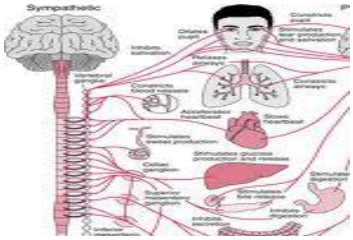
Module 1



Module 6

PSYCHIATRY

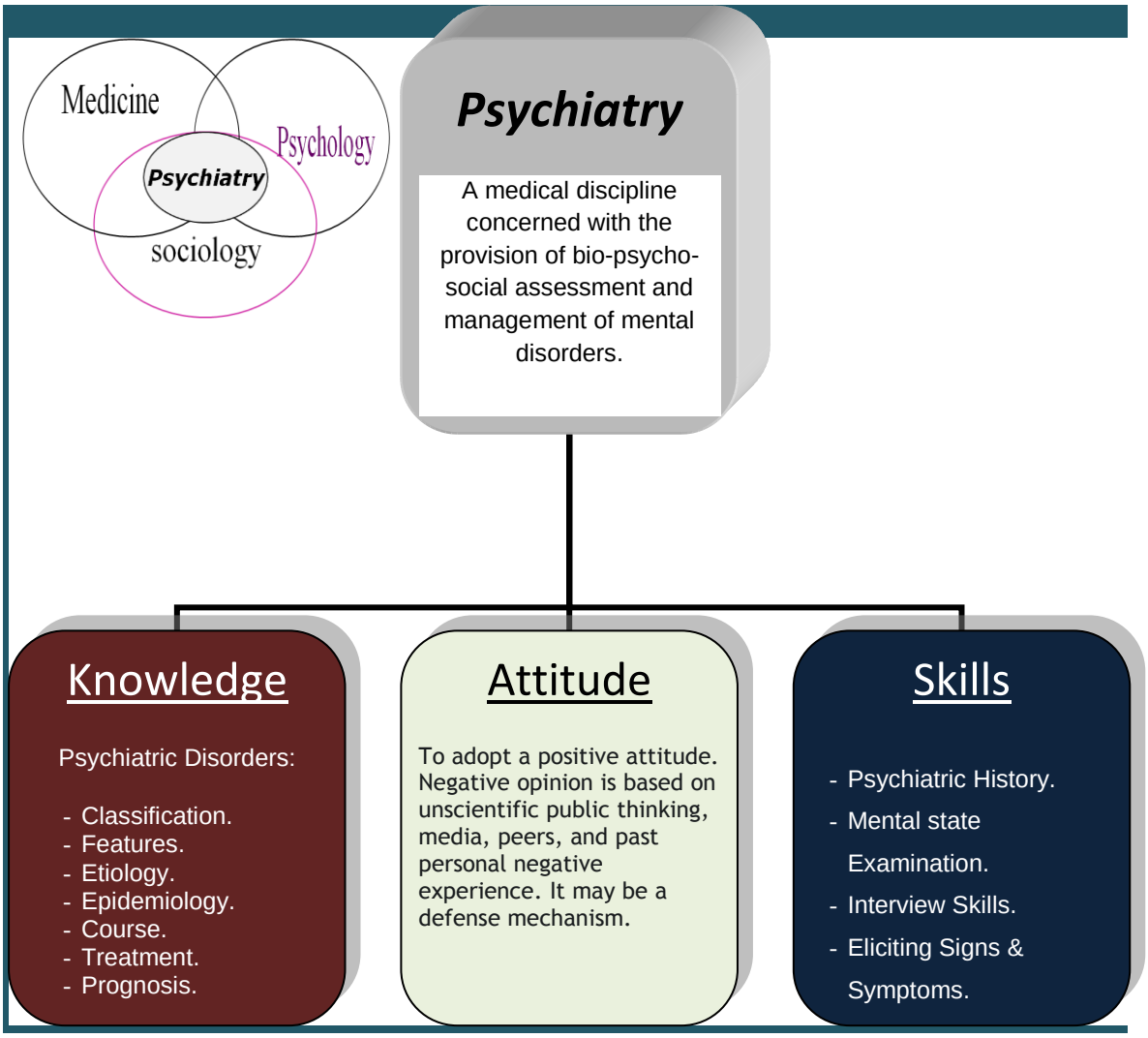
Course: 462 Psych

Module 2

Module 5

Module 4

Module 3



	Negative attitude	Positive attitude
Etiology	Vague/due to poor adherence to religion/always due to supernatural causes.	Many aspects have been scientifically explored & approved >>> good Rx.
Diagnosis	Subjective / unscientific.	Objective criteria & Scales.
Medications	Deleterious / addictive.	Benefit **>** risk in general.
Prognosis	Always bad.	There are many disorders with good prognosis.
Patients	Mad / bad / sad / aggressive / not easy to like / have low faith in Allah.	Human beings deserve respect.
Clinicians	Mentally unstable because of patients.	Like other clinicians but some may.. !?
Psychiatry	Unscientific & unappealing.	Scientific / Biopsychosocial approach.

Importance of Psychiatry Clerkship

One of the essential qualities of the clinician is interest in humanity.

Training in psychiatry will expand your understanding of the spectrum of human perception, thinking, emotion, and c behavior.

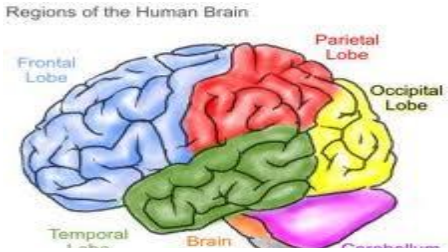
This will serve you well in self-awareness, interpersonal relationships, and patients' care.

Whatever medical specialty you choose in the future, training in psychiatry will upgrade your clinical skills in:

- Putting the patient at ease.
- Recognizing the patient's state of mind.
- Understanding the patient's suffering.
- Expressing empathy for the patient's suffering.
- Establishing good rapport with you patient.

Before Psychiatry Clerkship

- Neuroanatomy.
- Neurophysiology
- Neurotransmitters
- Clinical Psychology



It is advisable to review these basics.

See Basic Psychiatry chapter 1.

2-Etiology in Psychiatry

Basic Psychiatry chapter 5

The Complexity of etiology in Psychiatry

1. Time factor: causes are often remote in time from the effect they produce.

2. Single cause may lead to several psychological effects e.g. deprivation from parental affection may lead to depression or conduct disorder in children and adolescents.

3. Single effect may arise from several causes e.g. depression may be due to accumulation of several causes like endocrinopathies, psychosocial stresses and side effects of some drugs. Most psychiatric disorders are multifactorial.

Classification of Causes

Etiological Factors can be classified into biological, psychological, and social factors; *Bio-Psycho-Social Approach* [Engel 1977]:

Nature \ Effect		**Predisposing**	**Precipitating**	**Aggravating**	**Maintaining**
NATURE	***Bio***	E.g. Genetic predisposition e.g. panic disorder	E.g. First dose of cannabis abuse	E.g. Further abuse	E.g. Continuation of cannabis abuse
	Psycho	E.g. Abnormal personally traits with poor stress adaptation	E.g. Sudden or severe psychological stress	E.g. Further psychological stresses	E.g. Continuation of such stresses
	Social	E.g. Parental separation	E.g. Marriage	E.g. Marital conflict	E.g. continuation of marital problems

Main causative factors in psychiatry:

A. **Genetic :** e.g. in schizophrenia , mood disorders , panic disorder and agoraphobia.

B. **Neuropathological**: e.g. dementias ,delirium.

C. **Endocrinopathological**: e.g. hyperthyroidism / hypothyroidism.

D. **Pharmacological**: side effects of medications e.g. steroids > mood changes.

E. **Social**: e.g. marital discord /occupational problems/financial difficulties.

F. **Psychological** : behavioral ,cognitive , or psychodynamic problems (subconscious processes that involve distortion of reality in order to deal with, and resolve the intra-psychic conflict (defense mechanism).

Supernatural issues; although many cultures view black magic (sorcery), evil eye, and devil possession hidden causes of mental diseases it is impossible to subjects such supernatural matters to empirical research.

الأسباب الغيبيّة : المس والسحر والعين
Supernatural Causes

في الشرع

١ - تأثيرها على صحة البشر ثابت.

٢ -أما الكيفية والعلامات لكل منها فلم يرد فيها تفصيل بخلاف ما يفعله كثير من الرقاة.

٣ -الرقية الشرعية للاستشفاء لا لتشخيص الأمراض وأسبابها.

في المجتمع

١- النظرة الاجتماعية لا تمثل الشرع (لا تطابق تماما و لا تخالف تماما).

٢ - مبالغة وتعميم وقلة علم بالشرع وبالطب.

٣ - وسيلة شهرة وتكسب و ...

Etiology in Psychiatry - Prof. Alsughayir 2007

الأسباب الغيبيّة : المس والسحر والعين
Supernatural Causes

آثار سلبية للتخبط في هذا المجال:

١ - حرمان المرضى من العلاج الطبي السليم.

٢ - التدخل في التشخيص والجزم بناء على خبرات شخصية.

٣ - التدخل في طريقة التداوي دون مسئولية.

٤ - إيذاء المرضى بالضرب والكهرباء وغيرها.

٥ - تجاوزات أخلاقية / مالية / اجتماعية ...

تساؤلات مهمة

١ - هل الطب النفسي ينكر السحر / المس/ العين ؟

٢ - هل السحر والمس والعين تسبب أمراضاً نفسية أم لا ؟

٣ - هل نستطيع أن نضبط أعراضها ونعزلها عن الأمراض النفسية؟

٤ - هل يكتفى بالرقية الشرعية في علاج الحالات النفسية ؟

هل .... هل .... هل ...

Etiology in Psychiatry - Prof. Alsughayir 2007

المبالغة في العين والسحر والمس: يبالغ بعض الناس في عزو أسباب العلل النفسية إلى العين والسحر متجاهلين دور العوامل الأخرى التي قد تسبب الأمراض النفسية وهي كثيرة ومتنوعة. فالوراثة لها دور كبير في عدد من الأمراض النفسية كالفصام العقلي واضطرابات الوجدان ونوبات الهلع والوسواس القهري وغير ذلك مما أوضحته دراسات عالمية علمية متعددة وكذا الضغوط الاجتماعية والمادية والنفسية لها دور في ذلك (كشقاق الوالدين وانفصالهما وخلافات الأبناء مع الآباء والخلافات الزوجية ونحو ذلك). والأمراض الجسدية العضوية كذلك سواء أثرت على الدماغ مباشرة (كأورام والتهابات الدماغ) أو أثرت على بعض الأعضاء الحيوية (كالقلب أو الكبد أو الكلى أو الرئتين) وغير ذلك.

جعل الرقية وسيلة تشخيص : الرقية دعاء و تضرع إلى الله تعالى أن يكشف المرض ، ولم يجعلها الله تعالى وسيلة للتشخيص وطريقة لاختبار أسباب المرض كما يفعله بعض الرقاة اليوم ممن توسعوا في تنويع طريقة الرقية والآيات المستخدمة فيها بينهم في الحالة الواحدة بل إن الراقي نفسه قد يشخص اليوم تشخيصاً ينقضه في غده ثم ينقضه أخرى وذلك لأجل اعتماده على تأثر المريض بآيات دون غيرها في كل مرة وجعل ذلك وسيلة لتشخيص المرض فإن تأثر المريض عند قراءة آيات السحر شُخّص بأنه مسحور وإن تأثر عند قراءة ما يتعلق بالعين شُخّص بأنه مصاب بعين وهكذا مع المس وإن تأثر بذلك كله شُخّص بأنه مصاب بالثلاثة (سحر وعين ومس). وسيأتي مزيد بيان لذلك عند الحديث عن العين والسحر لاحقاً.

هل الرقية محصورة في أناس دون غيرهم ؟: يظن كثير من الناس أن الرقية لا تنفع إلا إذا كانت من راق مختص بها وأن المريض إذا كان ذا ذنوب ومعاصٍ فلا ينتفع برقيته على نفسه أو أن للرقية طريقة معقدة مفصلة لاتعرف إلا بدراسة خاصة أو خبرة معينة، ولذا فإن كثيراً منهم يذهب يطلب الرقية عند الرقاة وقد يسافر إليهم في بلاد بعيدة ويظن أن الرقية من هؤلاء لها شأن مختلف من حيث قوة التأثير وسرعته. ويهمل كثير من الناس الاستشفاء بالقرآن مباشرة والرقية الشرعية على أنفسهم دون وسيط. والصواب أن الرقية ليست محصورة في أناس دون غيرهم وكلما قوي تضرع المريض إلى ا÷ تعالى صار مظنة الاستجابة وقد قال ا÷ تعالى: {أَمَّن يُجِيبُ الْمُضْطَرَّ إِذَا دَعَاهُ وَيَكْشِفُ السُّوءَ} [النمل: ٦٢].

هل يُكتفى بالرقية في علاج الحالات النفسية وهل يجوز التداوي بالأدوية النفسية؟ الرقية الشرعية سبب عظيم من أسباب الشفاء للأمراض كلها (نفسية وجسدية) ولا تعارض الرقية الأسباب الأخرى المباحة والتي منها الأدوية النفسية، والعبد مأمور ببذل الأسباب المباحة (سواء كانت شرعية أو طبية) وقد أباحت الشريعة التداوي للعلل النفسية بالمباح من الأطعمة والأدوية ويشهد لهذا الحديث الصحيح " **التلبينة مجمّة لفؤاد المريض تذهب ببعض الحزن**" والتلبينة نوع من الطعام (حساء من دقيق وعسل).

المرض النفسي ليس وصمة عار وقد يُصيب المؤمن: المؤمن عرضة للابتلاء (لتكفير الذنوب ورفعة الدرجات) وقد يصيبه المرض النفسي كغيره من الناس متى ما وجدت أسباب المرض وليس في ذلك عار عليه ولا عيب وإن توهم كثير من الناس اليوم أن المرض النفسي إنما يعكس عيباً في شخصية المريض وسلوكه أو في تدينه وإيمانه وقد مر سابقاً (في حِكم المرض وفوائده) شيء من تفصيل ذلك، ولا شك أن للإيمان بالله تعالى دوراً كبيراً في قوة النفس ورفع درجة صبرها وتحملها وتخفيف معاناتها.

صحيفة سبق الإلكترونية (١٧ شوال ١٤٣٤):

ضبطت هيئة الأمر بالمعروف والنهي عن المُنكر بحي الوسام بمحافظة الطائف راقي نساء باكستاني يعمل كإمام مسجد، على الرغم من أنه بمهنة "سائق خاص" ويتولى رُقية النساء بداخل مُصلاهن بالمسجد، واستغلال ذلك في التحرش بهن ، مُدعياً أنه يرقي ويعرف السحر والمسحور.

وكانت امرأة شعرت بآلام فهاتفته وأخبرته بما لديها من مُشكلة صحية، فأبلغها بأنها مسحورة، وأن السحر موضوع لها في رحمها، وأنه يجب أن يتولى تمريخها من أجل استخراج ذلك السحر من ذلك المكان الحساس، كما طلب منها أن تتصل به في الليل من دون علم زوجها واتصلت عليه المرأة في الليل فأبلغها بأنه لا بد أن تحضر لديه في مُصلى النساء بالمسجد ليقوم بتلك المُهمة وأبلغته بأنها ستُخبر زوجها لكي تأتي برفقته، لكنه منعها قائلاً: "استعينوا بقضاء حوائجكم بالكتمان" فأبلغت الهيئة فتم ضبطه .

3-Diagnosis & Classification in Psychiatry

Basic Psychiatry chapter 4

Making a diagnosis in psychiatry can be difficult because of the following:
A. Most diagnoses are made at the level of symptoms and signs, which are non-specific.
B. Lack of biological markers.
Psychiatric diagnosis has long been criticized as vague.
However, classification attempts to avoid these pitfalls using well-defined criteria.

Significance:
1. To distinguish one diagnosis from another.
2. To enable clinicians to communicate with one another about their patients' symptoms, treatment and prognosis.
3. To ensure that psychiatric research can be conducted

In everyday psychiatric practice the distinction between organic (neurocognitive) and functional mental disorders is still commonly used .

Organic Mental Disorders: Neurocognitive structural brain pathology that can be detected by clinical assessment or usual tests. E.g. delirium, dementia, substance-induced mental disorders, and medication-induced mental disorders.

Features Suggestive of Organic Mental Disorders *(CNS pathology);*
Disturbed consciousness +/- other cognitive disturbance in: attention, concentration, orientation or memory. Physical illness (e.g. diabetes, hypertension). Vital signs disturbances (e.g. fever, high BP). Neurological features (e.g. ataxia, dysarthria).

Non-organic (functional) Mental Disorders:
No obvious structural brain pathology**.** E.g. Schizophrenia, mood disorders, anxiety disorders, adjustment disorders.

Broad Categories of Psychiatric Disorders: **Psychoses Vs. Neuroses.**

Although this classification is no longer used in the official current systems of classification, in everyday clinical practice these terms are still used widely; hence it is of practical value to know this distinction.

Psychoses (pleural of psychosis -الذهان)	**Neuroses** (pleural of neurosis -العُصاب)
	
Mental disorders in which the patient lacks insight and is unable to distinguish between subjective experience and external reality, as evidenced by disturbances in thinking (delusions), perception (hallucinations), or behavior (e.g. violence). Examples: schizophrenia, severe mood disorders, delusional disorders. It can be due to an organic cause (organic psychosis) e.g. delirium, dementia, substance abuse, head injury. Features are abnormal in quality (e.g. delusions, hallucinations).	Generally less severe forms of psychiatry disorders in which the patient is able to distinguish between subjective experience and external reality. No lack of insight, delusions or hallucinations. Examples: dysthymic disorder, anxiety, panic & phobic disorders. Features are abnormal in quantity (e.g. excessive fear and avoidance).

DSM-5 Classification (May 2013) is an evidence-based manual that is useful to clinicians in helping them accurately and consistently diagnose mental disorders. In preparation for the release of DSM-5, experts from psychiatry, psychology, social work, neuroscience, pediatrics and other fields have committed years to reviewing scientific research and clinical data, analyzing the findings of extensive field trials and reviewing thousand of comments from the public. DSM-5 represents the contributions of more than 700 distinguished mental health and medical experts during an extensive and rigorous 14-year development process. ***(Source: http://www.dsm5.org/)***

- Neurocognitive Disorders
  - Delirium
  - Mild Neurocognitive Disorders
  - Major Neurocognitive Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
  - Schizophrenia
  - Brief Psychotic Disorder
  - Schizophreniform Disorder
  - Schizoaffective Disorder
  - Delusional Disorder
  - Substance/Medication-Induced Psychotic Disorder
  - Psychotic Disorder Due to Another Medical Condition
  - **Catatonia**
- Bipolar and Related Disorders
  - Bipolar I & II Disorders
  - Cyclothymic Disorder
  - Substance/Medication-Induced Bipolar and Related Disorder
  - Bipolar and Related Disorder Due to Another Medical Condition
- Depressive Disorders
  - Disruptive Mood Dysregulation Disorder
  - Major Depressive Disorder, Single and Recurrent Episodes
  - Persistent Depressive Disorder (Dysthymic Disorder)
  - Premenstrual Dysphoric Disorder
  - Substance/Medication-Induced Depressive Disorder
  - Depressive Disorder Due to Another Medical Condition
  - Other Specified Depressive Disorder
  - Unspecified Depressive Disorder
- Anxiety Disorders
  - Panic Disorder
  - Agoraphobia
  - Social Phobia
  - Specific Phobia
  - Generalized Anxiety Disorder
  - Separation Anxiety Disorder
  - Selective Mutism
  - Substance/Medication-Induced Anxiety Disorder
  - Anxiety Disorder Due to Another Medical Condition
- Obsessive-Compulsive and Related Disorders
  - Obsessive-Compulsive Disorder
  - Body Dysmorphic Disorder
  - Hoarding Disorder
  - Trichotillomania (Hair-Pulling Disorder)
  - Excoriation (Skin-Picking) Disorder
  - Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
  - Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
- Trauma- and Stressor-Related Disorders
  - Adjustment Disorders
  - Acute Stress Disorder
  - Posttraumatic Stress Disorder
  - Reactive Attachment Disorder
  - Disinhibited Social Engagement Disorder
  - Other Specified Trauma- and Stressor-Related Disorder
- Somatic Symptom and Related Disorders
  - Somatic Symptom Disorder
  - Illness Anxiety Disorder
  - Conversion Disorder (Functional Neurological Symptom Disorder)
  - Psychological Factors Affecting Other Medical Conditions
  - Factitious Disorder
  - Other Specified Somatic Symptom and Related Disorder
- Dissociative Disorders
  - Dissociative Identity Disorder
  - Dissociative Amnesia
  - Depersonalization/Derealization Disorder
  - Other Specified Dissociative Disorder
- Personality Disorders
- Neurodevelopmental Disorders
  - Intellectual Disabilities
  - Communication Disorders
  - Autism Spectrum Disorder
  - Attention-Deficit/Hyperactivity Disorder
  - Specific Learning Disorder
  - Motor Disorders
  - Other Neurodevelopmental Disorders
- Feeding and Eating Disorders
  - Pica
  - Rumination Disorder
  - Avoidant/Restrictive Food Intake Disorder
  - Anorexia Nervosa
  - Bulimia Nervosa
  - Binge-Eating Disorder
  - Other Specified Feeding or Eating Disorder
- Elimination Disorders
  - Enuresis
  - Encopresis
  - Other Specified Elimination Disorder
- Sleep-Wake Disorders
  - Insomnia Disorder
  - Hypersomnolence Disorder
  - Narcolepsy
  - Breathing-Related Sleep Disorders
  - Obstructive Sleep Apnea
  - Central Sleep Apnea

4-Psychiatic Assessment

Basic Psychiatry chapter 3

A 20-year-old male seen at the Emergency Department appeared fully awake but unable to talk, unresponsive to stimuli, and immobile. **How would you assess him?**

A thorough assessment of a psychiatric patient consists of a psychiatric history, mental status examination, physical examination, and certain relevant laboratory and psychological tests. The psychiatric history and mental status examination are usually obtained during the initial psychiatric interview.

Psychiatric Interview

Goals :

1. To establish a relationship with the patient.
2. To obtain information.
3. To assess psychopathology (nature, severity …) of the illness.
4. To provide feedback and formulate a treatment plan.

The clinical interview is very important in psychiatry; it requires practical skills, which cannot be learnt effectively without enough practical training under supervision of experienced interviewers.

Interview Skills

A--Opening phase (5 min):
1- Greet the patient by name and introduce yourself.
2-Put the patient at ease; arrange for a private comfortable setting, and appropriately tell the purpose of the interview.
3- Build good rapport and alliance.

B—Interview Proper (35 min):

1- Be attentive, encouraging, supportive, and observe the patient's nonverbal behavior.

2- Use open-ended questions and facilitative verbal and non-verbal techniques.

3-Avoid excessive note taking, premature reassurance, advice, and diagnosis.

4- Make graceful transitions throughout the interview.

5- Pay attention to the severity and complications of the problem.

6-Utelize time efficiently. **7- Use interview techniques**:

C--Closing phase(5min) :
1- Know when to close the interview.
2- Give the patient a chance to ask questions and let him know future plans.

Interview Techniques:

1- Facilitation: providing verbal and nonverbal cues that encourage the patient to keep talking. E.g. saying, Yes, go on, or Uh-huh, leaning forward in the chair, nodding one's head.

2- Clarification: getting details from the patient about what he has already said.

3- Direction/redirection: gracefully using focused questions to maintain the proper track of the interview.

4- Obstruction: providing verbal and nonverbal cues that block a very talkative patient..

5- Reflection: a doctor repeats to a patient, in a supportive manner, something that the patient has said, to let the patient know that the doctor is perceiving what is being said & to assure the doctor that he has correctly understood what the patient said.

6- Summation: periodic summarization of what a patient has said thus far to make sure that the doctor has heard the same information conveyed by the patient.

7- Silence: not every moment must be filled with talk. Silence , allow patients to ventilate emotions (e.g. weeping) and to contemplate.

THE PSYCHIATRIC HISTORY

The psychiatric history is the chronological story of the patient's life from birth to present (history=his-story). It includes information about who the patient is, his problem and its possible causes and available support. It should be emphasized that:

1. Much more attention needs to be paid to psychological and social aspects.
2. Patient's feelings, thoughts, perception and behavior during the interview are considered part of the mental status examination (*not the psychiatric history*).

The history should be compiled from the patient and other informants (the informant's relationship to the patient should be noted together with the interviewer's impression of the informant's reliability).

✧ The Main Items of the Psychiatric History

1	Identification data
2	Source of referral
3	Chief complaint
4	History of present illness
5	Family history
6	Personal history
7	Medical history
8	Past psychiatric history
9	Personality traits

- **Identification of the Patient:** Name, age, sex, marital status, occupation, education, nationality, residency and religion.

- **Referral Source:** Brief statement of how patient came to the clinic and the expectations of the consultation.

- **Chief Complaint:** Exactly why patient came to the psychiatrist, preferably in the patient's own words (a verbatim statement). Note if the chief complaint differs significantly from the reports of those who accompany patient (other informants).

- **History of Present Illness:** Chronological background of the psychiatric problem: nature, onset, course, severity, duration, effects on patient (social life, job, family…), review of the relevant problems, symptoms not mentioned by patient (e.g. sleep, appetite …), and treatment taken so far (nature and effect).

- **Family History:** Family history is important in psychiatry for several reasons:

  1. Events happening currently to a family member may act as a stressor to patient.
  2. Family atmosphere has an effect on the patient's psychological condition.
  3. Some psychiatric disorders run in families and have an important genetic contribution.

∗ Mother and father: current age (if died mention age and cause of death, and patient's age at that time), relationship with each other and with patient.

∗ Siblings: list, in order of age, brothers and sisters, education, occupation, marital status, major illnesses and relationship with patient. Ask about mental illnesses in second-degree relatives (grandparents, uncles, aunts, nephews, & nieces).

- **Personal History:** (relatives may be a source of information). Personal history helps in constructing a brief biography of the patient & forms a background against which you understand the presenting complaints and predict future behavior.

  - *Birth*: any known obstetric or prenatal difficulties?.

  -*Early development*: developmental milestones (motor and language), early childhood attitudes and relationships with parents, siblings and others, any emotional or behavioral difficulties.

  - *School*: age at starting and end of school life, approximate academic ability, specific difficulties, attitudes and relationships with teachers and pupils and highest grade attained.

  - *Occupations*: age at starting work, jobs held, reasons for change, satisfaction in work, relationships with workmates and with supervisors.

  - *Puberty:* age at onset, knowledge, attitude and practice of sex.

  - Adolescence: attitude to growing up, to peers, to family and authority figures, and emotional or behavioral problems.

  - *Marital history*: age at marriage, relationships within the marriage, number of children and attitude toward them.

  - *Current social situation*: social environment and social relationships, financial circumstances and social difficulties.

  - Tobacco and substance abuse, and legal (forensic) problems.

- **Medical History:**
  All major illnesses should be listed (nature, extent, dates, treatment, outcome, and patient's reaction and attitude). Women should be asked about menstrual (and, if appropriate, about menopausal) difficulties.

- **Past Psychiatric History:**
  Any previous psychiatric illness (nature, extent, dates, treatment, outcome and patient's reaction and attitude).

- **Personality Traits:**

  It is important to obtain adequate information (from a variety of sources) about patient's characteristic traits that distinguish him as an individual. Patient's personality usually interacts with his illness and should be separated from episodes of illness. Elicit information about the following:

  - Attitude to self (self-appraisal, performance, satisfaction, past achievements and failures, future..)
  - Major values, moral / religious attitudes, and standards.
  - Prevailing mood and emotions.
  - Reaction to stress (ability to tolerate frustration and disappointments, pattern of coping strategies).
  - Interpersonal relationships (width & depth).
  - Personal interests, habits, hobbies and leisure activities.

MENTAL STATE EXAMINATION (MSE)

It is a cross-sectional, systematic documentation of the quality of mental functioning at the time of interview. It serves as a baseline for future comparison and follow-up of the progress of the patient.

Items of Mental State Examination

1. **Appearance;** Note and describe overall appearance, body build, self-care, grooming, facial expressions, and any unusual features (e.g. weight loss)

2- Behavior; Note level of activity, posture, and unusual movements (tics, grimacing, tremor, disinhibited behavior…)

3- Attitude; Note patient's attitude during the interview (interested, bored, cooperative, uncooperative, sarcastic, aggressive …).Patient's attitude is reflected on his non-verbal behavior (eye contact, posture…).

4- Speech; Listen to and describe how patient speaks, noting: (1) amount of speech (2) flow (3) tone (4) coherence (5) continuity (6) speech impairments (stuttering, dysarthria…).

5 - Affect (See below).

6- Perception (See below).

7-Awareness of self and others; When indicated ask about the extreme feelings of "as if detached from self" (depersonalization) & "as if detached from the environment" (derealization).

8-Thoughts & Abstract thinking (See below).

9- Judgment; Test patient's predicted response and behavior in imaginary situations (e.g. what would you do if you smelled smoke in a crowded place?/ if you heard a loud scream coming from your neighbor' house?).

10- Insight (مدى بصيرة المريض بمرضه النفسي): see below

11-Cognitive functions and consciousness

-Consciousness level.

-Attention.

-Concentration.

-Orientation (time, place, person).

-Memory.

(See below).

12- Visuospatial ability; Ask patient either; 1- to copy a figure such as *interlocking pentagons*

0r 2- to draw a clock (*clock Drawing Test):* to indicate a specific time (e.g.10:10).

13-Language and reading

(See below; Mini-mental state Examination).

Affect (the patient's present emotional state):

- *Subjective affect*: verbal expression of feelings by the patient (some authors call it mood; however , **mood** actually is defined as a pervasive and sustained emotion -over several days-weeks - that colors the person's perception of the world).
- *Objective affect:* examiner's evaluation of patient's observable expression of affect, through nonverbal signs; facial expression, posture & movements.
  Note any abnormality in the nature of affect (e.g. anxiety, depression, elation…), the variability of affect (constricted affect, labile affect..), and whether the affect is appropriate to the thought content, the culture, and the setting of the examination.

Perception: Ask patient about perceptual disturbances (auditory, visual, olfactory, gustatory, tactile and somatic), and ascertain whether the disturbances are **illusions** (misperceptions of real external stimuli), **hallucinations** (perceptions without external stimuli) or **pseudo-hallucinations** (sensory deceptions perceived as emanating from within the mind). Determine the exact nature and complexity of perceptual distortions. Hallucinations of voices discussing patient (third person hallucinations) should be distinguished from voices talking to patient (second person hallucinations). Ask patient about the content of the hallucinations (e.g. what do the voices tell you) his reaction to hallucinations.

Clinical Skills

How to assess auditory hallucinations (الهلاوس السمعية):

1-While fully awake, do you hear voices of someone when actually nobody is speaking around you? How many voices you are hearing?
2- How do the voices refer you (e.g., as "you" or "him/her")?
3- Are they accusing/ordering you /commenting on what you are doing? Or discussing you between themselves?
4- What do the voices say? & what is your reaction to them?.

youtube.com/watch?v=0tn8xLQY53U

Thought: Thoughts are usually reflected in the person's speech. Note stream, link, & content of thoughts see p 19 & 20.

Clinical Skills

How to assess delusions (الضلالات الفكرية):

1-Do you believe that some events or others' behavior refer to you in particular?
2-Do you believe that someone is persecuting you/following you for harm?
3-Do you believe that you have special power, ability, or identity?
4-Do you believe that your actions, emotions, or thoughts are being forced on you by someone else? If yes, tell me more about that?
5- Do you feel that someone is putting thoughts into your head or taking them away?
6- Do you feel that that your thoughts can be transmitted to others in some way?
7- To what extent you are sure of such a belief
8- On what basis you have adopted this belief?

youtube.com/watch?v=Iigs060bxSs

Abstract Thinking: It is the ability to deal with concepts beyond literal meaning and to make appropriate inferences from sentences. It can be tested by:

1. ***Proverbs****:* ask patient to interpret one or two proverbs e.g., "Mr. X has two faces" this means Mr. X has hypocritical double-dealing (abstract thinking). Some patients (psychotics or mentally retarded) may give a concrete answer (e.g., Mr. X has two real combined faces).

2. ***Similarities & difference****:* Tell me the similarity between "car and train". Tell me the difference between "book and notebook".

Insight: Ask patient about the degree of awareness of his illness.

1. Do you believe that you have abnormal experiences?
2. Do you believe that your abnormal experiences are symptoms of illness?
3. Do you believe that the illness is psychiatric?
4. Do you believe that psychiatric treatment might benefit you?

Patient's compliance with psychiatric treatment depends on his insight.

Consciousness and Cognitive Functions:

- **Consciousness:** note patient's general state of awareness (alert, drowsy…)
- **Attention:** (*The ability to focus on the matter in the hand)*. Attention is assessed by asking patient to spell a word backward (e.g. World), to mention 5 words with the same letter, or by the digit span test (see memory below).
- **Concentration:** (*The ability to sustain attention*). Concentration is tested by naming the months of the year in reverse order or by subtracting serial 7s from 100 (serial 7s test): patient is asked to subtract 7 from 100 then to take 7 from the remainder repeatedly until it is less than seven. Psychiatrist assesses whether patient can concentrate on this task. Serial 3s test can be used if patient lacks skill in arithmetic.

- **Orientation to Time, Place and Person**.
  - **Time**: note whether patient identifies the day correctly (e.g. Monday), time of the day (e.g. afternoon) and the approximate date (day, month, and year).
  - **Place**: note whether patient knows where he or she is (city- area-building).
  - **Person**: note whether patient knows other people in the same place (e.g. relatives, hospital staff).

  Disorientation is an important feature of **delirium,** which indicates impaired consciousness. It usually appears in this order: time - place -person, and clears in the reverse order: person - place - time.

- **Memory** (registration >> retention >> recall):

1. ***Immediate memory*** (registration and immediate recall/ frontal lobe function): it is tested by the digit span test; ability to repeat 7 digits (e.g. 3,8,1,4,7,2,9) after an examiner dictates them slowly, first forward, then backward. A normal person can repeat 7 digits correctly, impaired registration should be considered if less than 5 digits could be repeated. This test is also used to assess attention because it requires enough focus. Defect indicates **frontal lobe impairment.**

2. ***Short term recall***: mention **3** names to the patient to remember (e.g. a banana, a clock and a car), and then after 5 minutes ask for recall, during which time you distract patient by doing something else. Defect indicates temporal lobe impairment **(Amnestic Syndrome).**

3. ***Recent memory*****:** ask questions regarding the last few days in patient's life events that you can verify (e.g., what the patient did yesterday morning), defect occurs in **early dementia but may occur in normal elderly and because of medications side effects (e.g., SSRIs, antipsychotics). Recent past memory**: ability to recall events in the past few months, defected in **dementia.**

4. ***Remote memory*** (long-term memory): ask patient to recall personal events (e.g. birth date, wedding date) or well-known public events from some years before, provided that these events (personal or public) are known with certainty to you. Note also the sequence of events. Defect indicates global cortical impairment; **advanced dementia.**

Mini-Mental State Examination (MMSE);

It is a brief instrument designed to assess higher mental functions. It is widely used as a screening test that can be applied during a patient's clinical examination, and as a test to track the changes in a patient's cognitive state. It assesses orientation, memory, calculations, writing and reading capacity, language, and visuospatial ability.

Function / test	Score
1. Orientation	
What is the day, time of the day & date (day, month, and year)?	5 points
Where are we (building/hospital, area, city, country)?	5 points
2. Registration; Name three objects (e.g. a tree, a pen, and a car) repeat them (after the interviewer).	3 points
3. Attention and calculation	
Spell "world" backward (attention).	5 points
Tell the months of the year backward (concentration), or serial 7s test.	
4. Retention & Recall; Name the three objects mentioned above 5 minutes later.	3 points
5. Language (aphasias)	
Ask patient to name two objects (e.g. a pen and a watch)- for *nominal aphasia*-.	2 points
Ask patient to repeat after you certain words Say, "No ifs, ands, or buts." -for *expressive aphasia*-.	1 point
Ask patient to carry out a three-step verbal commands e.g., take a pencil in your right hand, put in your left hand, and then put it on the floor-for *receptive aphasia* (auditory functions)-.	3 points
6. Reading comprehension; ask patient to read a sentence with written command	
Close your eyes.	1 point
Write a sentence.	1 point
Copy a design.	1 point
TOTAL	**30 points**

A score of less than 24 points suggests impairment, and a score of less than 20 indicates a definite organic mental impairment (most common are delirium & dementia).It is advised to be done by more than one interviewer and repeated over a period of time.

5-Symptoms & Signs in Psychiatry (Psychopathology)

Basic Psychiatry chapter 2

A 75-year-old patient misperceives pictures on the wall as frightening figures.

Psychiatric symptoms and signs are common in patients of all kinds; therefore, medical students require sound knowledge of these symptoms and signs. In psychiatric clinical practice, diagnosis is not made on a single symptom or sign, but on the pattern of several clinical features.

For simplification, symptoms and signs in psychiatry can be grouped into the following categories:

Abnormalities of behavior and movements

1. **Psychomotor Retardation:** slowed motor activities and mental functions (e.g. delayed answers), seen in *depressed patients.*
2. **Stupor:** a state in which a person, although is fully awake with open eyes, does not react to the surroundings: mute, immobile and unresponsive. It can be due to organic or functional psychiatric disorders. **Catatonic Stupor:** stupor with rigid muscles and posturing seen mainly in schizophrenia ;catatonic type.
3. **Agitation:** restlessness with inner tension. Patient is **not** fully aware of restlessness. It can be due to many psychiatric disorders: mania, depression, schizophrenia, substance abuse ,delirium …e t c.
4. **Akathisia:** inability to keep sitting still, due to a compelling subjective feeling of restlessness. Patient is fully aware of restlessness. It is due to antidopaminergic drugs. When akathisia is mistaken for agitation, patient may be given unnecessary doses of antidopaminergic drugs that exacerbates akathisia in a vicious circle.
5. **Acute Dystonia:** very painful severe muscle spasms (neck, back, eyes, and, tongue).

It is due to a *recent* use of anti-dopaminergics, which induces a hypercholinergic state in the basal ganglia. See S/E of antipsychotics.

youtube.com/watch?v=2krwEbm5hB

6. **Tardive Dyskinesia:** restless movements of group of muscles, mainly in the orofacial muscles.

Hand muscles may be involved. It is due to *a prolonged* use of anti-dopaminergics.

youtube.com/watch?v=FUr8ltXh1Pc > No. 6 / 9 / 10

7. **Waxy Flexibility (catalepsy):** patient's limbs may be moved like wax, holding position for long period of time before returning to previous position, seen mainly in *schizophrenia ;catatonic type.*
8. **Cataplexy:** temporary sudden loss of muscle tone, causing immobilization; can be precipitated by a variety of emotional states and is often followed by sleep. Seen in patients with *narcolepsy* (attacks of sudden sleep).
9. **Stereotypies:** purposeless repetitive involuntary movements. E.g. foot tapping, thigh rocking, seen in normal people but when severe they indicate a psychotic disorder .
10. **Mannerism:** odd goal-directed movements. E.g. repeated hand movement resembling a military salute. They indicate a psychotic disorder .

Abnormalities of mood and emotion:

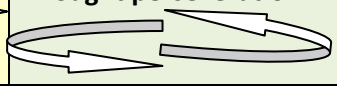
1. **Anxiety:** feeling of apprehension accompanied by autonomic symptoms (such as muscles tension, perspiration and tachycardia), caused by anticipation of danger.

   Free-floating anxiety: diffuse, unfocused anxiety, not attached to a specific danger.
2. **Fear:** anxiety caused by realistic consciously recognized danger.
3. **Panic:** acute, self-limiting, episodic intense attack of anxiety associated with overwhelming dread and autonomic symptoms.
4. **Phobia:** irrational exaggerated fear and avoidance of a specific object, situation or activity.
5. **Dysphoria:** mixture feelings of sadness and apprehension.
6. **Depressed mood:** feeling of sadness, pessimism and a sense of loneliness.
7. **Anhedonia:** lack of pleasure in acts that are normally pleasurable.
8. **Euphoria:** intense elation with feeling of grandeur seen in *patients with mania or substance abuse*.
9. **Egomania**: morbid self-centeredness and self-inflation. Seen in narcissistic personality and grandiose delusions.
10. **Constricted Affect:** significant reduction in the normal emotional responses.
11. **Flat Affect:** absence of emotional expression.
12. **Apathy:** lack of emotion, interest or concern, associated with detachment.
13. **Inappropriate Affect:** disharmony between emotions and the idea, thought, or speech, accompanying it seen in *chronic schizophrenia*.

Abnrmalities of speech:

1. **Poverty of Speech:** restricted amount of speech seen in depression and schizophrenia.
2. **Pressure of Speech:** rapid, uninterrupted speech that is increased in amount seen in *patients with mania or stimulant abuse.*
3. **Stuttering (Stammering):** frequent repetition or prolongation of a sound or syllable, leading to markedly impaired speech fluency.
4. **Clang Associations (Rhyming):** association of word similar in sound but not in meaning (e.g. deep, keep, sleep) seen in *patients with mania or substance abuse.* (السجع)
5. **Punning:** playing upon words, by using a word of more than one meaning (e.g. ant, aunt). seen in *patients with mania or substance abuse*. (التورية)
6. **Neologism:** new word or phrase whose derivation cannot be understood; often seen in *schizophrenia.*
7. **Word Salad:** incoherent mixture of words, seen in *chronic schizophrenia*.
8. **Circumstantiality:** over inclusion of unnecessary details delaying reaching the desired goal, seen *in obsessional personality.*
9. **Echolalia:** imitation of words or phrases made by others, seen in *some schizophrenic patients, mentally retarded and some organic mental disorders.*

Abnormalities of thoughts & thinking

	Abnormality in Thought	Type	Definition & DDx
A	Stream	**Poverty of thoughts**	Slow, few, unvaried thoughts associated with poverty of speech, seen in *chronic schizophrenia and depression.*
		Pressure of thoughts	Rapid abundant varying thoughts associated with pressure of speech and flight of ideas, seen in *mania and stimulant abuse*.
		Thought block youtube.com/watch?v=0u9d96b-Tyc	Sudden cessation of thought flow with complete emptying of the mind, not caused by an external influence, seen in *schizophrenia.*
B	Link	**Loose association** youtube.com/watch?v=xwAXobX2z1Y	Lack of logic connection between thoughts, seen in *chronic schizophrenia.*
		Flight of ideas youtube.com/watch?v=zA-fqvC02oM	Successive rapidly shifting incomplete ideas but with an understandable link (usually associated with pressure of speech and thought) seen in *mania and stimulant intoxication.*
		Thought perseveration 	Repeating the same sequence of thoughts persistently and inappropriately, seen in *organic brain pathology (e.g. dementia).*
C	Content 	**Overvalued ideas**	Strongly held false but shakable ideas (e.g., vitiligo is a contagious illness / patient's conviction that he has a hidden serious physical disease).
		Obsessions  youtube.com/watch?v=fSRIa0Gqe	Undesirable repetitive ideas insistently entering person's mind against his will despite resistance, seen in *obsessive-compulsive disorder (OCD).* *Obsessional forms*: Thoughts. Images. Urges. Feelings. *Obsessional Contents*: *Dirt/Contamination. Religious acts/beliefs. Doubts/Checking. As if committing offences.* Obsessions (also called ruminations) are frequently, but not always, followed by compelling actions (called compulsions or rituals).
		Delusions  youtube.com/watch?v=xIrA6iCke2M	False beliefs characterized by being: **1**.fixed unshakable, **2**. not arrived at through logic thinking, **3**.not amenable to reasoning & **4**. out of keeping with the person's cultural background. Seen in many ***psychotic disorders*;** brief psychosis, schizophreniform disorder, delusional disorders, schizophrenia, mood disorders, psychosis induced by medications or substance abuse, delirium, and dementia.

Concrete Thinking: thinking characterized by actual visual image of things, rather than by abstractions; seen in schizophrenic persons and in young children. Compare with **abstract thinking**: thinking characterized by the ability to grasp the symbolic meaning beyond words. E.g. "Mr. X has two faces" this means Mr. X has hypocritical double-dealing (abstract thinking). Some patients (psychotics or mentally retarded) may give a concrete answer (e.g., Mr. X has two real combined faces).

Common Types of Delusions (Delusional Contents):

1. **Persecutory delusion**: Delusion of being persecuted (cheated, mistreated, harassed, followed for harm etc.). Persecutory delusion is sometimes called **paranoid delusion** , however, paranoid delusion means not only being persecuted but being persecuted because of having special importance.
2. **Grandiose delusion:** Delusion of exaggerated self-importance, power or identity.
3. **Delusion of jealousy:** (infidelity delusion).Delusion that a loved person (wife/husband) is unfaithful.
4. **Erotomanic delusion:** Delusion that someone, (usually inaccessible, high social class person) is deeply in love with the patient.
5. **Nihilistic delusion:** Delusion of nonexistence of body organ, belongings, self, others or the world. Seen in some patients suffering from major depression with psychotic features. youtube.com/watch?v=zX9OTDzyNd
6. **Delusion of self - accusation:** Delusion that a patient has done something sinful, with excessive pathological feeling of remorse and guilt seen in severe depression.
7. **Delusion of reference:** Delusion that some events and others' behavior refer to oneself in particular. It can be seen in any type of psychosis. Note that : in some manic patients they feel happy with the content of the delusion, perceiving it as a sign of self importance.
8. **Delusion of influence** (delusion of control= passivity phenomena):Delusion that person's actions, feelings, or thoughts are controlled by outside forces, *seen in schizophrenia.*

Thought alienation (thought control) is a kind of delusion of control concerning patient's thoughts. It can take different forms:

Thought Insertion	Thought Withdrawal / Broadcasting	Thought (mind) Reading
Thoughts being **put into** his mind against his will by an external force (other people, a certain agency). 	Thoughts being **taken out** of his mind against his will (withdrawal) +/- being **broadcast** over the air, radio, TV, newspapers or some other unusual way. 	Somebody (or others) can know exactly (read) his hidden thoughts from a distance. 

* **Delusions can be either :**

Mood-Congruent Delusion	Mood-Incongruent Delusions
Delusional content has association to mood: . in depressed mood: delusion of self - accusation. . in elevated mood: grandiose delusion.	Delusional content has no association to mood, e.g. patient with elevated mood has delusion of thought insertion.

* **Delusions can be either:**

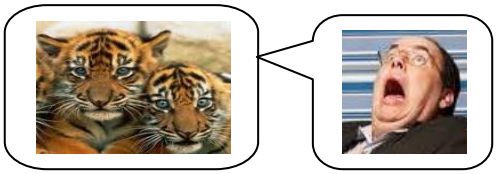
Systematized; united by a single event or theme e.g. delusion of jealousy.	**Bizarre** ; totally odd and strange delusional belief, e.g. delusion that stars control patient's acts.

Howeve, in DSM-5 bizarre & non-bizarre distinction has been eliminated.

Abnormalities of perception:

- **Illusions:**

  Misperceptions of real external sensory stimuli: E.g., shadows/wallpapers may be misperceived as frightening figures. Illusions are non-specific signs, seen in many psychiatric cases: delirium, substance abuse and others. They may occur in normal people (dim light/exhaustion).



- **Pseudo-Hallucinations:**

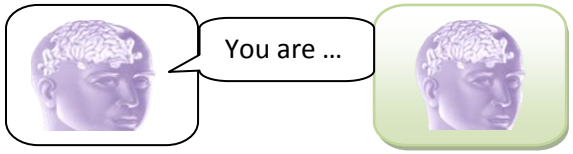
  Normal sensory deceptions perceived as emanating from within the mind (person has insight). E.g. After listening to an audio tape for long time, the same material can be re-experienced even with no actual source.

- **Hallucinations**:(auditory,visual,tactile,olfactory,gustatory,somatic)

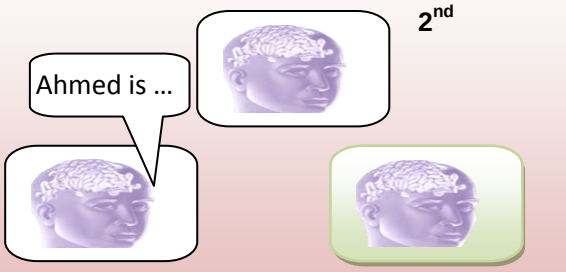
  Abnormal perception in the absence of real external stimuli; experienced as true perception coming from the external world (not within the mind) e.g. hearing a voice of someone when actually nobody is speaking within the hearing distance. Patient has no insight. They indicate major mental illness (psychosis).

- **Auditory hallucinations** (voice, sound, noise).

Second-person hallucinations: voices of a person speaking to the patient addressing him/her directly. E.g., "you are bad". These are seen in many disorders: schizophrenia (usually derogatory voices calling bad names /giving orders), severe depression with psychotic features (usually self-depreciating associated with guilt feeling), mania (usually self-appreciating associated with acceptance).



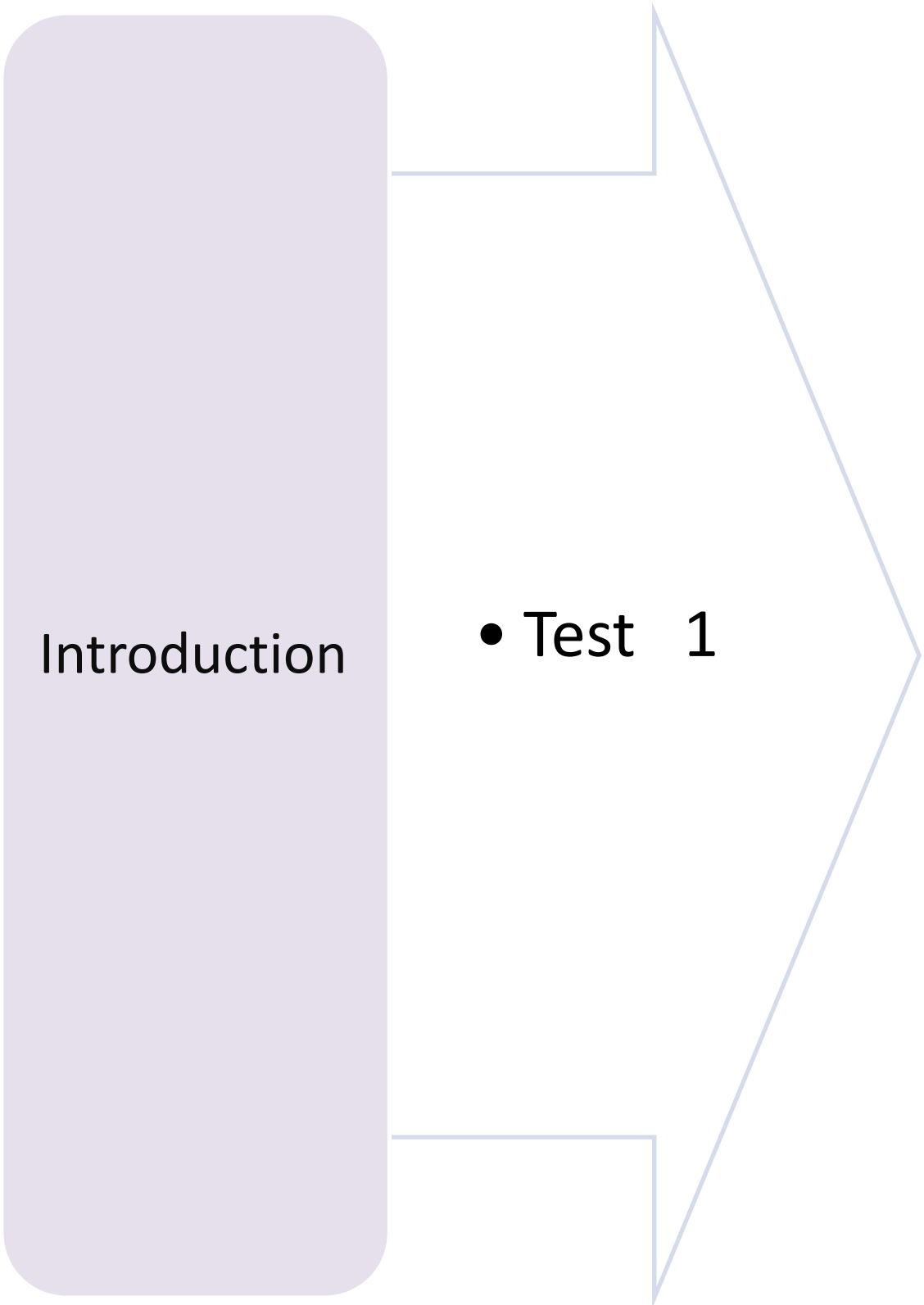
Third-person hallucinations: voices of a person talking to another person about the patient. E.g. "look! he is bad" , *(seen in schizophrenia).*



youtube.com/watch?v=0tn8xLQY53U

Thought echo: hearing one's own thoughts spoken aloud *(seen in schizophrenia).*

Visual hallucinations (images/sights): indicate an organic mental disorder (e.g. delirium, intoxication with drugs, uremia) or schizophrenia.


Introduction
• Test 1

1. A 25-year-old woman said, *"The news anchor on the TV talks about me in particular*". The most likely psychopathology in this case is:
   a. Nihilistic delusion.
   b. Delusion of reference.
   c. Paranoid delusion.
   d. Delusion of influence.

2. A 22-year-old man said: "actors on the TV are able to make me do what they want". The most likely psychopathology in this case is:
   a. Persecutory delusion.
   b. Delusion of reference.
   c. Hallucinations.
   d. Delusion of control.

3. A psychiatrist asked a patient about the patient's reaction to usual life stresses. The psychiatrist was assessing the patient's :
   a. Thinking process.
   b. Personality traits.
   c. Judgment.
   d. Personal history.

4. A 19-year-old male seen at the Emergency Department appeared fully awake but was unable to talk, unresponsive to stimuli, and immobile. He has
   a. Akathisia.
   b. Stupor.
   c. Dyskinesia.
   d. Dystonia.

5. A 42-year-old mother of 8 children has bronchial asthma and hyperthyroidism. Her parents separated since her childhood. She has several weeks' history of irritability, tremor, and insomnia. She is worried about the cause of her problem. Her aunt told her that:" your illness is due to an evil eye". The most immediate step in the management is :

   a. Convince her that *evil eye* is not the cause of her problem.
   b. Inform her that parental separation is the precipitating factor.
   c. Take detailed psychosocial history and ask about current medications.
   d. Explain how bronchial asthma has precipitated her illness.

1	2	3	4	5
b	d	b	b	c

6. A 29-year-old psychiatric patient has sudden cessation of thought flow with complete emptying of the mind not caused by an external influence. This indicates:
   a. A psychotic disorder.
   b. An organic etiology.
   c. Poverty of thoughts.
   d. Obsessive thoughts.

7. While interviewing a 66 -year-old woman she could not identify the date correctly, although she was fully conscious. She has impaired:

   a. Memory.
   b. Registration.
   c. Attention.
   d. Orientation.

8. The psychiatrist asked a patient to express his current feelings during the interview. The psychiatrist was assessing:
   a. Concrete thinking.
   b. Self-awareness.
   c. Subjective affect.
   d. Objective mood.

9. While assessing a 19-year-old man, you ask him to tell you the difference between “a book and a notebook”. You test patient's:
   a. Cognitive functions.
   b. Visuospatial ability.
   c. General Knowledge.
   d. Abstract thinking.

10. While assessing a 21-year-old man, the psychiatrist asked his patient "do you think that you are mentally ill?" He was assessing patient's:
    a. Intelligence.
    b. Insight.
    c. Perception.
    d. Judgment.

6	7	8	9	10
a	d	c	d	b

11. A 41-year-old man seen at Emergency Department with his wife because he strongly believes that there are certain cameras implanted throughout the city to watch him. He has:

    a. Paranoid delusion.
    b. Hallucinations.
    c. Thought insertion.
    d. Obsessive ideas.

12. While evaluating a patient the psychiatrist requested the patient to repeat 7 digits after the psychiatrist dictates them slowly. The psychiatrist was assessing patient's:

    a. Perception.
    b. Short term recall.
    c. Attention.
    d. Concentration.

13. A 23-year-old psychiatric patient is unable to keep sitting still and is fully aware of his restlessness. This condition is called:

    a. Agitation.
    b. Mannerism.
    c. Akathisia.
    d. Stereotypes.

14. While evaluating a 24-year-old woman, she indicated that she feels as if she heard voices of her relatives inside her head without their presence. This psychopathology is called:

    a. Pseudo-hallucinations.
    b. Derealization.
    c. Illusions.
    d. Hallucinations.

15. While assessing a 67-year-old man you ask him to tell you what the time is. You suspect:

    a. A psychotic disorder.
    b. Impaired concentration.
    c. Impaired judgment.
    d. An organic disorder.

11	12	13	14	15
a	c	c	a	d