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GENERAL CHARACTERISTICS OF PSYCHOGENIC AND THEIR CLASSIFICATION. NEUROSES. ACUTE AND PROLONGED REACTIVE PSYCHOSES. PSYCHIATRY OF DISASTERS AND NATURAL DISASTERS. MENTAL DISORDERS IN PATIENTS WITH SOMATIC, ENDOCRINE AND VASCULAR DISEASES

Neurotic, stress-related and somatoform disorders (F40-F48)

F40 Phobic anxiety disorders

A group of disorders in which anxiety is evoked only, or predominantly, in certain well-defined situations that are not currently dangerous. As a result these situations are characteristically avoided or endured with dread. The patient's concern may be focused on individual symptoms like palpitations or feeling faint and is often associated with secondary fears of dying, losing control, or going mad. Contemplating entry to the phobic situation usually generates anticipatory anxiety. Phobic anxiety and depression often coexist. Whether two diagnoses, phobic anxiety and depressive episode, are needed, or only one, is determined by the time course of the two conditions and by therapeutic considerations at the time of consultation.

F41 Other anxiety disorders

Disorders in which manifestation of anxiety is the major symptom and is not restricted to any particular environmental situation. Depressive and obsessional symptoms, and even some elements of phobic anxiety, may also be present, provided that they are clearly secondary or less severe.

F42 Obsessive-compulsive disorder

The essential feature is recurrent obsessional thoughts or compulsive acts. Obsessional thoughts are ideas, images, or impulses that enter the patient's mind again and again in a stereotyped form. They are almost invariably distressing and the patient often tries, unsuccessfully, to resist them. They are, however, recognized as his or her own thoughts, even though they are involuntary and often repugnant. Compulsive acts or rituals are stereotyped behaviours that are repeated again and again. They are not inherently enjoyable, nor do they result in the completion of inherently useful tasks. Their function is to prevent some objectively unlikely event, often involving harm to or caused by the patient, which he or she fears might otherwise occur. Usually, this behaviour is recognized by the patient as pointless or ineffectual and repeated attempts are made to resist. Anxiety is almost invariably present. If compulsive acts are resisted the anxiety gets worse.

Neurotic, stress-related and somatoform disorders (F40-F48)

F43 Reaction to severe stress, and adjustment disorders

This category differs from others in that it includes disorders identifiable on the basis of not only symptoms and course but also the existence of one or other of two causative influences: an exceptionally stressful life event producing an acute stress reaction, or a significant life change leading to continued unpleasant circumstances that result in an adjustment disorder. Although less severe psychosocial stress ("life events") may precipitate the onset or contribute to the presentation of a very wide range of disorders classified elsewhere in this chapter, its etiological importance is not always clear and in each case will be found to depend on individual, often idiosyncratic, vulnerability, i.e. the life events are neither necessary nor sufficient to explain the occurrence and form of the disorder. In contrast, the disorders brought together here are thought to arise always as a direct consequence of acute severe stress or continued trauma. The stressful events or the continuing unpleasant circumstances are the primary and overriding causal factor and the disorder would not have occurred without their impact. The disorders in this section can thus be regarded as maladaptive responses to severe or continued stress, in that they interfere with successful coping mechanisms and therefore lead to problems of social functioning.

Neurotic, stress-related and somatoform disorders (F40-F48)

F44 Dissociative [conversion] disorders

The common themes that are shared by dissociative or conversion disorders are a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements. All types of dissociative disorders tend to remit after a few weeks or months, particularly if their onset is associated with a traumatic life event. More chronic disorders, particularly paralyses and anaesthesias, may develop if the onset is associated with insoluble problems or interpersonal difficulties. These disorders have previously been classified as various types of "conversion hysteria". They are presumed to be psychogenic in origin, being associated closely in time with traumatic events, insoluble and intolerable problems, or disturbed relationships. The symptoms often represent the patient's concept of how a physical illness would be manifest. Medical examination and investigation do not reveal the presence of any known physical or neurological disorder. In addition, there is evidence that the loss of function is an expression of emotional conflicts or needs. The symptoms may develop in close relationship to psychological stress, and often appear suddenly. Only disorders of physical functions normally under voluntary control and loss of sensations are included here. Disorders involving pain and other complex physical sensations mediated by the autonomic nervous system are classified under somatization disorder (F45.0). The possibility of the later appearance of serious physical or psychiatric disorders should always be kept in mind.

F45 Somatoform disorders

The main feature is repeated presentation of physical symptoms together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and preoccupation of the patient.

F48 Other neurotic disorders

Triad of Karl Jaspers (1910)

- Psychogenic disorder is developing immediately after exposure to psychic trauma.
- Manifestations of the disease derives directly from the content of the psychological trauma, among them there are psychologically understandable communication.
- Course of the disease is closely associated with the severity and actuality psychological trauma. Its resolution leads to termination or significant weakening disease manifestations.

NB! Psychogenic mental disorders occur as a result of interaction between the patient's personality and psychological trauma.

The most general violations that are typical for borderline conditions:

- Relationship between mental disorders and vegetative dysfunction, violation of nocturnal sleep and somatic symptoms.
- The leading role of psychogenic factors in the occurrence of decompensation and psychical disorders.
- Presence, in most cases, of "organic predisposition" (minimal neurological dysfunction of brain systems), promoting development of decompensation and painful manifestations.
- Relationship with psychical disorders with personality-typical characteristics of the patient.
- Presence of a critical attitude to psychical condition.

Reaction of loss

- *– normal personality reaction to the loss of a loved one. Submitted by grief, reflecting the adoption of loss.*
- *However, as people tend to avoid the adoption of loss and grief. This can be done in three ways:*
- *Avoiding reality, life with a sense of presence of the deceased (memories, dreams, mental conversations).*
- *Search for the guilty (revenge, self-incrimination).*
- *Suppression of grief ("the frozen grief").*

Post-traumatic stress disorder

- Presented by result of two processes:

- *1. Personality attemption to integrate into the world structure, to understand what happened, why, whether it was done correctly , what to do to avoid this in the future.*

- *2. The desire to avoid an unpleasant experiences, associated with trauma.*

- These two trends are reflected in the two main groups of symptoms:
- Symptoms of trauma-invasion (memories, thoughts, dreams, sudden actions or feeling as if the traumatic event is repeated again).

- symptoms of prevention of the events that recalls traumatic situation, up to the complete isolation from contacts with the outside world.

- In addition, there is a third group of non-specific symptoms, wich reflect the general level of stress of the psyche, in connection with these processes (insomnia, irritability, anxiety).

Development of PTSD can be of delayed in time

- Prevalence - 20-30% of war veterans, 37% of workers "ambulance" and rescuers, 57% of victims of violence
- Comorbidity with alcohol abuse (27%), drugs (8%), the collapse of a career, family breakdown
- Comorbidity with depression, transformation into the major depression

Risk Factors - female gender, severity and exposure of trauma

Treatment:

- Cognitive-behavioural and family therapy
- Desensitization of "avoidance behaviour"
- SSRIs
- Avoid the use of benzodiazepines

And PTSD, and the reaction of the loss can often be complicated by a secondary alcohol and drug abuse.

- In the absence of a successful resolutions of the situation, prolongation, accession of neurotic disorders and psychosomatic diseases, as well as the formation of personality changes is possible

Reactive psychosis

- *- A mental disorder that occurs due to the impact of psychosocial stress and having similarities with other psychoses, but its lability, affective variability and intensity are more pronounced.*

Reactive psychosis

- **Acute (shock) reactive psychoses** (psychogenic shock) occur under the influence of sudden trauma superstrong, posing a threat to the existence (for example, a sudden attack of criminals, earthquake, flood, fire), or associated with the unexpected news of the irretrievable loss of the most significant for the individual values (death loved one, loss of property, arrest, etc.). There are two forms:

- Hypokinetic and hyperkinetic

Subacute reactive psychosis are the most common, especially in forensic psychiatric practice. These are:

- ***Main syndromes:***
- *Hysterical twilight dizziness*— disorder that occurs on a background of affective narrowing of consciousness and manifested by anxiety, emotional instability (unmotivated laughter suddenly gives way to tears), and sometimes visual hallucinations, pseudodementia).
- *Hanzer's syndrome*
- *Pseudodementia (pseudodementia Wernicke)* - regression of mental activity wich mimicking dementia. Patients disoriented, giving ridiculous answer the most basic questions, performig basic tasks with gross errors But their answers always fit the theme of the posed question (for example, they call white - black, summer - in winter, etc.). There is a violation of speech and writing - agrammatisms, omission of letters and words.
- Facial expression - confused with meaningless smile.

- *Puerilism* is regression of mental activity characterised as childish behavior in an adult. Patients say with children's intonation, lisp, willingly play childish games, often capricious displeasure pouts, hurt cry. Disorder characterized by dissociating, children's behavioural traits are preserved with some habits of an adult, like smoking or correct manner of lighting matches.

- *The syndrome of delusional fantasies is* the delusional ideas of grandeur, wealth, inventions, developing in affective mood and anxiety background and reflecting the desire of the person to oust traumatic experiences.

- *The savagery syndrome is* an disintegration of complex mental functions on the background of the fear affect. Patients act like an animals. They are losing skills of self-service, crawling, barking, growling, sniffing the food and objects, eating food by hands

- *Hysterical stupor (psychogenic stupor, pseudo catatonic stupor, emotional stupor, dissociative stupor)* is the severe psychomotor retardation, accompanied by mutism, severe emotional tension. The eloquent facial expressions reflects the affect (suffering, despair, anger). When the psychotrauma is reminded patient's pulse becomes frequent, his eyes are filling with tears, eyelids and nostrils are shivering.

- ***REACTIVE PARANOID***

- Occurs on more or less aggravated ground, as a reaction to psychological stress.
- Presented by unstructured, emotionally saturated delirium.

- In case of social isolation (emigrant's delirium, hypoacusis) the induced delirium occurs .

- ***PARANOID REACTION***

- Pathological reaction on the psychotraumatic situation.

- Based on the supervaluable ideas

Hysterical reactive psychoses (primitive personality reactions).

- The necessary condition for occurrence of hysterical reactive psychosis is immaturity and permittivity of personality reactions. In fact, they are rather reactive personal psychotic reactions than reactive psychosis.
- Their clinic is polymorphic and represented by hysterical twilight state, a state of regression (pseudodementia, puerilism savagery syndrome).
- Hysterical psychosis represents an attempt of mind to deal with the situation by shifting responsibility to others (regression).

Reactive depression

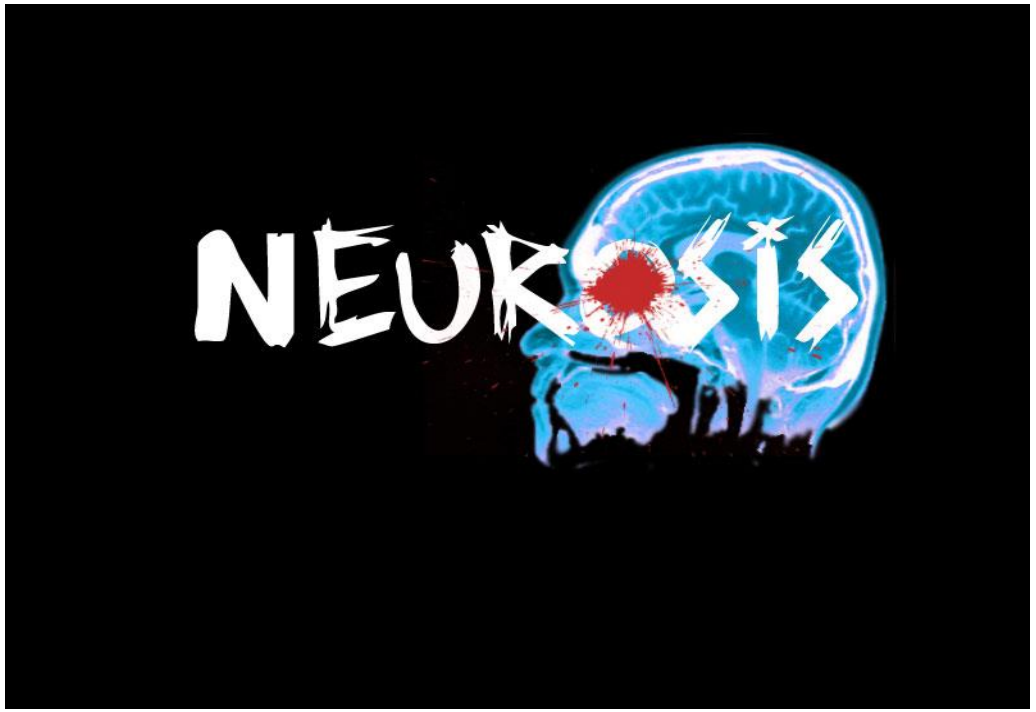
- Most often reactive depression is a prolonged reaction of grief in one of its pathological variants (fault, longing or "the frozen grief").
- In this case the person is unable to cope with the intensity of emotions. They are closely connected with the experienced psychological trauma.
- Ideas of self-abasement and self-incrimination reflect it.

Neurosis

- *Nonpsychotic disorders often associated with long, hard going conflict situations.*
- *Functional, usually accompanied by disturbances in the somatic-vegetative sphere*
- *Patients preserve criticism, understand the nature of the painful symptoms tend to get rid of them.*

Neuroses are divided into:

- **Neurotic reactions** (some symptoms occasionally occur in healthy people).
- **Neurosis per se.**
- **Neurotic development.**



Classification of neurosis

- Types of neurosis according to the clinical picture :
- ***Obsessive-phobic (obsessive-compulsive disorder)***
- Hysterical neurosis
- ***Neurasthenia***

Obsessive-phobic neurosis (obsessive-compulsive disorder)

- Characterized by complaints of anxiety, **obsessive-compulsive phenomena (obsessions)** and **fears (phobias)**. In the modern classification according to their dominance distinguished:

- Generalized anxiety disorder.
- Panic disorder.
- Phobic disorder.
- Agoraphobia.
- Social phobia.
- Simple phobias.
- Obsessive-compulsive disorder.

Obsessive-compulsive disorder

- OCD patient involuntarily appear intrusive, disturbing or frightening thoughts (**obsessions**). He constantly and unsuccessfully tries to get rid of the thoughts of anxiety caused by a equally obsessive and tedious actions (compulsions). Obsessive (predominantly obsessions) and compulsive (mostly compulsions) disorder separately are allocated.

- Obsessions and/or compulsions should b the days for at least two consecutive weeks.

- They are a source of distress and disturb

Diagnostic criteria

a) They should be regarded as own patient 's thoughts or impulses.

- b) Should be have at least one idea in which the patient unsuccessfully resists, even if there are present other thoughts and / or actions that the patient no longer resists.
- c) Idea of making an obsessive action should not be pleasant itself(simple reduction of tension or anxiety is not considered in this context as pleasant)
- d) Thoughts, images or impulses should be unpleasantly repeated.
  - *Note that making of compulsive actions are not in all cases necessarily relate to specific concerns or intrusive thoughts. It may be directed to the disposal of spontaneously occurring internal feelings of discomfort and / or anxiety.*

Hysterical neurosis

- Manifested by demonstrative emotional reactions (tears, laughter, crying), convulsive hyperkinesia, transient paralysis, loss of sensation, deafness, blindness, loss of consciousness, hallucinations, and others. The mechanism of hysterical neurosis based on "flight into illness", "conditional pleasentness or desirability" painful symptom.
- Hysterical neurosis is characterized by two main processes: **dissociation** and **conversion**.
- In **dissotiation** some defined function is suppressed in result of deplacement (sensitivity distubance, amnesia, paralysis, paresis, astasia-abasia).
- In **conversion** the dislodged processes are transformed into symptoms (cramps, pain, blepharospasm, laryngospasm, lump in the throat, writer's cramp, tics, spasms).

Hysterical neurosis

- ***Clinical picture :***
- **Hysterical fits** (polymorphic seizures after unpleasant experiences with stormy vegetative manifestations,theatricality and saved pupil reaction)
- **Sensitive disorders** (an-, hypo-, hyperesthesia and hysterical pain)
- **Disorders of the senses** (visual and hearing impairment, can be combined with mutism)
- Speech disorders (aphonia, mutism, stuttering, hysterical chant)
- **Movement disorders (paresis,** contracture, the inability to perform complex movement)
- **Disorders of internal organs function** (disorders in the gastrointestinal tract, cough, sexual coldness, hysterical angina)
- **Mental changes** (egocentrism, increased emotiveness, irritability, lability…)

The asthenic neurosis (neurasthenia)**The combination of irritability with tireness and exhaustion -** "asthenic weakness"

- **Manifestations:**
- irritability,
- headaches (like helmets),
- insomnia,
- attention disorders,
- intolerance to strong stimuli,
- decreased working capacity,
- complaints for intellectual inconsistency,
- lot of somatic-vegetative complaints (discomfort, pain in the heart area, disturbances of the gastrointestinal tract, respiratory disorder, pollakiuria ...)

Neurotic development

- *Chronic morbid state, lasting years, developing at unfavourable prolonged course of neurosis. Abnormal patterns of behaviour become habitual. Patients become integral to the neurosis, change their lifestyle, adjust all their behaviour to the requirements of the disease.*
- Constantly depressed mood background.
- The constant presence of functional somatic-vegetative disorders.
- The fixed role of the sick becomes the only form of role behaviour.
- Transformation of the "disease concept" to the "concept of a failed life"
- Blurring the triggering stressful factors at the conscious of the patient.
- The universality of response by gaining neurotic symptoms at any stress factor.

Somatoform disorders

- *Group of psychogenic illness in which mental disoders are hidden behind somato-vegetative life symptoms. It looks like some physical disease, but it does not show any organic manifestations, which could be attributed to a known medical illness, although there are often non-specific functional impairment.*
    - The prevalence of this type of disease varies between **0.1-0.5%** of the population, and averages about **280 cases by 1000.** Currently, patients with somatoform disorders, according to WHO, up to 25% of patients somatic practice. Somatoform disorders occur more frequently in women. Somatoform disorders are specific to adults, but can occur since primary school age.

Signs of SFD:

- Repeated occurrence of physical symptoms along with the constant demands of medical examinations, despite the negative results of investigations and doctors assurances on the absence of physical basis for the symptoms.
- The exist physical symptoms don`t explain the nature and severity of symptoms or distress and concerns of the patient.
- Even when the origin and preservation of symptoms closely associated with unpleasant life events, difficulties or conflicts, the patient resists attempts to discuss its psychological conditioning.
- This can occur even in the presence of distinct depressive and anxiety symptoms
- Some power of of hysterical behavior to attract attention, expesially to convince the doctors to continue invastigations.
- Some patients can convince doctors in some distinct pathology when the are convinced themselves (Munchausen Syndrome).

There are a lot of syndromes entering the somatoform disorders, especially:

- conversion syndromes;
- asthenic conditions;
- depressive syndromes;
- anorexia nervosa syndrome;
- dysmorphophobia(dismorphomania) syndrome;
- somatization disorder;
- undifferentiated somatoform disorder;
- hypochondriacal disorder;
- organ neuroses;
- chronic somatoform pain disorder.

Psychosomatic diseases

- *(from grech ψυχή — soul u грeч. σομα — body)*

- - group painful conditions that result from the interaction of psychological and physiological factors.
- Represent
- mental disorder, manifested at the physiological level;
- physiological disorders, manifested on the psychic level
- physiological pathology, developing under the influence of psychogenic factors.

Diagnostic creteria fo different forms of psychosomatic deseases

- Functional character.
- Reversibility.
- Duration of existence.
- localization.
- Character connection with features of personality.
- Features of the relationship with psychological factors.

The classification of psychosomatic disorders

- A. By clinical picture:

- **psychosomatic disorders in traditional scene** - somatic pathology, manifestation or exacerbation of which is related to the ability of the body in relation to the impact of psychotraumatic social stress factors (ischemic heart disease, essential hypertension, peptic ulcer and duodenal ulcers, psoriasis, some endocrine and allergic diseases);
- **somatized mental reactions.**
  - **Nosogenia** — psychogenic reactions arising in connection with physical illness (the latter acts as a traumatic event) and relating to a group of reactive states.
  - **Somatogenia** (exogenic reaction type or symptomatic psychoses).

- B. By localozation

- - cardiovascular variant;
- - respiratory;
- - gastro-intestinal and etc.

Eating disoders

- group of psychogenic determinated syndromes associated with disturbances in eating. Among others eating disoders include anorexia nervosa, bulimia nervosa Binge eating disorder.
- **Anorexia nervosa -** a disorder characterized by deliberate weight loss, induced and / or maintained by the patient. Also there is an atypical anorexia nervosa, when missing one or more key signs of anorexia nervosa, such as amenorrhea, or significant weight loss, but otherwise the clinical picture is fairly typical.
- **Bulimia nervosa -** a disorder characterized by recurrent episodes of overeating and excessive concern about controlling the body weight which leads the patient to take extreme measures for mitigating the "fatting" influence of eaten food. Also there is an atypical form of bulimia neurosa when one or more symptoms are missed.

- **Binge eating disorder (psychogenic overeating)** leads to the appearance of excess weight, and it's a reaction to the distress. It may be caused by loss of relatives, accidents, surgery, and emotional distress, especially in individuals predisposed to be overweight.

- **Psychogenic vomiting -** apart from causes vomiting in bulimia nervosa, repeated vomiting can occur with dissociative disorders, hypochondriacal disorder, where it can be one of the somatic symptoms, and in pregnancy, when the origin of nausea and vomiting are caused by emotional factors.

- **Other eating disorders**
- Eating nonedible products of mineral origin in adults.
- Eating inedible (pica) in adults.
- Psychogenic loss of appetite.
- Unclassified eating disorders.

Other classifications

- ***Ortorexia***-the obsessive desire to eat only healthy food.
- **Drunkorexia**—an eating disorder characterized by the transition of man to so-called "alcohol diet", when food intake is replaced by alcohol for the purpose of deliberate weight loss or control it.
- Selective eating disoder — a refusal of eating some specific products developing into use only a limited list of products and unwillingness to try new foods. Principles of food choices can be any, from their color, to species.
- ***Obsessive-compulsive overeating*** - overeating associated with obsessive-compulsive disorder being an part of compulsive rituals.
- **Allotriophagia** —eating nonedible substances. Patients often swallow extremely dangerous and sharp objects: glass, nails, and so on. In a milder form of the disorder occurs in pregnant women, as a consequence of endointoxication.

General recommendations for the treatment of psychogenic disorders

- Patients visits to the doctor should be short, but frequent; With the improvement of the condition intervals between visits should be increased .
- The patient should have only one physician.
- Unnecessary tests and consultations must be avoided.
- Empathy on the part of the doctor - with concentration on psychosocial issues, not on physical symptoms.
- Remember that patients symptoms are real and cause him trouble, but not to speak to him, "in the language of signs", not to say that "all in the head" of the patient and does not persuade; the best strategy of conversation - "I'll try to help you".
- Scheme of medical treatment should be simple, with priority monotherapy; minimize benzodiazepines, sedatives and hypnotics.

Mental disorders that occur with acute, prolonged and chronic somatic (or endocrine) diseases are called somatogenic mental disorders (somatopsychic disorders) and are classified into the following groups:

- non-psychotic mental disorders (asthenic, astheno-hypochondriac, astheno-depressive, astheno-dysthymic, anxiety-phobic, hysteroform);
- psychotic disorders (amensic, delirious, delirious-amensic, catatonic, paranoid, depressive);
- defective organic conditions (psychoorganic and dementia).

Pathogenesis.

In the pathogenesis of many somatogenic mental disorders, intoxication, which develops in diseases of the liver, kidneys, and digestive tract, plays a role. Hypoxia of the brain as a result of cerebral hemodynamic disorders, endocrine shifts observed in some internal diseases, exhaustion factor, impaired metabolism and immune properties of the body, morphological changes in the brain that develop in some chronic and endocrine diseases are also important.

Peculiarities of mental disorders in certain somatic diseases

- With acute heart failure, stupor or a delirious syndrome with unstable hallucinatory experiences occurs. Myocardial infarction and angina pectoris are accompanied by asthenic states with anxiety and fear.
- In the case of chronic cardiovascular insufficiency, on the background of asthenic and asthenoneurotic symptoms, sometimes there is a syndrome and dimming of consciousness and epileptiform excitement.
- Asthenic and neurosis-like syndromes, as well as psychotic disorders: delirious, amentic, anxiety-depressive, hallucinatory-paranoid, are noted in rheumatic heart defects.
- During an exacerbation of bronchial asthma, a depressive-paranoid syndrome with fear develops in a number of cases, which lasts for several weeks and usually ends with recovery.

Peculiarities of mental disorders in certain somatic diseases

- Diseases of the organs of the alimentary canal lead to the development of asthenic and asthenoneurotic conditions, exacerbation of the nature of psychological characteristics of the personality, hypochondriasis, and the appearance of overvalued thoughts about the severity of the disease.
- With hepatitis, acute psychosis in the form of a depressive syndrome sometimes develops, against the background of which delirium may occur.
- In the case of chronic renal failure, psychosis occurs in the form of depressive, hallucinatory-paranoid or catatonic syndrome, and sometimes – epileptiform syndrome, intellectual and cognitive decline.

Peculiarities of mental disorders in certain somatic diseases

- During pregnancy, women often experience fear of childbirth, emotional instability, shyness, and increased vulnerability.In primiparous women during childbirth, neurotic or psychotic reactions are observed due to fear of childbirth (their consciousness narrows, hysterical or fugiform reactions develop). Sometimes childbirth is a provoking factor of endogenous psychoses: schizophrenia, TIR.
- In the postpartum period, psychosis may occur a few days or weeks after childbirth. Acute psychotic states are usually in the form of an amentive syndrome and are caused by a postpartum infection. Catatonic and depressive-paranoid states in this period develop mainly against the background of stupor.