راجع نموذجية - طب نفسي
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Answer question ١

clinical picture of schizophrenia types

The following symptoms are highly suggestive of schizophrenia, if they are fixed and prominent in the course of the illness:

- Disorders in the form of thinking (formal thought disorders): loosening of association, derailment, and incoherence
- Delusion of control, thought insertion, thought withdrawal and thought broadcasting
- Bizarre delusions and behavior
- Third person auditory hallucinations
- Commanding auditory hallucinations with the patient obeying those commands even if absurd, irrational or dangerous
- Flattening of affect, inappropriate affect and marked ambivalence
- Marked social withdrawal, not secondary to a delusion or a depressed mood.

Symptoms of schizophrenia are generally divided into positive symptoms and negative symptoms.

a. Positive symptoms include all manifestations related to delusions and hallucinations. They usually respond to typical antipsychotics.

b. Negative symptoms include flat affect, social withdrawal and avolition. They are usually handicapping. They prevent the patient from integration into the society or resuming his previous social and occupational levels of functioning. They do not respond to typical antipsychotics, but improve on using atypical antipsychotics and different psychotherapies and rehabilitation techniques.

Types

١- Disorganized Schizophrenia

- All symptoms of schizophrenia are present
- Delusions are bizarre, fragmented and malsystematized
- Speech and behavior are grossly disorganized
- There is marked social and occupational deterioration

٢- Paranoid Schizophrenia

- There is preoccupation with one or more delusions, or frequent hallucinations.
- None of the following is prominent: disorganized speech; disorganized or catatonic behavior; flat or inappropriate affect.
- Social dysfunction and occupational deterioration is less than all the other types.

٣- Catatonic Schizophrenia

- This is a type of schizophrenia where catatonic features

dominate the clinical picture (see chapter on symptomatology)

• Other symptoms of schizophrenia are present as well

• Social and occupational deterioration is profound

٤- Undifferentiated Schizophrenia

• It is an intermediate form between paranoid and disorganized types

• Delusions and hallucinations are less than those encountered in paranoid schizophrenia

• Disorganization is less than that seen in the disorganized type

• Social dysfunction and occupational deterioration is intermediate between the paranoid type and the disorganized type.

٥- Residual Schizophrenia

• Symptoms and deterioration in functioning are even less than that seen in the undifferentiated type.

• It is usually the result of partial improvement on treatment

٦- Schizoaffective Disorder

• There is a prominent and persistent mood disturbance in the form of depression or elation, in the presence of schizophrenic symptoms.

• The diagnosis is given to cases when neither a mood disorder nor a frank schizophrenia can be diagnosed

• Two types are recognized:

- Schizoaffective disorder - depressive type
- Schizoaffective disorder - bipolar type

" Some authors do not consider this disorder as a type of schizophrenia. It is an intermediate disorder between mood disorders and schizophrenia.

٧- Simple Schizophrenia

• There are no positive symptoms.

" There is only vague thinking, flat affect and social withdrawal.

• Occupational deterioration is very gradual but profound

• Onset is usually in early adolescence. It is very gradual over many years. Course is slowly progressive.

• The family usually recognizes the change in personality after many years of deterioration.

• It is one of the most malignant types of schizophrenia.

Answer question ٢ Disorders of Perception

Perception is the process by which sensory stimuli are given a meaning (i.e., transferring physical stimulation into psychological information). Common disorders of perception are the following:

١. Illusions:

• Misinterpretation of real external sensory stimuli (e.g., mistaking a rope for a snake, mirage).

• May affect any sensory modality (visual, auditory, etc...).

• May occur in normal or pathological conditions (e.g., delirium).

٢. Hallucinations:

Hallucination is a false perception in the absence of any external stimulus.

Types of Hallucinations

According to complexity:

• Elementary (e.g., noises, flashes of light).

• Complex (voices, music, faces, scenes).

According to sensory modalities :

a. Auditory Hallucinations:

They are the most common type of hallucinations. They mainly occur in psychotic disorders especially schizophrenia.

Varieties:

• Voices talking to the patient (٢nd person), i.e., addressing or commanding

• Voices talking about the patient (٣rd person), e.g., commenting on his thoughts or actions

• Voices repeating patient's thoughts (echo de pensee)

b. Visual Hallucinations:

• Most common in organic mental conditions, (e.g., delirium, substance intoxication or withdrawal).

• May occur in schizophrenia, severe mood disorders or dissociative disorders.

c. Tactile Hallucinations:

• False perception of touch.

• e.g., phantom limb (from amputated limb); and crawling sensation on or under the skin in cocaine intoxication and withdrawal.

d. Olfactory (smell) and Gustatory (taste) Hallucinations:

• Most common in organic conditions, e.g., temporal lobe epilepsy.

• May occur in schizophrenia or severe mood disorders.

e. Somatic Hallucinations:

• False sensation of things occurring in the body (mostly visceral). They usually occur in psychotic disorders, particularly schizophrenia.

٢.Depersonalization and Derealization:

Disturbed perception of oneself or the surrounding environment:

a. Depersonalization: the person perceives himself, his body or parts of his body as different, unreal or unfamiliar.

b. Derealization: the person perceives the external world, objects or people as different, strange or unreal.

Depersonalization and Derealization may occur in normal people (during stress), in anxiety disorders, mood disorders, schizophrenia, and in organic conditions (e.g., temporal lobe epilepsy).

Answer question ٣

Panic Disorder

Clinical Features

Recurrent spontaneous or unexpected panic attacks, i.e., acute episodes of intense anxiety. It may be associated with agoraphobia (about ١/٣ of patients).

Diagnosis of panic disorder is made if the attacks arc repeated (٤ attacks in a month), or if the patient becomes concerned about having additional attacks (anticipatory anxiety). This causes gross impairment of functioning. The patient may fear or worry about the implications of the attacks (e.g., developing a heart attack, going crazy, or lose control over oneself).

The Panic Attack:

A panic attack is a discrete period of intense anxiety not related to any particular situation or circumstances. It develops abruptly, reaches the peak over ١٠ minutes, and lasts for a limited time (٥-٣٠ minutes).

During the attack there is a mixture of physical and psychological symptoms. They develop acutely and include:

١- Physical anxiety symptoms:

* Palpitation or accelerated heart rate
* Chest pain or discomfort
* Shortness of breathing or smothering sensation
* Sense of chocking
* Sweating
* Chills or hot flushes
* Trembling or shaking
* Feeling dizzy, light-headed, unsteady or about to faint
* Nausea, abdominal distress, abdominal colics and diarrhea
* Parasthesia (numbness or tingling)

٢. Psychological symptoms:

* Fear of dying.
* Fear of loss of control or going crazy.
* Depersonalization and/or derealization

N.B. Due to the abruptness of the attacks and their typical physical symptoms, panic attacks are usually mistaken by the patient (and physicians) for acute cardiac conditions (ischemic attack or arrhythmia). This leads to repeated admissions to ICU and costly investigations.

Answer question ٤

Treatment of Depressive disorders

Major Depressive episodes are treatable in ٧٠-٨٠٪ of patients. The therapist should integrate pharmacotherapy and psychotherapeutic interventions, as well as other lines of treatment. The following are the general lines of treatment:

١. **Hospitalization** is needed in severe cases and is mandatory in suicidal cases.

٢. **Pharmacotherapy:**

* Tricyclic and tetracyclic antidepressants are relatively inexpensive. They are started if the patient's economic condition does not allow for the more expensive recent antidepressants. Their side-effects make them inappropriate for many patients.
* SSRIs and other more recent antidepressants are expensive drugs and are used if no response to tricyclic antidepressants occurs or if anticholinergic side effects need to be avoided. SSRIs may be the drugs of choice for Dysthymic Disorder.
* Maintenance treatment should be continued for at least ٦ month to prevent relapse.
* Long treatment is needed with chronic or recurrent major depression
* Maximum dose for sufficient duration should be administered before shifting to second lines of treatment.
* Efficacy of antidepressants is reinforced by the addition of other drugs such as Lithium, Antipsychotics in small dose and Antiepileptics.

٣. **Electro-Convulsive Therapy (ECT)** is indicated in:

* Refractory Depression
* If it is associated with psychotic features
* Suicidal patients
* When antidepressants are contraindicated for medical reasons.

٤. **Psychotherapy:**

* Psychotherapy in conjunction with antidepressants is more effective than either alone.
* Cognitive Therapy: Short term treatment aiming to correct the negative cognitive symptoms of depression.

* Supportive Psychotherapy: A treatment of intermediate length aiming for providing emotional support, ventilation and reinforcement and his family.
* Family therapy: Indicated when patient's depression is disrupting family stability or related to family events.

Answer question ٥

Behavioral Therapies

Behavioral therapy is based on the theory that symptoms are persistent inaladaptive behaviors acquired by conditioning or learning. Therapy consists of "deconditioning" or "unlearning" of such behavioral habits and "relearning" of new adaptive behaviors.
e.g., phobia represents a conditioned habit of reacting with anxiety to a non-dangerous stimulus. Therapy consists of breaking down this conditioning.

Techniques

١- Systematic desensitization

Graduated exposure in imagination to anxiety provoking situation while in a state of relaxation

٢- Graded exposure

Similar to systematic desensitization but performed in real-life situations without relaxation

٣- Flooding

The patient confronts the undesired situation directly without graduation or relaxation and remains in the situation until he becomes calm

N.B. The above techniques are useful in phobic, and obsessive compulsive disorders and some sexual disorders.

٤- Aversive conditioning

Pairing of a maladaptive behavior with a noxious stimulus (punishment) leads to inhibition and extinction of that behavior.
e.g.,: In treating alcoholism, patients are given a drug (Disulfiram) which causes severe nausea and vomiting if the patient drinks alcohol.

٥- Positive reinforcement (reward)

- Pairing of a positive desired behavior with a reward (e.g.. food, praise, avoidance of pain) leads to reinforcing the behavior and establishing it as a habit.

- Helps well in rehabilitation (i.e., improving self-care, social behavioral, etc...) or chronic patients (e.g.. schizophrenia, autistic disorder, M.R..).

٦- Participant modeling

- Based on observational learning or learning by imitation.
- e.g., a child fearful of dogs can overcome his fears by watching and imitating other children playing with a dog.