ASSESSMENT MATERIALS FOR INTERMEDIATE CERTIFICATION BY DISCIPLINE

PSYCHIATRY, MEDICAL PSYCHOLOGY

Curriculum	31.05.01 General Medicine
Specialty	General Medicine
Form of education	Full-time
Designer Department	Multidisciplinary clinical training
Graduate Department	Internal disease

STANDARD TASKS FOR CONTROL WORK (9 SEMESTER)

TEST

The test is carried out with the aim of monitoring students' assimilation of knowledge from the lecture course, assessing the knowledge and skills acquired during practical classes, as well as testing the ability to solve various types of problems that develop professional abilities in accordance with the requirements of the specialist's qualification characteristics. Test work is carried out according to the schedule during class hours in the amount provided for by the work program for the discipline and the teaching load of the teacher. The time to prepare for the test is included in the hours of students' independent work and should not exceed 4 hours. The test work is assessed using a differentiated assessment. In case of an unsatisfactory grade received by the student, a new deadline for writing the test is assigned outside of class time. (Surgut State University Quality management system QMS SurGU STO-2.12.5-15 Organization of ongoing monitoring of academic performance and intermediate certification of students Revision No. 2 page 7 of 21)

Situational tasks for the test:

TASK No. 1.

Patient S., 30 years old. She was admitted to a psychiatric hospital shortly after giving birth. She looks pale, exhausted, her lips are dry and parched. The mental state is extremely changeable. At times she is excited, tosses about in bed, tears off her underwear, and takes passionate poses. The facial expression is anxious, confused, attention is fixed on random objects. The speech is incoherent: "You took away my baby... It's a shame... You think of living with Vanya, but you need to live with God... I'm a devil, not a god... You'll all go crazy... I have inhibitions. .. Aminazine, and then to the store...", etc. From individual fragmentary statements one can understand that the patient hears the voices of relatives coming from somewhere below, the screams and cries of children.. The mood changes: from deeply depressed to enthusiastic -euphoric. At the same time, he easily becomes embittered and threatens to gouge out his eyes. The state of excitement suddenly gives way to deep prostration. The patient falls silent, powerlessly lowers her head onto the pillow, and looks around with melancholy and confusion. At this time, it is possible to make contact with her and get answers to simple questions. It turns out that the patient does not know where she is, cannot name the current date or month, confuses the time of year, and cannot give almost any information about herself and her family. During a short conversation, he quickly becomes exhausted and stops answering questions.

TASK No. 2.

Patient R., 24 years old, disabled person of the 1st group. For many years he has been in a psychiatric hospital almost continuously. In the department he is completely passive, most of the time he is not busy with anything, he sits on a chair, looking at one point. The facial expression is dull, indifferent, the mouth is half open. Sometimes, at the invitation of other patients, he sits down to play chess. However, he plays without interest, always loses, gets up and goes to his place. He is extremely sloppy, does not take care of his appearance, washes his face and combs his hair only at the insistence of the department staff. He is reluctant to go out on a date with his mother. Without greeting her, he immediately reaches into his bag, takes out the food he brought and, slightly nodding his head, goes into his room. He eats a lot and greedily, eats everything - sour, sweet, salty. One day the patient was taken to a lecture on psychiatry for demonstration to students. He entered with an air of complete indifference and sat down without even looking at the audience. He answers questions reluctantly, in monosyllables, while looking away. Here is a sample conversation with a patient:

Professor: How do you feel? Is anything bothering you?

Patient: No, nothing. I am well.

Professor: Why are you in the hospital?

Patient: I don't know... The treatment is not finished yet.

Professor: What treatment if you are healthy?

The patient is silent and does not answer the question.

Professor: I heard that several years ago you jumped out of a 3rd floor window and broke your leg. Why did you do this?

Patient: So... I wanted to shake myself up.

Professor: You have been in the hospital for many years now. Wouldn't you like to go home and do something?

Patient: No, I don't want to. I'll stay here…

IDENTIFY THE MAIN CLINICAL SYNDROME.

TASK No. 3.

Patient B., 28 years old, mathematics teacher. I went to the doctor with complaints of periodic headaches that worsened with mental work, a feeling of constant weakness and increased fatigue. Carrying out ordinary work began to require great strain of spiritual and physical strength. In the morning, it's difficult to force yourself to get out of bed and get down to business as usual. He sits down to read a book, but after reading half a page, he notices that he is mechanically running his eyes over the lines, but his thoughts are somewhere far away. By the second half of the working day, I get better at it, my head becomes fresher, but by the evening I feel completely exhausted. Lately he has become irritable and has lost his usual restraint. During the lesson, he rudely shouted at the student, after which he immediately repented internally, could not calm down for a long time, and imagined the possible unpleasant consequences of this act. At home, everything infuriates me, the radio, the noisy fuss of my five-year-old daughter irritate me. Once he even hit her, and he was upset to the point of tears and asked his daughter for forgiveness. Even the touch of clothes on the body is annoying: "I feel like I'm wearing a hair shirt!" During a conversation with a doctor, the patient becomes worried, his face becomes covered with red spots, his voice trembles, and tears well up in his eyes. He is embarrassed by this, tries to hide his excitement; prone to pessimistic assessment of future treatment results.

IDENTIFY THE MAIN CLINICAL SYNDROME.

TASK No. 4.

Patient K., 33 years old, shop foreman. The disease began due to conflicts at work. He began to write complaints against his employees to various authorities, accusing them of "anti-state policies," immoral behavior, etc. The idea arose that his wife had been in a relationship with the director of the enterprise before marriage. Her influence on the director is such that she can decide all issues, including sending employees on business trips abroad. He recalls how, at his request, the director returned to the shop several workers who had been temporarily transferred to another job. During a tour of the workshop, the director approached him and shook his hand. All this, according to the patient, testifies to the director's relationship with his wife. Fearing exposure, the director wants to remove the patient from the plant. On his orders, the employees "hint" the patient about dismissal, the neighbors record all his conversations with his wife and report them to the director, the attending physician was deliberately incorrectly informed, etc. The patient is completely full of thoughts about "persecution." Any conversation turns to the topic of what measures he took in his defense, where he wrote. Hints at "influential friends," without whom he "would have been in Kolyma long ago." I intend to continue the fight, "to expose whoever should be."

IDENTIFY THE MAIN CLINICAL SYNDROME.

TASK No. 5.

Patient Sh., 26 years old, engineer. The disease began quite acutely. He became anxious, agitated, locked himself in his room, curtained the windows, declared that he was being watched from the opposite house, and cut his shirts and handkerchiefs into pieces. In the department of a psychiatric hospital, he is tense, suspicious, and afraid. He hears some voices, knocking, music from outside the window and through the wall, and plugs his ears with cotton wool. He looks at the doctor incredulously, gloomily. He considers himself healthy and requires discharge. He declares that "everything is rigged" around him, mistakes a doctor for a famous film actress, and patients for artists of a Russian folk choir: "It's some kind of masquerade here, everyone is pretending to be sick, but they are artists!" In the words of others he hears "hints" and threats addressed to himself. Everything around acquired its own special meaning for the patient: the carpet - the road to the cemetery ("This means I will die soon!"); the deer depicted in the painting means "laziness" - hence he is considered lazy; perceives a conversation with a doctor as a sign that he is considered a spy.

IDENTIFY THE MAIN CLINICAL SYNDROME.

TASK No. 6.

Patient B., 50 years old. In the department of a psychiatric hospital, he is self-confident, speaks with aplomb, is angry, and can be aggressive. He calls himself "Field Marshal", "Ruler of the World". He hears "voices" coming from other worlds and talks with them. He declares that he can freely be transferred to the Moon, Jupiter, and other planets, from where he controls the Universe and the movement of celestial bodies. He often smells gasoline and alcohol, which are "put into his nose using a special technique." At the same time, he gets irritated and demands that "this disgrace be stopped immediately." He feels how, with the help of the apparatus, they act on him with "protons", create "perverted thoughts", "wrap them around the brain", and act from London with the help of "electrons". With his eyes closed, he sees various animals - crayfish, scorpions, etc. Requires immediate discharge; wants to go to Moscow, where he "will be given as much money as he wants." At the same time, when talking about abstract topics, he shows sufficient prudence, gives accurate assessments of his employees, patients in the department, has a good understanding of the essence of current political events, etc.

IDENTIFY THE MAIN CLINICAL SYNDROME.

TASK No. 7.

Patient S., 60 years old, pensioner. About 5 years ago, I once quarreled with my neighbor, got upset, cried, and didn't sleep well at night. The next morning I heard the voices of a neighbor and her relatives behind the wall, who threatened to kill her and the children. Fear developed, she couldn't stay at home alone, she was afraid to go into the common kitchen. Since then, for 5 years, she has almost constantly heard the same voices that threaten the patient, order her to throw herself out of the window, and call her insulting names. Sometimes she hears the voice of her son, who calms the patient and advises her to get treatment. Voices come from behind the wall, from behind the window, and are perceived by the patient as real, ordinary human speech. In this speech, the same phrases are often repeated, sounding in the same timbre, with the same voice modulations. Sometimes words are pronounced rhythmically, like the ticking of a clock, in time with the painful pulsation of blood vessels that is felt. When voices intensify in silence, especially at night, the patient becomes anxious, runs to the windows, claims that her children are now being killed, and she can do nothing to help them. In a noisy room and during a conversation with a patient, voices completely disappear. She readily agrees that these voices have a painful origin, but immediately asks why the neighbor wants to kill her.

IDENTIFY THE MAIN CLINICAL SYNDROME.

TASK No. 8.

Patient K., 17 years old. Has been ill since adolescence. She was repeatedly treated in a psychiatric hospital. This admission is again associated with abnormal behavior and disinhibition. In the department, the patient, in the

presence of other people and especially male interns, lies down in bed, lifts up her robe, and dangles her bare legs in the air. In response to the nurse's remark, he boldly declares: "What's wrong with that? I have a good ass... Let everyone see it!" Constantly grimaces, wrinkles his forehead, closes his eyes, frowns. Suddenly, for no apparent reason, he bursts into senseless laughter. On a date with her parents she is unfriendly, cold, and irritable. He immediately eats the food they bring, and also tries to snatch food from other patients.

When talking with a doctor, she is not frank; she answers questions formally and evasively. She asks to be allowed to go home, but she does not persist in asking to be discharged, although she considers herself mentally healthy. Being in the hospital for more than 2 months, he makes no attempt to understand the reasons for his hospitalization. Not worried about college interruption: "Nothing special. They'll transfer you to another course anyway." When meeting with relatives, he does not show any joy.

IDENTIFY THE MAIN CLINICAL SYNDROME.

TASK No. 9.

Patient V., 37 years old, mechanic. Three days ago, an incomprehensible anxiety and restlessness appeared. It seemed that his room was filled with people, some people were shouting from behind the wall, threatening to kill him, calling him to "go for a drink." I didn't sleep at night, I saw a monster with horns and sparkling eyes crawling from under the bed, gray mice, half dogs, half cats, were running around the room, I heard knocking on the window, cries for help. In fear, he ran out of the house and rushed to the police station, fleeing "persecution." From there he was taken to a psychiatric hospital. In the hospital, he is agitated, especially in the evening, and rushes to the doors and windows. During a conversation, it is difficult to concentrate attention on the topic of conversation, trembles, and looks around with anxiety. Suddenly he begins to shake something off himself, says that he is shaking off insects crawling on him, sees "grimacing faces" in front of him, points his finger at them, laughs loudly.

IDENTIFY THE MAIN CLINICAL SYNDROME.

TASK No. 10.

Patient R., 23 years old. Three years ago I began to feel a constant unpleasant odor from my feet and armpits. Then it began to seem to him that the smell of feces, urine and rot was coming from the genitals and anus. He noticed that the people next to him seemed to "twitch their noses" and turn away. In the conversations of those around me, the words were heard: "The smell... Pig..." I felt guilty, I washed myself several times a day, changed my underwear, but the "smell" did not disappear. Due to this, he could not be among people and tried to be alone. Thoughts about suicide appeared. All attempts by the doctor to convince the patient that no one around him smells an unpleasant odor are met with complete disbelief by the patient, claiming that everyone feels the odor, but they want to hide it from him.

IDENTIFY THE MAIN CLINICAL SYNDROME.

TASK No. 11.

The patient complained of constant aching pain in the lower abdomen. During the interview, he clarifies that the pain is of an indeterminate diffuse nature, is not associated with food intake, and does not subside after the medications prescribed to him for gastritis.

In a conversation with a patient, one notices a certain monotony of his speech, poor facial expressions, rare blinking, and sluggish movements. To clarifying questions, the patient replied that he was not in a bad mood, although he was upset about his illness. However, it happens that he doesn't want to do anything and it's difficult to force himself to work, but by "forcing" himself to start working, he "gets involved" and can work quite productively and for a long time.

The patient also complained of poor appetite, unstable stool - constipation followed by diarrhea, shallow sleep, and emaciation. I am inclined to explain the above as "stomach disease."

On examination, the following is noted: the skin is dry, somewhat flabby, the abdomen is soft, pain on palpation does not increase, moderate bradycardia.

IDENTIFY THE MAIN CLINICAL SYNDROME.

TASK No. 12.

Patient O., 54 years old, disabled group II. He is being treated in a psychiatric hospital. She is hardly noticeable in the department and is uncommunicative. Most of the time she is not busy with anything, sits on

her bed, often sighs heavily. There is an expression of melancholy and anxiety on the face. When talking with a doctor, he gets agitated, trembles slightly, and constantly moves his hands through his clothes. There are tears in my eyes. Complains of depressed mood, insomnia, and an influx of endless anxious thoughts about home. Life seems unnecessary and aimless to the patient; she often thinks that life is not worth living. Here is an excerpt from a conversation between a doctor and a patient.

Doctor: why do you think that no one needs you? At home you run the household and raise your grandchildren. It would be difficult for your children without you.

Patient: The grandchildren are probably no longer alive... They are gone!

Doctor: why do you say that? After all, just yesterday you had your son on a date. He said everything was fine at home.

Patient: I don't know... Probably everyone died. Doctor, what's wrong with me? Do something, help…

IDENTIFY THE MAIN CLINICAL SYNDROME.

Patient N., 35 years old, mechanic. He has not worked for several months and constantly seeks help from different doctors. Complains of weakness, lack of appetite, insomnia. He notices a lot of unpleasant sensations throughout his body: he doesn't have enough breath, his heart "feels like something hot was poured on it" and it's about to burst. You feel some kind of heat, there is a "pepper" in your head, your head feels clogged, "jammed," the blood freezes in your veins, and "needles pass" throughout your body. When examining the patient, no pathological changes in the internal organs were revealed. Despite the negative research data, the patient remains anxious and suspects some serious illness.

IDENTIFY THE MAIN CLINICAL SYNDROME.

TASK No. 14.

Patient K., 19 years old. The patient's behavior shows excessive mobility, but the movements are unnatural in nature - mannered, pretentious. There is grimacing and antics. The background mood is often elevated. There is pronounced speech agitation with ridiculous statements, flat jokes, neologisms, impulsive cries. Periodically, the patient begins to laugh, giggle, sing, dance, stomp, imitate others, sometimes the movements resemble the movements of animals. Fragmentary hallucinatory and delusional experiences are noted. In general, behavior is characterized by its unproductiveness and absurdity.

IDENTIFY THE MAIN CLINICAL SYNDROME.

Patient K., 23 years old, rural resident. For many weeks he is almost completely motionless, lying bent over in bed, knees brought to his stomach. Doesn't talk, doesn't answer questions. The face is amicable, greasy, saliva flows from the mouth. Raised from bed, he stands motionless, head bowed. You can give the patient any position, which he then maintains for 10-15 minutes. Retains feces and urine for a long time. After eating, he wanders around the wards, looking at the patients with curiosity. At this time, it is possible to come into contact with the patient. He reports that he hears "voices" coming from the wall, from under the floor, which intimidate the patient and threaten to beat him. Various images of people and shadows of animals are seen on the wall, blue rays come from the heating radiator, which affect the patient, causing a headache. It seems that all his thoughts are known to those around him, he was "killed for two days and then resurrected," he asks the doctor "if there is hope for life." 40-50 minutes after the administration of sodium amytal, a state of lethargy sets in again.

SAMPLE QUESTIONS FOR TEST (9 SEMESTER)

TASK No. 1.
Patient S., 30 years old. She was admitted to a psychiatric hospital shortly after giving birth. She looks pale, exhausted, her lips are dry and parched. The mental state is extremely changeable. At times she is excited, tosses about in bed, tears off her underwear, and takes passionate poses. The facial expression is anxious, confused, attention is fixed on random objects. The speech is incoherent: “You took away my baby... It’s a shame... You think of living with Vanya, but you need to live with God... I’m a devil, not a god... You’ll all go crazy... I have inhibitions. .. Aminazine, and then to the store...”, etc. From individual fragmentary statements one can understand that the patient hears the voices of relatives coming from somewhere below, the screams and cries of children.. The mood changes: from deeply depressed to enthusiastic -euphoric. At the same time, he easily becomes embittered and threatens to gouge out his eyes. The state of excitement suddenly gives way to deep prostration. The patient falls silent, powerlessly lowers her head onto the pillow, and looks around with melancholy and confusion. At this time, it is possible to make contact with her and get answers to simple questions. It turns out that the patient does not know where she is, cannot name the current date or month, confuses the time of year, and cannot give almost any information about herself and her family. During a short conversation, he quickly becomes exhausted and stops answering questions.
A) make a diagnosis
B) prescribe treatment

TASK No. 2.
Patient R., 24 years old, disabled person of the 1st group. For many years he has been in a psychiatric hospital almost continuously. In the department he is completely passive, most of the time he is not busy with anything, he sits on a chair, looking at one point. The facial expression is dull, indifferent, the mouth is half open. Sometimes, at the invitation of other patients, he sits down to play chess. However, he plays without interest, always loses, gets up and goes to his place. He is extremely sloppy, does not take care of his appearance, washes his face and combs his hair only at the insistence of the department staff. He is reluctant to go out on a date with his mother. Without greeting her, he immediately reaches into his bag, takes out the food he brought and, slightly nodding his head, goes into his room. He eats a lot and greedily, eats everything - sour, sweet, salty. One day the patient was taken to a lecture on psychiatry for demonstration to students. He entered with an air of complete indifference and sat down without even looking at the audience. He answers questions reluctantly, in monosyllables, while looking away. Here is a sample conversation with a patient:
Professor: How do you feel? Is anything bothering you?
Patient: No, nothing. I am well.
Professor: Why are you in the hospital?
Patient: I don’t know... The treatment is not finished yet.
Professor: What treatment if you are healthy?
The patient is silent and does not answer the question.
Professor: I heard that several years ago you jumped out of a 3rd floor window and broke your leg. Why did you do this?
Patient: So... I wanted to shake myself up.
Professor: You have been in the hospital for many years now. Wouldn't you like to go home and do something?
Patient: No, I don’t want to. I'll stay here...
A) make a diagnosis
B) prescribe treatment

TASK No. 3.
Patient B., 28 years old, mathematics teacher. I went to the doctor with complaints of periodic headaches that worsened with mental work, a feeling of constant weakness and increased fatigue. Carrying out ordinary work began to require great strain of spiritual and physical strength. In the morning, it’s difficult to force yourself to get out of bed and get down to business as usual. He sits down to read a book, but after reading half a page, he notices that he is mechanically running his eyes over the lines, but his thoughts are somewhere far away. By the second half of the working day, I get better at it, my head becomes fresher, but by the evening I feel completely exhausted. Lately he has become irritable and has lost his usual restraint. During the lesson, he rudely shouted at the student, after which he immediately repented internally, could not calm down for a long time, and imagined the possible unpleasant consequences of this act. At home, everything infuriates me, the radio, the noisy fuss of my five-year-old daughter irritate me. Once he even hit her, and he was upset to the point of tears and asked his daughter for forgiveness. Even the touch of clothes on the body is annoying: “I feel like I’m wearing a hair shirt!” During a conversation with a doctor, the patient becomes worried, his face becomes covered with red spots, his voice trembles, and tears well up in

his eyes. He is embarrassed by this, tries to hide his excitement; prone to pessimistic assessment of future treatment results.
A) make a diagnosis
B) prescribe treatment

STANDARD TASKS FOR CONTROL WORK (10 SEMESTER)

WRITING A CLINICAL HISTORY OF A DISEASE

The student independently selects a nosological form, develops and defends a medical history according to the proposed scheme

The main stages of writing an educational history:
Title page (separate page)
Passport part.
Complaints: the main ones and those found during the survey by organ system.
History of the main and concomitant diseases.
Anamnesis of life.
Data from an objective examination of the patient.
Rationale for the preliminary diagnosis and its formulation.
Survey plan.
Laboratory and instrumental research data, consultants' opinions.
Final clinical diagnosis (rationale and formulation).
Differential diagnosis.
Treatment of the patient and its rationale.
Forecast.
Prevention (primary and secondary).
Epicrisis.
Supervision diary.
List of used literature.

SAMPLE QUESTIONS FOR THE EXAM (10 SEMESTER)

1.Historical stages of development and main directions in psychiatry.
2.Organization of psychiatric care.
3.Psychiatric hospital.
4. Outpatient psychiatric care.
5. Issues of labor, judicial and military examination.
6.Psychohygiene and psychoprophylaxis,
7.Deontology and medical ethics.
8. The concept of health and norms in psychiatry.
9. E. Bleuler’s concept of the boundaries of mental pathology.
10. The role of F. Pinel, J. Connolly in establishing the legal foundations of psychiatry.
11. History of observance of civil rights and freedoms of the mentally ill and regulation of psychiatric care in Russia.
12. Law on psychiatric care in the Russian Federation and guarantees of the rights of citizens during its provision.
13. Criteria for involuntary examination and involuntary hospitalization of mentally ill patients.
1.Clinical research (questioning, observation, examination).
2.Ethological method and sociobiological approach in psychiatry.
3.Anthropoecological method.

4.Trans- and cross-cultural analysis in psychiatry. The role of E Kraepelin.

5.Pathopsychological research (verbal and projective methods of psychodiagnostic testing).

6.Neuropsychological diagnostics.

7.X-ray diagnostics in psychiatry.

8. Neurophysiological study of the brain, incl. neuroimaging. Laboratory and consultative examination.

9. History of the creation of the classification of mental illnesses.

10. The role of E. Kraepelin in the development of taxonomy and nosological criteria for the diagnosis of mental illness.

11. Nomenclature and diagnostic innovations in the section of mental and behavioral disorders of the ICD - 10.

12. The concept of psychiatric stigma and stigmatization with a psychiatric diagnosis.

13.Criterion of cultural adequacy of a mental phenomenon.

14. Hyperesthesia, hypoesthesia, anesthesia, paresthesia, synesthesia.

15. Homonomic and heteronomous senestopathies, senestalgia.

16.Illusions and pareidolia.

17. True hallucinations and pseudohallucinations.

18. The role of V.H. Kandinsky in the study of perceptual disorders.

19. Hallucinoids.

20.Psychosensory disorders.

21. Definition of emotion. Concept of mood, affect, stress, distress, frustration. Hypotymia, hyperthymia.

22. Depression, dysphoria.

23. Euphoria, moria, mania.

24.Emotional lability, inadequacy.

25.Emotional ambivalence.

26.Emotional coldness, apathy.

27. Determination of will. Classification of volitional disorders.

28. Abulia, hypobulia, hyperbulia, parabulia.

29. Drive disorders: impulsive, instinctive (sexual, food, self-preservation).

30.Motor-volitional disorders: akinesia, stupor, stereotypies, negativism, ambition, mannerism, pretentiousness.

31.Definition and functions of memory (fixation, retention, reproduction).

32. Classification of memory disorders.

33.Qualitative memory disorders (paramnesia and cryptomnesia).

34. Quantitative memory disorders (amnesia, hypermnesia, hypomnesia), their clinical varieties.

35. Ribot's Law.

36. Korsakov's syndrome.

37.Definition of intelligence.

38. IQ and its measurement.

39.Mental retardation (mild, moderate, severe, profound).

40. Acquired dementia (lacunar, total)

41.E. Bleuler and P.B. Gannushkin about borderline variants of the intellectual norm.

42.Forms of mental activity.

43. Stages of development (types) of thinking.

44.Properties of developed thinking.

45. Classification of thinking disorders.

46. Disorders of thinking based on tempo.

47.Structural disorders of thinking.

48.Thinking disorders by content: obsessions, overvalued ideas, delusions. Immanent signs of delirium according to K. Jaspers.

49.Forms of delusion and clinical varieties of delusional ideas.

50. Recognition of delirium, its differential diagnosis with obsessive and overvalued ideas.

51. Phyloontogenesis of consciousness.

52.Types of orientation.
53. Classification of disorders of consciousness.
54. Quantitative disturbances of consciousness (stunning, stupor, coma).
55.Qualitative disorders of consciousness (delirium, amentia, oneiroid, twilia)