial account does not work well. Deep decrease in memory on current events and on the past comes to light. Cannot find the chamber, a bed, cannot call any dish from a breakfast which he just ate, does not remember a name and a middle name of the doctor, could not tell what profession at it. Agrees with the doctor that he has the poor memory, complains of "confusion in the head", but at the same time declares what can work in state farm as the agronomist.

In office it is fussy, aimlessly wanders about chambers, suddenly begins to look for something, politely exchanges bows with all passers. Between objects in chamber moves freely. Gradually the speech breaks up: in 77 years pronounces only separate words or senseless phrases. Becomes helpless, cannot serve itself, it is slovenly, cannot self-contained eat. The patient died in 79 years at the phenomena of the progressing pneumonia and a pulmonary heart.

Clinical diagnosis: *Alzheimer's disease.*

In this case in the beginning diseases (at an initial stage) in a symptomatology the amnestic syndrome prevailed. From 70-year age at the patient not rough asemic frustration are shown (speeches, a praksisa). The special type lacunar dementias with the relative safety of criticism, mimic and emotional reactions and at the same time rough intellectual мнестической insolvency is formed. With progressing of Alzheimer's disease the expressed focal cortical frustration in the form of an afazo-aprakto-agnostic syndrome develop and the dementia phenomena accrue.

Peak illness.

Initial stage. The Peak onset of the illness in typical cases is shown by two options: 1. Aspontannym — with versions — and) aspontanno-apathetic (schizoform) with emotional impoverishment, lack of interests, inadequate ("paradoxical")

statements and acts; b) aspontanno-euphoric with separate ridiculous acts, blunt euphoria at an aspontannost and an adynamia. Due to the poor emotional contact and signs of intellectual insolvency of organic type at both options it is necessary to exclude a tumor or hemorrhage in frontal lobes. 2. Pseudoparalytic — with a disinhibition, violation of behavior, frequent ridiculous acts, euphoria, ideas of greatness. Differences from a paralytic dementia — stereotypies in thinking, the speech and actions, the best safety of memory, and first of all, lack of changes of liquor, a Wassermann reaction, typical for a general paralysis. At both options of an onset of the illness of Peak the categorial thinking is surprised (level of generalizations, possibilities of distinguishing and comprehension of the thin relations, the critic decrease). Passivity, apathy, careless euphoria feign rough dysmnesias. However at persistent inquiries patients report the anamnesis, they have no violation of orientation in hospital, they can localize events in time. In diagnostics of an onset of the illness of Peak motive and speech stereotypies, perseverations, difficulties of switching from one subject of conversation on another are of great importance. Patients can make stereotypic aimless actions – to come to relatives, silently, to sit several minutes and to leave, and in this way to repeat this action several times.

At pseudoparalytic option offer impracticable, ridiculous projects at work, for example, to assemble cedar cones, forcing down them the helicopter screw, pursue people around including children, with sexual offers.

At a **demonstrative stage** patients with an illness of Peak perceive only prime instructions. At aspontan option there is "initiative mutism" which reminds a mutism at a catatonic stupor or sometimes is accepted to the complete disintegration of the speech, however patients can answer questions when overcoming an aspontan with the exact pronouncing words and drawing up short phrases. In typical cases of an illness of Peak of a paraphasia were observed seldom. Speech stereotypies become the isolated automatic phrases which lose touch with a question, with a situation — "standing" turns, and are reproduced the patient out of questions at a meeting with the doctor, medical personnel, or at the beginning of conversation; they can be the most various contents and even ridiculous: "a pancake’s collar, a pan’s shirt", "once upon a

time there was Leva from Chisinau". The dynamic component of a praksis is roughly broken: patients cannot switch from one stage of action to another (only the first part of the instruction is carried out "to take a pencil and to give it to the doctor"), inertness of action, its multiple repetition is expressed (rise and go several times to bed, make "jogs" along the corridor of office, etc.). Poverty of motor manifestations is observed. The Aspontan, an adynamia feign sometimes action disintegration. At pseudoparalytic option patients can aimlessly wander about office with a constant smile upon the face, sometimes ridiculously try to joke. Because of the progressing impoverishment of a lexicon speech production low.

The terminating stage of an illness of Peak is characterized by impoverishment of speech reactions up to an initiative mutism, "standing" turns disappear, patients repeat in response to any question "yes", "I do not know", "I am illiterate", respond to the surname. There are signs of a touch aphasia. Patients only at motivation from out of move, but can self-contained eat, till last days find a bed, a toilet. They become absolutely helpless only at the expressed cachexia shortly before death.

TEST TASKS

(for self-preparation)

Choose one correct answer

1. ROUGHENING OF PERSONAL LINES, THE PROGRESSING AMNESIA, SHIFT OF THE SITUATION IN THE PAST, DEMENTIA GLOBARNOGO

1) vascular dementia
2) Alzheimer's disease
3) senile dementia
4) Peak illness

2. THE BEGINNING OF THE DISEASE TILL 65 YEARS, THE ASPONTAN, LACK OF CRITICISM, EUPHORIA, SPEECH AND MOTIVE STEREOTYPIES, STANDING TURNS OF SPEECH ARE CHARACTERISTIC

1) Peak illness

2) senile dementia of Alzheimer's type

3) Alzheimer's disease

4) senile atrophy

3. THE BEGINNING OF THE DISEASE TILL 65 YEARS WITH KORSAKOV-LIKE DEVELOPMENT OF THE AMNESTIC SYNDROME, ASEMIC DEMENTIA WITH THE AMNESTIC, TOUCH APHASIA, THE APRAXIA AND THE AGNOSIA IS TYPICAL

1) senile dementia of Alzheimer's type

2) senile atrophy

3) Alzheimer's disease

4) Peak illness

4. THE PSYCHASTHENIA, FAINTHEARTEDNESS, "FLUCTUATION" AND "FIBRILLATION" OF THE PSYCHOPATHOLOGICAL SYMPTOMATOLOGY ON DEPTH OF MANIFESTATIONS, LACUNAR TYPE THE DEMENTIA

1) senile dementia

2) vascular dementia

3) asemic dementia

4) aspontan-apathetic dementia

5. INTENSIVE TRUE HALLUCINATIONS OF MAINLY VERBAL CHARACTER, PSYCHASTHENIA, EMOTIONAL LABILITY, "FLUCTUATION" OF THE PSYCHOPATHOLOGICAL SYMPTOMATOLOGY

1) vascular hallucinosis

2) senile hallucinosis

3) vascular dementia

4) the true verbal hallucinosis

6. THE PSYCHASTHENIA, FAINTHEARTEDNESS, THE OLIGOTHYMIA WITH PSYCHOMOTOR RETARDATION WITH THE AGGRAVATION OF

SYMPTOMS IN THE EVENING, UNEASINESS, THE SLEEP DISORDER AND APPETITE

1) alarming and depressive syndrome

2) vascular dementia

3) vascular depression

4) cerebral-astenic syndrome

7. THE RESISTANT CRAZY IDEAS OF JEALOUSY WHICH ARE RATHER SYSTEMATIZED WITHOUT HALLUCINATIVE FRUSTRATION, WITH EXISTENCE OF FAINTHEARTEDNESS, CEREBRAL-ASTENIC COMPLAINTS, "FLUCTUATION" AND "FIBRILLATION" OF THE PSYCHOPATHOLOGICAL SYMPTOMATOLOGY

1) paraphrenic syndrome

2) paranoiac syndrome

3) vascular dementia

4) vascular crazy syndrome