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Resource name	Psychiatry
Resource description	Psychiatry
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PSYCHIATRY NOTES

MENTAL STATE EXAMINATION

I. APPEARANCE AND BEHAVIOUR

- State and colour of clothes
- Eye contact (Poor eye contact in depression)
- Tearful (Depression)
- Down cast gaze
- Agitation (seen in depressive illness, anxiety, psychosis)
- Tremor, Fidgeting
- Distracted
- Visual scanning (for danger)

II. MOOD AND AFFECT

The patient has an emotion and feeling, tells the doctor their mood and the doctor observes the patient affect
 Affect is the mood by appearance of the patient as judged by the doctor

Mood Alteration

Persistent change in mood
 Fluctuating or labile mood
 Inconsistent or incongruent mood

A persistent change in mood

1. **Depression:**

- Low mood
- Feeling sad
- Tearful & low in spirits
- Feeling guilty & low confidence level
- Anhedonia – loss of interest in daily activities
- Loss of appetite & weight
- Loss of libido

2. **Anxiety:** A feeling of constant inappropriate or excessive worry, fear or tension. Common in young women
3. **Irritability:** Temper or impatient
4. **Elation:** Feeling of high spirits e.g. mania
5. **Blunting of affect:** Total absence of emotion, seen more commonly in chronic schizophrenia

Fluctuating or labile mood

This is when different emotions rapidly follow one another so that a patient is crying one moment and laughing the next.

Inconsistent or incongruous mood

This occurs when emotional expression fails to match thoughts and actions

e.g. Patient may laugh when describing the death of a relative

SPEECH

Disorders of stream of thought

1. Pressure of speech:

Can be recognized by loudness, rapidity and difficulty in interrupting speech e.g. mania

2. Poverty of speech:

Absence of any thought and patient report their mind to be empty e.g. in schizophrenia

3. Thought block:

Speech is normal initially and then it stops suddenly

Occurs in schizophrenia

i.e. there is an abrupt(sudden) and complete interruption of the stream of thought, so the mind goes blank

Disorders of form of thought

1. Flight of ideas

Patient's thoughts rapidly jump from one topic to the next, such that one train of thought is not completed

This is characteristic of mania and is often accompanied by pressure of speech

2. Preservation: persistent and inappropriate repetition of same thoughts or action.

Occurs in frontal lobe lesions e.g. If you ask patient to say No Ifs ands or buts, he will say No ifs ifs ifs.....

3. Loosening of associations: loss of normal structure of thinking

It is usually difficult to understand what the patient is speaking

4. Thought broadcasting

A feeling as if other people are hearing or understanding their thoughts despite not telling people what they are thinking. E.g. schizophrenia

5. Thought insertion

Feeling that someone is putting thoughts into their mind. Patient feels that the thoughts in his mind are not his/her. E.g. schizophrenia

6. Thought withdrawal

Feeling that someone is taking my thoughts away or stealing of thoughts

4, 5 and 6 are the 3 factor's which indicate schizophrenia

IV. THOUGHT CONTENT

1. **An obsessional rumination:** is a recurrent, persistent thought, impulse, image or musical theme that enters the mind despite individual's effort to resist it. E.g. Obsessive Compulsive Disorders

2. **Compulsion:** is a repetitive and seemingly purposeful action performed in a stereotyped way which is called a compulsive ritual. E.g. Obsessive Compulsive Disorder

V. INSIGHT

Is the awareness of the patient that he or she is unwell or has a problem.

ABNORMAL BELIEFS these are called delusions

A delusion is an abnormal belief that is held with absolute conviction

Not amenable to reason or modifiable by experience

Usually false

Not shared by those of common social or cultural background

ABNORMAL PERCEPTION

1. **Illusion:** This is the distortion or misinterpretation of external stimuli or real things e.g. see a tree as if it's a person

2. Hallucination: hearing or seeing things which are not there and without any stimuli. It is a false perception and not distortion.

- Hypnagogic Hallucinations: Episodes of seeing or hearing things as one is falling asleep. These dreams can be frightening and one can often cause a sudden jerk and arousal just before the sleep. It is associated with narcolepsy.
- Hypnopompic Hallucinations: Episodes of seeing, hearing or feeling things while getting up from sleep. E.g. Narcolepsy
- Auditory Hallucinations
- Visual Hallucinations e.g. schizophrenia, substance abuse- PCP or cocaine
- Tactile Hallucinations e.g. small insects crawling on skin in chronic alcoholics or alcohol abuse
- Gustatory Hallucinations
- Olfactory Hallucinations
- Third Person Hallucination (Usually auditory-Running commentary that he is an evil person and ants to kill me)

3. Pseudo or False hallucinations: usually auditory e.g. hear a voice in my head speaking to me. Patient have insight to the problem

4. Derealization: unpleasant feeling that the external environment has become unreal i.e. patient feel like that they are in a dream like state

5. Depersonalization: change in self awareness such that a person feels unreal or detached from their body

6. Déjà vu: a sudden familiarity with the situation or event as having been encountered before when it is in fact new.

7. Jamais vu: Failure to recognise an event or situation which was encountered before.

FUNCTIONAL DISORDERS

1. CHRONIC FATIGUE SYNDROME

- This is when a person feels tired, fatigued all the time
- All investigations are normal
- Fatigue and tiredness does not improve with rest
- No structural abnormalities found

Management: Education and reassurance, Education about appropriate rest and activity, CBT, Graded Exercise Program, relaxation therapies- yoga, meditation.

Referral to psychiatrist and psychologist

2. FIBROMYALGIA (Chronic widespread pain)

- This is a functional widespread pain all over the body
- All investigations are normal

3. IRRITABLE BOWEL SYNDROME

- Functional disorder
- Presents as abdominal pain which is usually relieved by passing flatus or stools
- Diarrhea, bloating, constipation
- All investigations are normal
- It is a diagnosis of exclusion
- No PR bleed
- No night symptoms
- No weight loss

Management: Education and symptomatic treatment

4. PREMENSTRUAL SYNDROME

- Physical and psychological symptoms that regularly occur during the premenstrual phase and diminishes soon after the period starts
- Cause is likely to be hormonal
- Abdominal pain, Irritability, Low mood, Bloating

SOMATOFORM DISORDERS

1. SOMATIZATION DISORDER

- This is multiple, recurrent, medically unexplained symptoms, usually starting early in life. Usually patient presents with one symptom at a time.
- Nausea, Vomiting, Abdomen pain
- Neck pain, Back pain, Headache
- Etiology is unknown
- Investigations are normal

2. HYPOCHONDRIASIS

- Preoccupation with assumed serious diseases.
- Commonly patient believes they are suffering from cancer or HIV even after repeated reassurance with normal investigations for symptoms and they repeatedly request investigations.

NB: Management of somatoform disorders is reassurance and education, Referral to psychologist.

DISSOCIATIVE DISORDERS (Conversion)

- Also known as hysteria.
- It is a condition where there is a profound loss of awareness or cognitive ability.
- E.g. Amnesia- loss of memory
- E.g. Pseudo-seizure (Psychogenic non epileptic seizures): Seizure like activity resembling epileptic fit but without any electrical discharges associated with epilepsy and the patient is not hurt during this seizure and usually tries to resist any attempt to change his posture by other people. Long-term video EEG & Serum prolactin is usually done to distinguish between true seizure and pseudo-seizure.

MOOD (Affective disorders)

Depressive disorders

- A. **Unipolar:** Depression occurring on it's own.
 B. **Bipolar:** Depression alternating with mania.

Bipolar affective disorder

A. DEPRESSION

1. Low mood
2. Low energy level
3. Feels sad
4. Anhedonia – loss of interest in daily activities
5. Early morning waking
6. Loss of appetite
7. Feeling guilty
8. Reduced self esteem
9. Thoughts of self-harm
10. Fatigability – feeling tired
11. Loss of libido

B. DYSTHYMIA

It is characterized by the mild depressive illness that lasts intermittently more than 2 years.

C. SEASONAL AFFECTIVE DISORDER

It is characterized by the recurrent episodes of depressive illness occurring during the winter months. It occurs annually usually in winters.

- Atypical symptoms
- Low mood, anhedonia
- Excessive sleep
- Increased appetite and weight gain

Management: Light therapy, Pscho-therapy and antidepressants.

D. POST NATAL DEPRESSION

- Occurs after delivery
- Poor sleep, low confidence, anhedonia
- Loss of appetite & weight
- Feeling that she is not capable of looking after her child
- Guilt feeling that she is not a good mother
- Tearful, Anxiety
- Occurs in the first 3 months after delivery
- Mother feels as if someone/partner wants to harm her baby

E. BABY BLUES

- Occurs in 50% women after giving birth
- Normal phenomena and resolves within a few days usually 3-4 days
- Poor sleep, anxiety, irritability, tearful, crying for no reason

Management: Family support & Reassurance

F. POST NATAL PSYCHOSIS

- Usually occurs within 2 weeks after delivery
- Usually starts with post-natal depression
- Delusional ideas that the baby is deformed, evil or otherwise affected in some way and she has intent to kill the baby, evils or self harm

G. BIPOLAR AFFECTIVE DISORDER

Mood swings of mania and depression

Treatment of depressive illness**1. SSRI: Selective Serotonin Re-uptake Inhibitors: First choice of treatment**

- Citalopram- Preferred in IHD
- Escitalopram
- Fluoxetine
- Paroxetine

2. Tricyclic Antidepressant (TCA)

- Amitryptilline
- Dosulepin
- Lofepamine, Trazodone

Contraindication: in Ischaemic Heart Disease (IHD) and Glaucoma

Side Effect's:

- Arrhythmia's
- Dry Mouth
- Constipation
- Raised Intra-ocular pressure- leads to Glaucoma

3. Other Anti depressants

- Mirtazapine
- Venlafaxine
- Reboxetine

4. Monoamine oxidase inhibitors (MAOI)

- Phenelzine

NB: 1. Depression with obesity=fluoxetine (It helps without weight loss)
 2. Depression with sexual dysfunction=mirtazapine
 3. Post stroke depression use nortriptyline (TCA)
 4. Depression with obsessive compulsive disorder=clomipramine (TCA)
 5. Depression with ischemic heart disease=SSRI e. g. citalopram

NON-MEDICAL TREATMENT**a. Electroconvulsive therapy (ECT)**

Indications:

1. Refusing to eat and drink and their weight is dangerously going low
2. Dangerously suicidal (Patient's looking for every opportunity to kill themselves)
3. Psychotic symptoms
4. Depression not responding to anti-depressants
5. Depression with Psychosis

b. Cognitive Behavior therapy

Good for mild to moderate depression. It is as effective as medical treatment.

Good for anxiety disorder

It involves identification of abnormal thinking that keeps triggering depressive, anxiety or any other symptoms and tries to fix or change it. E.g. Depression, OCD, PTSD

c. Behavior therapy

Based on learning theory

Works as desensitization e.g. in OCD, phobia (arachnophobia- fear of spiders, agoraphobia- fear of open spaces, claustrophobia- fear of closed spaces)

d. Interpersonal psychotherapy

Used for depression and eating disorder especially depression triggered by personal relationship

e. Couple therapy

When a patient with depression is having problems in relationship like sexual, emotional etc.

f. Family therapy

If family is supportive – educate the family about the condition and the members of the family

g. Supportive therapy

It is similar to counseling. E.g. Bereavement, baby blues

h. Group therapy

Where a problem involves a group of people e.g. drug abuse

I. Exposure and Response Prevention Therapy

Used in OCD & phobia's

SEROTONIN SYNDROME

- Toxic hyper-serotonergic state
- Occurs when SSRI and MAOIs are used together or overdose of SSRI's or when 2 SSRI's are started together.
Symptoms:
- Agitation
- Confusion
- Tremor
- Diarrhea
- Tachycardia
- Hypertension

II. MANIA AND HYPOMANIA

Elevated mood: characterized by euphoria, overactivity and disinhibition

Hypomania: is mild form of mania, it lasts shorter time and less severe

Mania: almost always occurs as bipolar affective disorder

Clinical features of Mania

- Elevated mood
- Fast pressurized speech, flight of ideas
- Excessive energy, anhedonia, self confident, Over-spending, delusion of wealth
- Delusion of Grandiose
- Delusion of Control
- Dis-inhibition
- Hallucination

Treatment of MANIA**ACUTE TREATMENT**

1. Lithium is the first choice
2. Antipsychotic is 2nd line eg. Halperidol or chlorpromazine

PROPHYLAXIS

1. Lithium is the first choice
2. If not responding to lithium then use anti convulsants e.g. Carbamazepine

Monitor patients on Lithium with Thyroid functions tests and U & Es**Lithium adverse affects:**

- Can cause nephrogenic diabetes insipidus which presents with polyuria, polydipsia.
- Hypothyroidism
- Nausea
- Tremor
- Weight gain

At therapeutic levels lithium has the following side effects

ANXIETY DISORDERS**1. Generalized anxiety disorder**

Patient is worried about different number of events every day. Almost everything triggers the anxiety.

2. Mixed anxiety and depressive disorders

There is equal amount of anxiety and depression

- Palpitation & chest pain
- Excessive worries
- Low mood
- Poor sleep & guilt feeling
- Reduced appetite

3. **Panic disorder or Anxiety attack**

- There is hyperventilation (SOB) difficult to take a deep breath
- Chest pain (all over the chest)
- Choking sensation
- Palpitation, sweating
- Perioral paresthesia & Tingling and numbness in the hands due to hyperventilation and CO₂ washout leading to low ionic calcium.
- Patient has belief of catastrophic illness e.g. MI or stroke
- Feeling of Impending doom or feeling as if having a heart attack or going to die.
- Feeling of butterfly's in tummy

Management

- Rebreathing bag
- Reassurance
- Relaxation therapy
- Beta-blocker can be used for upcoming stressful event e.g. an exam or a job interview but is not used acute attack of panic attack. In acute attack use re-breathing bag.
- Anxiolytics: E.g. Diazepam- If having severe symptoms

PHOBIA DISORDERS

1. **Agoraphobia**: translated as fear of the market place, fear of going out in open places. As soon as patient is out, starts to have panic attack. e. g shops, markets

2. **Social phobia**: Fear to socialize with other e.g. Meetings, Parties, Crowds and with normal life.

Simple phobias

Arachnophobia: Fear of spiders particularly in women. Treatment: Exposure and response prevention therapy, Desensitization, Behavioral therapy.

Treatment of anxiety disorder

1. Relaxation therapy: If symptoms have resolved
2. Behavior therapy: Graded exposure called systemic desensitization – first choice treatment for phobias.
3. CBT: Best Rx for panic disorder, endogenous phobia and anxiety disorder
4. Drugs: Anxiolytic: e.g. Benzodiazepine

ACUTE STRESS AND ADJUSTMENT DISORDERS

1. **Acute stress disorder**

- Occur in individual without psychiatric illness, in response to exceptional physical and/or psychological stress
- Symptoms are severe but they subside within hours or days include – sudden changes in some circumstances (accidents, rape)

2. **Adjustment disorder**

- This follows acute stress disorder usually in hospital
- It is prolonged lasting up to 6 months
- It is reaction to bad news or a significant event

3. **Pathological or abnormal grief**

- This is a type of adjustment disorder
- There is excessive and prolonged grief or denial of the bereavement
- Repeated dreams of a dead person
- Patients have anger at doctors or even the person who died him/ herself.

4. **Post traumatic stress disorder**

This is delayed or prolonged response to stressful situation

e. g: Sexual abuse

War, Road Traffic Accident

Human disaster

Clinical features

1. Flashbacks: reliving the event
2. Insomnia
3. Avoidance of activities – avoid similar circumstances
4. Hyper-vigilant and hyper-arousal

Treatment: CBT

Obsessive Compulsive Disorder

They are repetitive and intrusive (interfere with personal life and activities)

Common examples:

1. Checking doors locked all the time expectedly
2. Walking back and forth again and again
3. Cleaning the toilet repeatedly
4. Washing hands excessively

Treatment:

1. Cognitive Behavior therapy
2. Anxiolytics – Benzodiazepine

NB: Benzodiazepines:

They are used for alcohol withdrawal

Cause respiratory depression

Lorazepam is short acting

Diazepam & Chlordiazepoxide is long acting

NB: Treatment of anxiety or alcohol withdrawal use long -acting benzodiazepine.

ALCOHOL ABUSE

1. **Alcohol withdrawal**

- Delirium tremens
- Agitation
- Aggression
- Tremor (Usually these symptoms appears in a patient admitted for an operation & 2-3 days after operation or hospitalization due to any other medical reason)
- Confusion, Tachycardia, Hypotension
- Visual hallucinations are very common in alcohol withdrawal and they are very suggestive of alcohol abuse. E.g. insects crawling in beds, tactile hallucinations.

Management of alcohol withdrawal -detoxification program use Long acting benzodiazepines

1st choice: Chlordiazepoxide

2nd choice: Diazepam

2. **Wernicke's encephalopathy**

- Headache
- Confusion
- Flapping tremor, ataxia
- Ophthalmoplegia.

Management: IV high potent vitamins, IV Thiamine (Vitamin B1) followed by IM thiamine

General Management of alcohol abuse:

1. Detoxification program: This is during withdrawal period use long acting benzodiazepine e.g. chlordiazepoxide

Maintenance of abstinence:

1. Acamprosate: Decreases craving, decreases relapse
2. Disulfiram: Causes unpleasant symptoms if alcohol is consumed
3. Naltrexone: Not licensed in the UK for this purpose (but decreases craving and relapses)

DRUG ABUSE

1. **Opiate e. g heroin/morphine/methadone**

Detoxification (during withdrawal)= use methadone

Symptoms of withdrawal

- Flu like symptoms
- Muscle cramps
- Running nose
- Occurs 7-10 after stopping use of Opiates
- Agitation, restlessness
- Diarrhea, abdominal pain
- Yawning & sweating, difficulty to sleep

Maintainance use methadone as well.

Opiate overdose is treated with naloxone, usually there is decreased respiratory rate less than 12 and also pin point pupils or IV marks/ puncture marks on arms or legs.

NB: Cocaine is not an opiate its an amphetamine analogue.

HALLUCINOGENIC DRUGS

LSD-LYSERGIC ACID DIETHYLAMIDE

- Causes distortion of sensory perception and visual hallucination e.g. an orange tie of the teacher is speaking to me.

COCAINE:

- Usually sniffed
- Dilatation of pupils
- Tachycardia
- Hypertension
- Causes nasal perforation leading to the whistling in the nose.
- Overdose can lead to Sub-arachnoid hemorrhage, myocardial ischemia and acute MI.

Withdrawal symptoms of cocaine:

Tremor

Depression

Muscle pain

Investigation: Creatinine phosphokinase is elevated.

SCHIZOPHRENIA

Symptoms: The 3 main symptoms are:

1. Hallucinations
2. Delusion
3. Thought disorder
 - Thought Insertion
 - Thought With-drawl
 - Thought Broadcasting
 - Thought Blocking
 - Passivity Phenomenon e.g. there is a device in the brain trying to control patient.
 - Blunt Effect
 - Incongruence Mood
 - No Insight

Management: Anti psychotics - Can be classified into typical and atypical

Typical

Eg. Haloperidol or Chlorpromazine

Side effects: Neuroleptic syndrome, fever, hypothermia, tachycardia, fluctuating consciousness, increased WCC, abnormal LFT, hyperprolactinaemia

Atypical

Olanzapine, risperidone, clozapine, quetiapine, amisulpiride

SIDE EFFECT OF TYPICAL ANTI-PSYCHOTIC: Dopamine receptor blockage (Haloperidol and chlorpromazine)

Extra-pyramidal side effect:

- Parkinsonism: Brady-kinesia, tremor & rigidity
- Hyper-prolactinaemia causing Galactorrhoea, Amenorrhea, Infertility, Oligomenorrhoea.

If Extra-pyramidal side effects please switch to Quetiapine.

SIDE EFFECTS OF ATYPICAL ANTI-PSYCHOTICS

1. Clozapine causes Agranulocytosis
2. Risperidone & Olanzapine can cause extra-pyramidal side effect and hyperprolactinaemia in higher doses.
3. All atypical anti-psychotic can cause sexual dysfunction e.g erectile dysfunction, low libido, low arousal, anorgasmia, sexual dysfunction, weight gain.

EATING DISORDERS

Anorexia nervosa

Commonly young female

Mobid fear of being fat & distorted body shape

Weight loss

Amenorrhoea

BMI <17.5

Binge eating

Lack of sexual interest

Treatment: CBT
 If severe weight loss, BMI <15.5,
 Dizziness, weakness, Admit and
 Assess suicidal risk

Bulimia nervosa

Morbid fear of being fat
 Craves for food
 History of misuse of laxatives
 Fluctuating body weight
 Self induced vomiting
 Treatment: CBT

ANOREXIA NERVOSA

Mild Anorexia Nervosa:

- BMI > 17.5

Management: Educate, Refer to self help groups and make a food diary.

Moderate Anorexia Nervosa:

- BMI 15-17.5
- Evidence of organ failure

Management: Referral to Eating disorder Clinics, Adolescent mental health team.

Severe Anorexia Nervosa:

- BMI <13
- Rapid weight loss
- Evidence of systemic failure
- Arrhythmias
- Electrolyte imbalance
- Amenorrhea

Management: Urgent referral to Eating Disorder Unit or Medical Unit or Pediatric Ward

PERSONALITY DISORDERS

CLUSTER A: Odd or Eccentric

- Paranoid
- Schizoid
- Schizotypal

CLUSTER B: Dramatic, Emotional or Erratic

- Histrionic
- Anti- social
- Borderline
- Narcissistic

CLUSTER C: Anxious or Fearful

- Avoidant
- Dependent
- Obsessive Compulsive

1. **Borderline (emotionally unstable):** Act impulsively and develop intense but short-lived emotional attachment to others. They are usually attention seekers but not suicidal.

2. **Paranoid:**

- Extreme sensitivity
- Suspiciousness and a tendency to excessive self importance
- Suspicious of others to do harm to them or other
- Preoccupied with thoughts that others will harm them

3. **Schizoid (social withdrawal)**

- Lack of capacity to express emotions
- Little interest in sex
- Do not make friends
- Try to work at places where people do not come
- May precede depression

4. **Schizotypal**

- Idea of reference
- Magical thinking
- Unusual perception

5. **Histrionic**

- Attention seeking
- Excessive shallow emotion
- Self dramatization
- Shallow + labile emotion

6. **Antisocial personality disorder**

- Involved in criminal offences
- Aggressive and rude behavior
- Involved in dangerous acts
- Lack of capacity to maintain enduring relationship
- Low tolerance of frustration
- Inability to experience guilt

7. **Anankastic personality disorder (Similar to obsession disorder)**

- Perfectionism
- Feeling of excessive doubts

8. **Dependent personality disorder**

- Encourage other to make decisions for them
- Feel unable to care for themselves
- Constant fear of being abandoned
- Usually in women

9. **Avoidant (anxious) personality disorder**

- Feeling of tension and inadequacy
- Social inhibition
- They only interact with people if they know if they will be liked

UNUSUAL PSYCHIATRIC SYNDROMES

1. **Othello syndrome:**

- Pathological jealousy
- Patient is delusional convinced that their partner is being unfaithful (cheating)
- They try to prove the fact that the partner is cheating on them
- Common in men

2. **Cotard's syndrome**

Is characterized by nihilistic delusion in which patient believes that parts of their body are decaying or rotting or have ceased to exist. Patient may believe they are dead and they ask people to bury them.

3. **Folie-a-deux**

It is an induced or shared delusional disorder. It a delusional belief that is shared by 2 or more people of whom only one of them has features of psychiatric illness

4. **Erotomania**

Patient has a belief that someone is in love with him/her

Normally the object of there affection is someone from high society. E.g. Queen is in love with him or Angelina jolie is sending messages to him.

5. **Couvade syndrome**

Experience symptoms of pregnancy in men

Abdominal swelling, nausea, vomiting

Commonly in expecting father

6. **Munchausen's syndrome**

This is deliberately creating medical symptoms

- Usually these people have medical back ground
- Abdominal pain, sexual abuse, hallucination
- Multiple abdominal scars which suggests multiple managements.

Types of delusion

1. **Persecution:** Someone or something is interfering with the person

Worried that people are against him/her and trying to harm him/her

2. **Grandiose:** Being famous, having supernatural power or enormous wealth. Believe that they have exceptional abilities or talent and keep praising themselves. E.g. usually seen in high society figures- actors, mania.

3. [Delusion of reference](#): Other people, event, media are referring to the person or communicating a message. E.g. someone is giving them special messages through Newspaper, TV and radio.
4. [Passivity](#): Action, feeling or impulses can be controlled or interfered with by outside influence. Feeling another person is controlling what you are doing. E.g. Schizophrenia
5. [Paranoid Delusion](#): Feeling that people are trying to kill them.

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