HANDWRITTEN NOTES

DAMS

α

PSYCHIATRY

CRISP, CONCISE, CONCEPTUAL

Integrated Edition

Student first @DAMS

DAMS Publications

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HOW TO MAKE BEST USE OF NOTES?

A Message by Mentor Duo Specially for you,

- *Read the notes thoroughly, they are absolutely concise, crisp & conceptual and hence it is best advised not to add a lot of extra information to them as that will dilute the quality.*
- *Images have been provided alongside to aid in better understanding and also help you solve image-based questions, these images have been specially picked by the faculty so have a high probability of being asked in exams.*
- *Notes are handwritten in a way to help make them easier to retain, a lot of tables, graphs and algorithms have been used to simplify the learning.*
- *While reading notes try and use the CFAQ technique —*
  - *A. Use the C to denote concept part in the notes and ensure you are clear with this part in the first go if not then it's advisable to listen to this part of the video from your course.*
  - *B. Use the F To denotes facts in your notes, it is okay if you can't remember them in first go but will need repeat reading. But these facts are important for exams as they could be integrated to clinical questions.*
  - *C. Use A to denote applied parts, this is how concepts and facts are asked indirectly in exams. This will also help you develop MCQ solving skill.*
  - *D. Use Q to denote areas where faculty has said it's a direct question or a PYQ or a potential question.*
- *This technique will help you summarize your notes In way that your second reading will become easy and faster.*
- *Active space has been provided with these notes to make your own annotations alongside and this will help you maintain one single notebook for one subject.*
- *Try and solve MCQs with every topic from DQB. Your goal should be to start with at least 30 MCQs every day and then increase to at least 50 MCQs every day. Also, when you do a topic wrong write it alongside the notes that this topic needs to be read again but mark only the specific area that you have done wrong not the whole topic.*
- *After the topic is covered then in the active space try and summarize the topic in the form of mind map. This will help in active recall and make your revision easier.*

Best Wishes & Happy Learning!!!!!

INDEX

PSYCHIATRY

Chapter 1: GENERAL PSYCHIATRY

(Video 1.1 Introduction & History taking)

HISTORY OF PSYCHIATRY (as a subject):

Term "Psychiatry" was coined by: JOHANN REIL.

Mental Health experts are: PSYCHIATRISTS, PSYCHOLOGIST, PSW

Consultation liaison Psychiatry – PSYCHIATRIC symptoms in (Psychiatrist on call) Medically / Surgically Ill patients.

3 Parts of a psychiatric disorder's diagnostic criteria:

- Characteristic symptoms — DSM – Diagnostic & Statistical manual
- Significant Duration — ICD – International classification of Diseases
- Socio-occupational Dysfunction

How to make a Psychiatric diagnosis:-

HISTORY + Examination + Investigations

M. Important

(MSE – Mental States Examination)

A complete psychiatric work up of the patient needs to have following:

I. Psychiatric History:
   - **A.** Identification Data

     "A comment should be made regarding the reliability of the information provided.

Q1: Basis of Reliability of information of patient provided by informants depend on all except: (AIIMS 2017)

a. Biological relationship
b. ✓ Educational status
c. Observational skills
d. Duration of stay with patient

The reliability of the information provided by the informants should be assessed on the following parameters: (Ref : Niraj Ahuja Textbook)

1. Relationship with patient,
2. Intellectual and observational ability,
3. Familiarity with the patient and length of stay with the patient
4. Degree of concern regarding the patient."

ONSET → Acute / Gradual

B. Chief complaints
C. History of present illness (HOPI) → Duration, Progression
D. Past psychiatric and medical history
E. Family history (Heritable) → Episodic v/s Continuous
F. Personal history:

Q2. (AIIMS) Psychiatric personal history includes all except: -

a. ~~food~~ preferences — Ans
b. Academic history
c. Occupational history (work stress)
d. Marital history (Good Prognosis)

Personal history can be recorded under the following headings:

- Perinatal History
- Childhood History.
- Educational History
- Play History
- Puberty
- Menstrual and Obstetric History
- Occupational History
- Sexual and Marital History

70-79
Borderline.

Case: "decline in scholastic performance"

MC

Mental Retardation < 70 ← IQ TEST → Normal (90-110)

IQ TEST → Dull Normal (80-89)

"INTELLECTUAL Disability"

"OLIGOPHRENIA"

MILD MR ⇒ 50-69

Moderate MR ⇒ 35-49

Severe MR ⇒ 20-34

Profound MR ⇒ < 20

$IQ = \frac{\text{Mental age}}{\text{Chronological age}} \times 100$

Chronological age ⇓ maximum = 15

① ADHD
Attention deficit Hyperactivity disorder
↓ attention ⇓
↓ Concentration ⇓
↓ Memory ⇓
↓ Performance

② SLD
SPECIFIC Learning Disability
- READING Dyslexia
- WRITING Dysgraphia
- Calculations Dyscalculia.

Q3: All are causes of poor scholastic performance in children, except (DNB)

A. ADHD
B. Anxiety
C. Cerebral Palsy
D. PICA ✓

Eating NON-nutritive substances.

Video 1.2 (Thought disorders)

Mental status examination: (MSE) = MIND examination

I. Appearance and Behavior

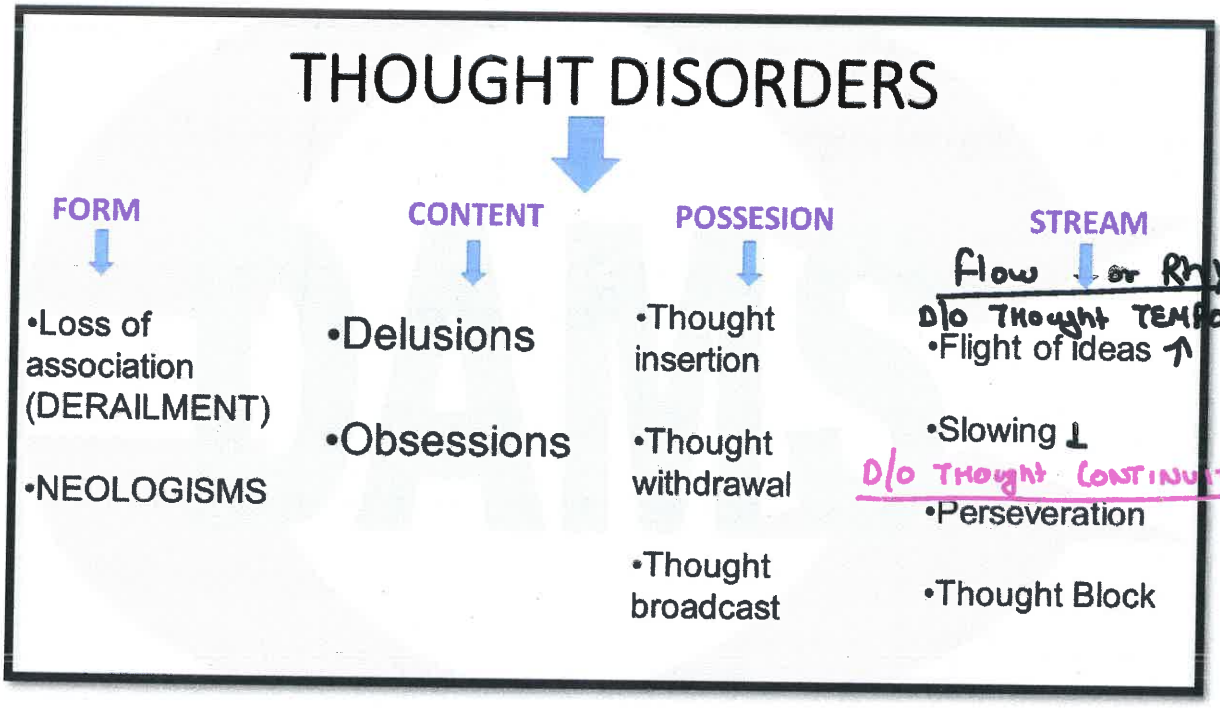
II. **Speech:** Rapid, slow, pressured, hesitant, emotional, monotonous, loud, whispered, slurred, mumbled, stuttering, intensity, pitch, ease, spontaneity, productivity, manner, reaction time, vocabulary, prosody(flow)

III. **Emotion:** It is a complex feeling state related to mood and affect, with psychological, somatic and behavior components. Mood and affect

IV. Thought disturbances

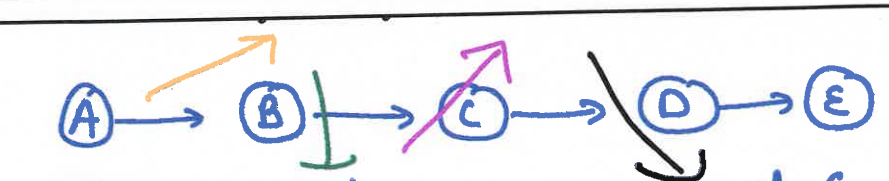
V. Perceptual disturbances

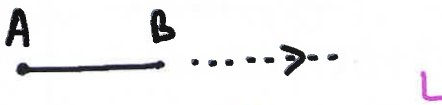
VI. Cognitive functions



form = formation (genesis of thought process)

Normal Thought





Loss of Logical sequence of Events

C → D FORM of thought disorder

1. **LOA (Derailment)** = Knight's move thinking (PGI)

NOT CONNECTED

THoughts → SPEECH

Disorganized thoughts = Disorganized speech (NOT- understandable)

∴ SCHIZOPHRENIA

2. **Neologisms** → SCHIZOPHRENIA

Coining new words that have a meaning to Patient, but NOT to the EXAMINER

eg:- "ABDU- DABDU"

3. **Delusion**

False, firm and fixed belief (unshakeable), that persists even after EVIDENCE against it is PROVIDED.

THEMES OF DELUSION:-

Examples

A. Delusion of persecution (Paranoid) ↗ Suspicious

People are planning against me, to cause a harm to myself, my family or my Property. [Deⁿ of Influence ⇒ (I am under CONTROL)

CONSPIRACY

SCHIZOPHRENIA
||
PRIMARY Delusions
|
Part of the Disease (Mood Incongruent)

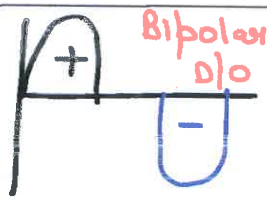
B. Delusion of reference

Person feels that things, acts, places, events or talks are related to me

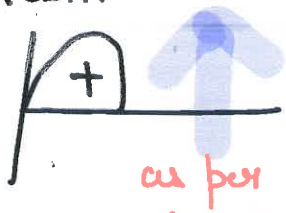
C. Delusion of Grandiosity (Supremacy)

WEALTH — POWER — POSITION.

MANIA



Bipolar D/o
||
SECONDARY Delusions
||
MOOD Congruent Delusions.

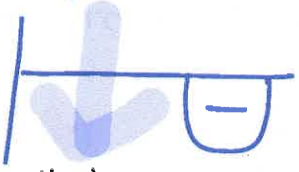


as per Mood ⇐

D. Delusion of Guilt/Sin — Inferior

Blaming himself

Depression



E. Delusion of Nihilism (negation)

DENIES the EXISTENCE → himself / Part of him / WORLD.

Deⁿ of ENORMITY I PRODUCE Catastrophe.

SEVERE Depression
Klas COTARD'S syndrome

Workbook contains class notes to be made by students, while attending psychiatry DAMS class by Dr Sachin.

Q:- Person refuses to URINATE ⇒ It may flood the world.

TYPES OF DELUSION:

BIZARRE — Implausible (can't happen)

Non-Bizarre — POSSIBLE.

4. Obsessions

Thought	Compulsions (MOTOR ACT)
DIRT contamination (MC)	WASHING
Pathological Doubt	CHECKING (MC)

Properties of obsession

D: DISTRESSING (EGO-DYSTONIC)

O: OWN Thought but unwanted (EGO-ALIEN)

I: Intrusive/Irresistible: Persists despite resistance & causes

Try to stop ⇓ ANXIETY

UNTREATED ⇓ Depression

R: Recurrent — eg:- Sexual, Religious (GUILT Producing)

S: Senseless

A: Ambivalency and Ambitendancy → Indecisiveness blw 2 actions

(2 thoughts, 2 actions)

INDECISIVENESS Blw 2 thoughts

M: Magical Thinking = (superstitions) ∞

My thinking makes things happen around me

eg:- Bad thoughts → (LEAD to) Bad outcomes

RITUALS → (Magical) → Compulsions

Disorders of possession of thought (THOUGHT ALIENATION)

5. Thought Insertion

Incoming → MIND

OUTSIDE thoughts COME IN.

6. Thought Withdrawal

MIND → Outgoing (few)

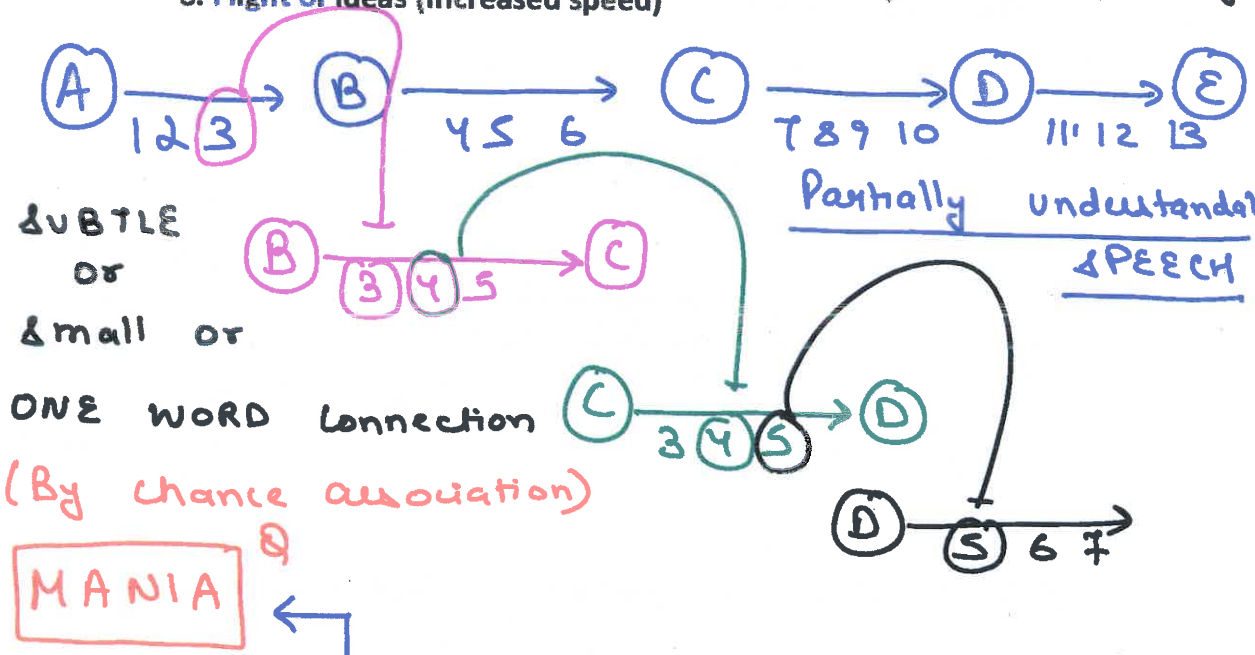
My thoughts OTHERS get to know w/o speaking

7. Thought Broadcast

MIND ⇓ Outgoing (many)

My thoughts many others get to know w/o speaking.

8. Flight of ideas (Increased speed)



SUBTLE or small or ONE WORD connection (By chance association)

MANIA

9. Clang associations: When words are linked to each other by RHYMING. Mania

10. Slowing of thinking Depression

11. Thought blocking: sudden break in train of thoughts

⇓

Ex:- Anxiety, SCHIZOPHRENIA.

12. PERSEVERATION : Persistence of same response beyond the point of relevance

Q:- Q1 WHAT's your name ? ANKUSH.

Organic Mental Disorders (Cause)

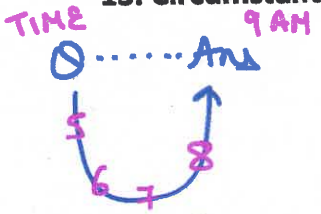
Q2 WHERE are you from? Ankush

Q3 Father's name ? Ankush

Q4 Qualification ? Ankush

Q5 Bfast today ? Ankush

13. Circumstantiality



Overinclusion of unnecessary details, but ultimately reaching the answer.

14. Tangentiality

Going off Track & never reaching the answer.

#extraedge

15. Verbigeration/Verbal Stereotypy

Meaningless repetition of words/phrases In between Normal speech

Normal VS Normal VS Normal

16. Vorbereiden/Past Pointing/Approximate Answers/GANSER's syndrome

PRISONER's (Hysterical PSEUDO Dementia)

"FIGHT" — Pretends "Head Injury"

Q WHAT's colour of Grass RED

II. DISORDERS OF PERCEPTION
(Video 1.3)

PAREIDOLIA

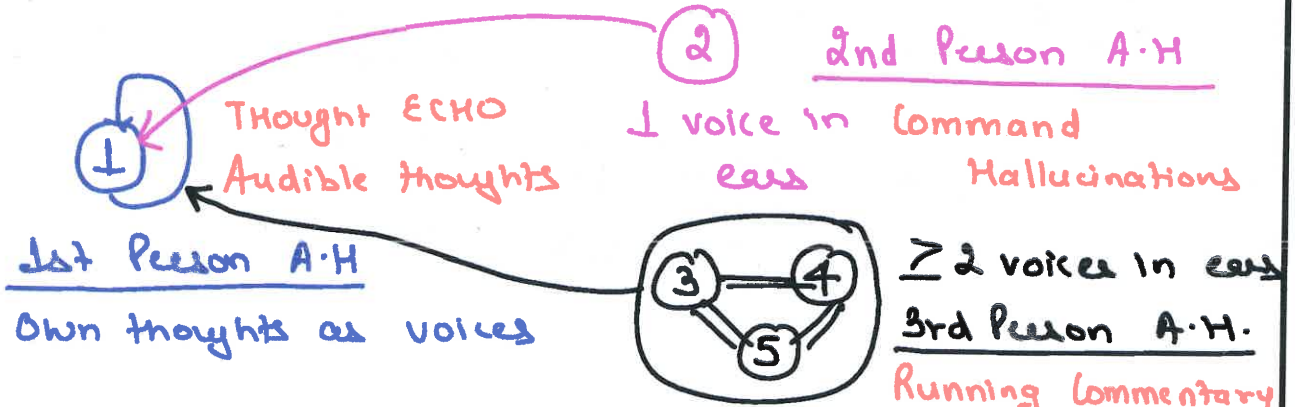
Hallucinations	Illusion
PERCEPTION Without STIMULI	Perceptual Misinterpretation
	eg:- MIRAGE

Types of hallucinations:

1. Auditory – MC type of Hallucination
2. Visual – MC in Organic disorders (Cause +)
3. Olfactory : Temporal Lobe epilepsy
4. Gustatory : temporal Lobe epilepsy
5. Tactile : **Cocaine Bugs /Magnan Symptom/ Formication**

#INICET.

Types of auditory hallucinations:



True hallucination	Pseudo-Hallucination
Outer objective space (in ears) ← VOICES →	Inner subjective space (in mind)
Sensory organs involved	Not involved
Clear (as clear as normal perception) Substantial	NOT clear, NOT substantial
NOT in Voluntary CONTROL.	somewhat in CONTROL.

Special types of hallucination (MISNOMERS) Stimulus +

Reflex hallucination (SYNAESTHESIA)	Functional hallucination
Stimulus in 1 modality ⇒ causes Perception in other modality.	STIMULUS & Perception are both in same modalities e.g. On hearing sound of running water from a tap, I also hear voices scolding ME.
e.g. I see sounds / I hear colours	

LSD- Lysergic acid Diethylamide.

III. Disturbances of emotions

MOOD	AFFECT
feel WE	express
Inner subjective feeling	outer objective expressions

- **Euthymic mood:** normal range of mood.
- **Dysphoric mood:** an unpleasant mood.
- **Irritable mood:** easily angered and annoyed.

MANIA

1. **Euphoric mood:** subjective sense of well-being and joy.
   - **Expansive mood:** feelings expressed without restraint.
2. **Elated mood:** feelings of joy and confidence associated with increased motor activity. (Euphoria) +
3. **Exaltation:** elation with feelings of grandeur.
4. **Ecstasy:** feelings of intense rapture.

- **Alexithymia:** inability to express emotions — can't describe in words
- **Apathy:** dulled emotional state associated with indifference.

Affect:

1. **Congruent to mood** (matching) → Mania / Depression

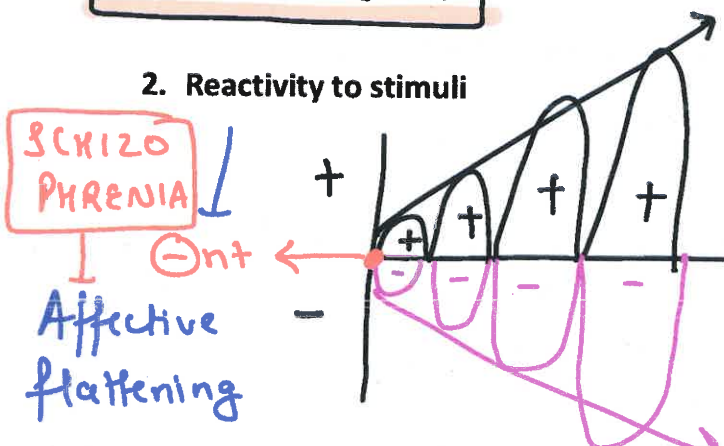
   OR

   Incongruent to mood (not matching) : Parathymia → Schizophrenia

Appropriate affect: emotions in harmony with the associate idea or speech.
Inappropriate affect: it is the incongruency between the affect and the emotional state or the associated idea reported.

eg: Dancing / Laughing @ FUNERAL → SCHIZOPHRENIA

2. **Reactivity to stimuli**

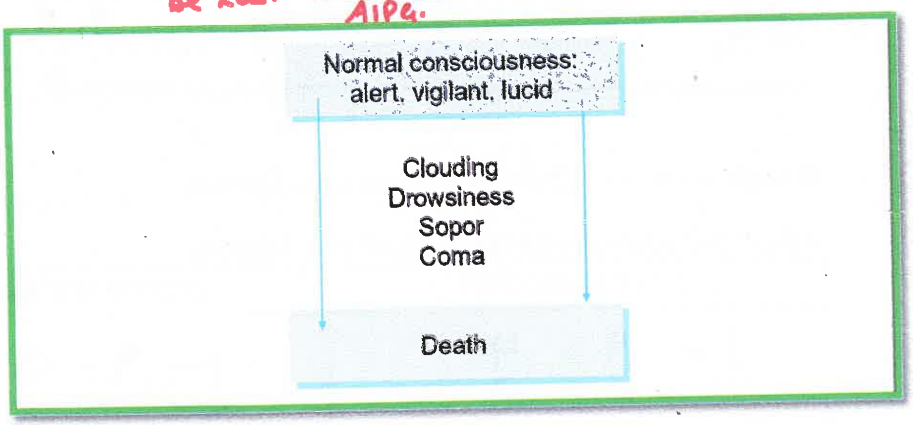


↑↑ Reactivity = labile affect ⇓ fluctuating expressions → Bipolar

Cognitive functions (HIGHER MENTAL FUNCTIONS): (Video 1.4)

1. Consciousness and Orientation

Last to be LOST TIME, Place, Person
AIIMS.



Examples of Impaired consciousness (INICET)
"STRUB BLACK"

The term **STUPOR** should be reserved for the syndrome in which mutism and akinesis occur; that is, the inability to initiate speech or action in a patient who appears awake and even alert.

A twilight state is a well-defined interruption of the continuity of consciousness. It is characterized by (a) abrupt onset and end; (b) variable duration, from a few hours to several weeks; and (c) the occurrence of unexpected violent acts or emotional outbursts during otherwise normal, quiet behaviour.

EDH Head Injury

Dream-Like (Oneiroid) State: The patient is disorientated, confused and experiences elaborate hallucinations, usually visual. There is impairment of consciousness and marked emotional change, which may be terror or enjoyment of the hallucinatory experiences; there may also be auditory or tactile hallucinations. The patient may appear to be living in a dream world.

Oneirophrenia: (INICET)

→ ONEROID Schizophrenia.

2. **Attention and concentration** (sustained attention)
Test

a) Serial (100-7) subtraction test (AIPG)

Q:- 93

86, 79, 72, 65, 58 → (5 steps)

B) Digit span test (Digit repetition test) (AIIMS)

1 digit per second and we stop after 2 failures

DIGIT FORWARD	DIGIT BACKWARDS
1 - 9 - 4 →	← 1 - 9 - 5
3 - 7 - 2 - 8 →	← 1 - 2 - 9 - 6
1 - 8 - 3 - 6 - 4 →	← 1 - 3 - 9 - 8 - 4
(7 steps)	(5 steps)

3. **Memory**

Immediate recall	Recent memory	Remote memory
Sec to minutes	minutes to hours to days	days to months to years
Attention test	Last 24 hrs recall test	Past events of life.

Test

SSS < Digit span (better)

Anterograde amnesia

Q:- Head Injury

Retrograde amnesia

Q:- Dementia.