

Introduction to Psychiatry

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1 Psychiatry and mental disorders

Psychiatry is a medical specialty focused on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders. As a field of medicine, psychiatrists are trained physicians who can prescribe medication, and they often use a combination of medical and psychotherapeutic techniques.

Psychology, in contrast, primarily deals with the study of the mind and behavior. Psychologists use various therapeutic techniques to help individuals cope with and overcome emotional and behavioral challenges, but they typically cannot prescribe medications unless they're specifically licensed to do so in certain jurisdictions.

While both fields aim to understand the mind and improve mental well-being, psychiatry has its roots in medicine and medical interventions, whereas psychology is rooted in understanding cognitive, emotional, and behavioral processes.

A **Mental Disorder** is a **syndrome** characterized by a **clinically significant disturbance** in an individual's cognition, emotion regulation, or behavior. This disturbance reflects a **dysfunction** in the psychological, biological, or developmental processes underlying mental functioning and is usually associated with significant **distress or disability** in social, occupational, or other essential activities.

Mental Health, on the other hand, refers to a state of well-being in which an individual realizes their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community. It's not just the absence of mental disorders but encompasses emotional, psychological, and social well-being.

2 Diagnosis in psychiatry

2.1 Outline of the diagnostic process in psychiatry

The **diagnostic process** in psychiatry follows this workflow: **Symptoms** are gathered from various sources: direct **interviews** with the patient, **observations** during consultations, third-party information (family, close friends), and occasionally from **indirect mediums** (creative activities, diaries, messages, suicide notes). Once these symptoms are collected, they are matched to known **syndromes** or patterns; for instance, depressive symptoms can be present in conditions like bipolar or depressive disorders. Understanding the **context** is paramount, considering factors such as age of onset, duration, and the course of the symptoms. In psychiatry, paraclinical examinations play a pivotal role in differentiating psychiatric symptoms from those caused by **underlying medical conditions**. For instance, delirium or acute confusional state often has a physical etiology. First-line investigations may involve blood tests, urine tests, and toxicological screenings. Brain imaging techniques such as CT and MRI are also used, with further insights gained from EEG. In rare cases, advanced functional brain imaging like SPECT, PET, and PET MR may be employed. These examinations ensure accurate diagnosis and appropriate management, highlighting their crucial importance in psychiatric practice.

2.2 Basics of psychopathology

Psychopathology serves as the bedrock of psychiatric diagnostics, emphasizing the meticulous delineation of symptoms. These symptoms are typically organized and described across specific domains, offering a structured insight into an individual's mental state.

Consciousness plays a pivotal role in our understanding of the world. When there's **disorientation**, an individual struggles to identify time, place, or even persons accurately. A more profound disturbance in consciousness are **somnolence**, **stupor** (**sopor** in the Czech context) and **coma**.

In the realm of **psychomotorics**, **akinesia** represents the absence or impairment of voluntary movements. Meanwhile, **catatonic symptoms** like **waxy flexibility** (where individuals maintain positions that are externally imposed), **motoric stereotypies** (repetitive, purposeless movements), and **echophenomena** (mimicking another's actions or speech) come to the fore. **Agitation** signifies excessive, often purposeless motor activity accompanied by feelings of inner unrest. The term **stupor** in the Czech terminology describes a noticeable lack of movement or response without necessarily indicating a decrease in alertness. Furthermore, behavioral manifestations can escalate to **aggression**, where there's a potential for physical harm to oneself or others.

Moving to the domain of **volitional behavior**, **abulia** stands out as a deficit in willpower, making it hard for individuals to act decisively. On the other hand, **compulsions** manifest as repetitive behaviors or mental acts that individuals feel driven to perform, often stemming from obsessions.

In the **emotional** sphere, the distinction between affect and mood is crucial. While **affect** pertains to immediate emotional expressions, **mood** denotes a prolonged emotional state, such as the pervasive sadness in a **depressive mood** or the elevated feelings in a **manic mood**. Feelings of **anxiety** and **anhedonia** further elaborate on this spectrum, signifying an overwhelming sense of fear or impending doom and a loss of interest or pleasure in activities, respectively.

Our **perception** molds our reality. Here, **hallucinations** emerge as sensory experiences without any external stimuli, such as hearing non-existent voices. Conversely, **illusions** are misinterpretations of real external stimuli.

Diving into the intricacies of **thought**, the speed can range from slowed down processes, termed **bradyphrenia**, to heightened, racing thoughts. The **formal structure** of thought can sometimes be disorganized, leading to **incoherence**. The **content** of one's thoughts can sometimes be dominated by **delusions**, which are false yet firmly held beliefs or by **obsessions**, which are recurrent and intrusive unwanted thoughts.

A significant component of our daily function is **attention**, and disruptions (**hypoprosexia**) here can cause difficulties in maintaining focus or lead to distractions by irrelevant stimuli. Our innate **appetite** can also fluctuate, manifesting as an increased or decreased desire for food.

Sleep disturbances, such as insomnia or hypersomnia, can severely impact health and well-being. **Insomnia** denotes difficulties in falling or maintaining sleep, while **hypersomnia** is characterized by excessive sleepiness.

In more severe manifestations, **suicidality** embodies thoughts, plans, or actions related to self-destruction. A related yet distinct phenomenon is NSSI (**Non-Suicidal Self-Injury**), where individuals harm themselves without the intention to die.

Lastly, **insight** is pivotal for understanding and managing disorders. A significant lack of insight (**anosognosia**), especially prevalent in psychotic disorders, means an unawareness or denial of a disorder and its ramifications.

2.3 Syndromes in psychiatry

A syndrome is a **group of symptoms** that consistently occur together and represent a particular medical condition or disorder. In psychiatry, symptoms, syndromes, and diagnoses are distinct entities: **symptoms** cluster into **syndromes**, and when a syndrome is combined with **context**, it forms a **diagnosis**. Currently, these clusters of symptoms and contextual information are codified in diagnostic manuals. However, from a didactic perspective, it's valuable to understand that certain symptoms tend to cluster in similar ways across various diagnoses, highlighting shared features or underlying mechanisms.

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Here are some notable examples of psychiatric syndromes, each representing a characteristic cluster of symptoms:

Dementia Syndrome: Characterized by cognitive deficits, memory impairment, and challenges in daily functioning. It's seen in conditions like Alzheimer's disease.

Delirium: A sudden disturbance in attention and cognition, often reversible. It is often accompanied with paranoia, paranoid delusions and hallucinations. Commonly arises due to medical conditions, substance intoxication, or withdrawal.

Catatonic Syndrome: Catatonia is a neuropsychiatric condition marked by motor disturbances, ranging from immobility (stupor) to excessive movement (hyperkinesia). Symptoms can include posturing, stereotypy, and echolalia. Once predominantly linked with schizophrenia, it's now known to appear in other disorders, such as mood disorders and can arise from physical illnesses like limbic encephalitis as well.

Withdrawal Syndrome: Symptoms that emerge when reducing or discontinuing a substance that the body has become dependent upon, such as alcohol or certain drugs. Its clinical presentation depends on substance.

Paranoid Syndrome: Dominated by paranoid delusions of persecution or grandeur, often without hallucinations.

Hallucinatory Syndrome: Mainly characterized by persistent hallucinations, most commonly auditory, without pronounced delusional content.

Paranoid-Hallucinatory Syndrome: A combination of delusions, primarily of persecution or grandeur, and persistent hallucinations. This syndrome is frequently seen in conditions like schizophrenia.

Depressive Syndrome: Symptoms like persistent sadness, lack of interest, weight changes, and feelings of hopelessness. Often seen in major depressive disorder.

Manic Syndrome: Features include elevated mood, increased energy, and impulsivity, commonly associated with bipolar disorder.

Obsessive Syndrome: Marked by persistent, intrusive thoughts (obsessions) and repetitive behaviors or mental acts (compulsions).

These represent just a few syndromes within psychiatry, providing a glimpse into the diverse manifestations of psychiatric symptoms.

2.4 Context

In psychiatric diagnoses, several contextual factors are essential for differentiation.

The **age of onset** often hints at specific disorders, such as ADHD in childhood or late-life depression in the elderly.

The **course** of a disorder is another important feature. The **remitting** course sees symptoms come and go with recovery periods in between (major depressive disorder). **Remitting with deterioration** involves episodes with a decline in baseline function after each (schizophrenia, bipolar disorder). **Chronic** disorders persist without significant remissions (generalized anxiety disorder). **Chronic with exacerbations** are ongoing conditions punctuated by periods of worsening symptoms (schizophrenia, bipolar disorder, generalized anxiety disorder). **Single episode** disorders occur once in a lifetime without recurrence (acute psychotic disorder). The **chronic with diminishing symptoms** over time course sees a significant reduction in symptoms over years (ADHD, Borderline personality disorder). Lastly, **chronic with deterioration** conditions present symptoms that progressively worsen over time (dementia).

The **severity of symptoms** helps gauge the intensity and urgency of the condition, while the **duration** reveals if symptoms are short-lived or persistent. By considering these factors, clinicians can ensure a nuanced and accurate diagnosis, leading to targeted treatment strategies.

Temporal sequence or progression of symptoms can provide valuable clues in distinguishing among disorders with overlapping symptomatology. For example in a patient presenting with both depressive symptoms and delusions, the chronology can be revealing - in depression with psychotic features depressive symptoms usually appear first, before onset of psychotic symptoms.

2.5 Diagnostic manuals

The purpose of **diagnostic manuals** in psychiatry is to **standardize and categorize** mental health conditions, ensuring consistent understanding and treatment across the medical community. These manuals provide **diagnostic criteria**, which are sets of symptoms (clustering into syndromes) and characteristics (context) that must be present for a specific diagnosis to be made. By following these criteria, psychiatrists can ensure accurate and consistent diagnoses. These manuals are periodically updated to reflect new knowledge and research, resulting in different versions over time. The most commonly used diagnostic manuals include **ICD-10** (International Classification of Disorders 10th Revision, prevalent in Europe), **DSM-V** (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, widely used in the USA and for research purposes), and **ICD-11**, which is currently being implemented.

3 Etiopathogenesis of psychiatric disorders

3.1 Biopsychosocial model

The **biopsychosocial model** presents a matrix-like understanding of mental health, considering both distinct domains and the sequence of events influencing mental well-being. Central are the three primary domains: **Biological factors** (e.g., genetics, brain chemistry, physical health), **Psychological factors** (e.g., personal experiences, emotions, coping mechanisms), and **Social factors** (e.g., societal structures, relationships, cultural norms). Interwoven with these are the "Three P's": **Predisposing factors** which increase vulnerability, **Precipitating factors** that trigger onset, and **Perpetuating factors** that maintain or exacerbate a disorder. While specific mental disorders often align with a set of recognized factors, the exact interplay can differ remarkably between individuals. This variation underscores the importance of individualized assessment and care, ensuring treatments are tailored to each person's unique constellation of influences. Following table shows examples of combinations of factors:

	Biological	Psychological	Social
Predisposing Factors	genetics, other congenital diseases	early life trauma, personality traits	growing up in an impoverished environment, cultural norms favoring maladaptive strategies
Precipitating Factors	physical illness, injury, medication with psychiatric side effects	significant stressors, psychiatric disorder	life other loss of social support, moving to a new country or city

(corticosteroids)

Perpetuating Factors chronic pain or maladaptive coping ongoing social disability substance abuse strategies (e.g. isolation, stigmatization avoidance in phobias)

3.2 Relevance of neurotransmitter systems in psychiatry

In the realm of biological psychiatry, neurotransmitter systems are of paramount importance. Neurotransmitters are chemical messengers that transmit signals across nerve endings, facilitating communication throughout the brain and body. Dysregulation in these systems can lead to a myriad of psychiatric symptoms. Consequently, many psychiatric treatments aim to modulate neurotransmitter activity to restore balance and alleviate symptoms.

Major symptoms often associated with neurotransmitter imbalances include mood fluctuations, anxiety, psychosis, and cognitive disturbances. Key regulatory neurotransmitters include:

Neurotransmitter	Examples of relevant symptom domains	Examples of relevant disorders
Serotonin (5-HT)	mood, appetite, sleep	mood disorders, anxiety disorders, obsessive-compulsive disorder
Dopamine (DA)	salience signaling, reward, motivation, volition	primary psychotic disorders, mood disorders, catatonia
Norepinephrine (NE)	alertness, energy	mood disorders, attention deficit and hyperactivity disorder (ADHD)
Gamma-Aminobutyric Acid (GABA)	primary neurotransmitter	inhibitory anxiety disorders, catatonia
Glutamate	main neurotransmitter, memory	excitatory learning, cognitive disturbances, depressive disorder, primary psychotic disorders
Acetylcholine	cognitive especially attention	processes, memory and Alzheimer's disease

4 Basic epidemiology of psychiatric disorders

Epidemiology is the study of the distribution, determinants, and frequency of disease conditions within a population. In the realm of psychiatry, understanding epidemiology is pivotal for grasping the prevalence (how common a disorder is in a population), incidence (the rate of new cases over a given time), and risk factors (elements that increase the likelihood of developing a disorder) associated with different psychiatric conditions. For instance:

Common disorders include major depressive disorder (MDD), anxiety disorders, and substance-related disorders. These inflict a significant burden as measured by Years Lived with Disability (YLD).

Less common disorders might encompass bipolar disorder or obsessive-compulsive disorder.

Rare disorders could be conditions like Dissociative Identity Disorder or rare variants of early-onset psychosis.

Factors influencing the epidemiology of these disorders can range from genetics and personal history to environmental triggers like trauma or societal stressors. Comprehensive epidemiological studies aid in shaping public health policies, tailoring interventions, and allocating resources effectively to address the mental health needs of a population.

5 Basics of treatment in Psychiatry

The treatment of psychiatric disorders is multifaceted and aims to alleviate symptoms, improve quality of life, and enhance the patient's ability to function in daily life. Depending on the nature and cause of the disorder, interventions can range from addressing underlying medical conditions to modulating brain functions and providing coping and adaptive strategies through psychotherapy. The comprehensive approach in psychiatry often requires a combination of these modalities tailored to the individual needs of the patient.

5.1 Causal Treatment of Underlying Cause

For psychiatric symptoms stemming from identifiable and treatable medical conditions, the primary approach is to address that underlying cause. Such cases are often termed as secondary psychiatric conditions. A classic example is delirium, a common occurrence in the general hospital setting, where rapid-onset confusion can arise from various causes such as infections, metabolic imbalances, or drug side effects. Treating the root cause – be it an infection, correcting the metabolic imbalance, or discontinuing the offending drug – leads to resolution of the psychiatric symptoms.

5.2 Biological Treatments

5.2.1 Pharmacotherapy

Psychotropic medications play a pivotal role in the management of numerous psychiatric disorders. They work by influencing the brain's neurotransmitter systems and include antidepressants, antipsychotics, mood stabilizers, anxiolytics, and stimulants among others.

5.2.1.1 Anxiolytics and Sedatives

Benzodiazepines: Enhance GABA-A receptor activity. (e.g., diazepam, clonazepam)

Z-compounds: Act on specific GABA-A receptor sites; primarily for insomnia. (e.g., zolpidem, zopiclone)

Pregabalin: Modulates calcium channels, leading to anxiolytic effects.

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5.2.1.2 Antidepressants

MAOI (Monoamine oxidase inhibitors): Increase monoamine neurotransmitter availability by inhibiting monoamine oxidase. (e.g., moclobemide)

Tricyclic: Increase serotonin and norepinephrine; known for more side effects due to wide receptor activity. (e.g., amitriptyline, imipramine)

Selective serotonin reuptake inhibitors (SSRI): Increase serotonin levels; typically fewer side effects than tricyclics. (e.g., fluoxetine, paroxetine)

Serotonin and norepinephrine reuptake inhibitors (SNRI): Boost serotonin and norepinephrine; can be more activating. (e.g., duloxetine, venlafaxine)

Serotonin antagonists and reuptake inhibitors (SARI): Affect serotonin receptors and reuptake. Can be sedating. (e.g., trazodone)

DNRI: Elevate dopamine and norepinephrine. (e.g., bupropion)

NaSSA: Affect specific serotonin pathways; often sedative. (e.g., mirtazapine)

Melatonin Agonist and Selective Serotonin Antagonist (MASSA): Affect melatonin and serotonin receptors (e.g. agomelatine)

SMS: Modulate serotonin receptors based on the body's current levels. (e.g., vortioxetine)

5.2.1.3 Antipsychotics

Typical

Sedative: Block dopamine receptors; tranquilizing. (e.g., chlorpromazine)

Incisive: Strong dopamine antagonists; more motor side effects. (e.g., haloperidol)

Atypical

D2/D3 antagonists: Affect dopamine (e.g. sulpiride, amisulpride)

Serotonin and dopamine antagonists (SDA): Affect dopamine and serotonin receptors. (e.g., risperidone, olanzapine)

Multi receptor antagonists (MARTA): Multimodal action, often less extrapyramidal side effects (e.g., clozapine, olanzapine, quetiapine)

Partial dopamine agonists: Modulate dopamine activity based on the situation. (e.g., aripiprazole, brexpiprazole, cariprazine)

5.2.1.4 Mood Stabilizers

Lithium: Modulates neurotransmitters; exact mechanism complex.

Anticonvulsants: Influence ion channels and enhance GABA neurotransmission. (e.g., valproate, carbamazepine, lamotrigine)

5.2.1.5 Cognitives

Acetylcholinesterase inhibitors: Increase acetylcholine by inhibiting its breakdown. (e.g., donepezil, rivastigmine)

Glutamate antagonists: Modulate glutamatergic neurotransmission by blocking NMDA receptors. (e.g., memantine)

5.2.1.6 Stimulants and ADHD medication

Stimulants: Boost dopamine and norepinephrine. (e.g., methylphenidate, amphetamine/dextroamphetamine)

Atomoxetine: Increases norepinephrine and dopamine in prefrontal cortex.

5.2.2 Stimulation Methods

Electroconvulsive Therapy (ECT) and Repetitive Transcranial Magnetic Stimulation (rTMS) are therapeutic modalities that use electrical or magnetic fields to stimulate certain brain areas.

Electroconvulsive Therapy (ECT): ECT is a highly effective treatment method, especially notable for producing rapid relief of severe symptoms. It's particularly beneficial for patients with severe depression accompanied by psychotic symptoms or those with catatonia. In some of these cases, due to its effectiveness and rapid onset of action, ECT may even be considered as a first-line treatment. The procedure involves passing a controlled electric current through the brain, inducing a therapeutic seizure. Despite misconceptions and historical stigmas associated with ECT, it is a safe and well-tolerated treatment when conducted under appropriate medical supervision.

Repetitive Transcranial Magnetic Stimulation (rTMS): This non-invasive procedure uses magnetic fields to stimulate nerve cells in the brain, primarily used for treating depression when other treatments haven't been effective.

5.2.3 Other

Other biological interventions such as bright-light therapy can be used for conditions like Seasonal Affective Disorder. Nutritional support, ensuring adequate vitamins and minerals, can also play a role in the holistic treatment of some psychiatric conditions.

5.3 Psychotherapy

Also termed as "talk therapy", psychotherapy is a method where mental health professionals help patients by talking through strategies for understanding and dealing with their disorder. Types include Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), psychodynamic therapy, interpersonal therapy, and others. It can be applied in individual, couple, family, or group settings.

It's worth noting that many patients benefit from a combination of these treatments, especially for complex or chronic disorders. The choice of treatment depends on the nature of the disorder, its severity, the patient's preference, and other individual factors.

6 Basic legal aspects in Psychiatry

Hospitalization and treatment are usually performed with the informed consent of the patient. However, psychiatric disorders can influence the judgment of patients and their behavior. In some situations, the patient or his surroundings can be in danger due to psychiatric conditions. In such cases, the patient's autonomy is impaired and psychiatric hospitalization and treatment aim to return this autonomy. In the Czech Republic, there are several situations when hospitalization without a patient's consent is permitted. These situations are described in Act 372/2011 on Health Services and on Conditions of their Provision. The most relevant situations are as follows:

The patient may be hospitalized without their consent if:

1. they endanger themselves or others in the imminent and serious manner and shows signs of mental disorder or suffers from it, or is under the influence of an addictive substance unless the threat to the patient or to others can be avoided otherwise, or

2. their health condition requires the provision of urgent care and at the same time, it does not allow them to provide consent.

Furthermore, the patient may only be provided urgent care without his/her consent, in the case:

1. where the health condition does not allow the patient to provide this consent
2. of a treatment of serious mental disorder if, in the absence of treatment, it is likely to cause serious damage to the patient's health.

7 Basic groups of psychiatric disorders

This section includes a list of major diagnostic groups of psychiatric disorders according to ICD-11 together with the most common age of onset, course type and treatment. Of note is that while this information pertains to "average" patients, there are possibilities of other course types and may vary between specific diagnoses inside the group and between individuals.

7.1 Neurodevelopmental disorders

Description: Developmental deficits that cause impairments in personal, social, academic, or occupational functioning.

Examples: Autism, ADHD.

Age of Onset: Early childhood.

Course: Chronic with some symptoms possibly improving with age and intervention.

Treatment: Behavioral therapy, stimulant medications for ADHD, and tailored educational interventions.

7.2 Primary psychotic disorders

Description: Disorders characterized by a distorted sense of reality, including hallucinations and delusions.

Examples: Schizophrenia, delusional disorder.

Age of Onset: Late teens to early 30s.

Course: Remitting with deterioration, chronic with exacerbations

Treatment: Antipsychotic medications and psychosocial interventions.

7.3 Catatonia

Description: Behavioral syndrome marked by an inability to move normally. It is associated with other psychiatric disorders or medical conditions.

Examples: Catatonic schizophrenia, mood disorder with catatonic features.

Age of Onset: Can vary widely.

Course: Depends on underlying cause.

Treatment: Benzodiazepines, ECT for severe cases.

7.4 Mood disorders

Description: Disorders that influence mood regulation and can lead to emotional distress.

Examples: Depressive disorder, bipolar disorder (with episodes of mania).

Age of Onset: Late teens to early adulthood.

Course: Remitting, chronic

Treatment: Antidepressants, mood stabilizers, antipsychotics, and psychotherapy.

7.5 Anxiety disorders

Description: Excessive fear or anxiety which can be situational or generalized.

Examples: Panic disorder, GAD, phobic disorders.

Age of Onset: Childhood to adulthood.

Course: Chronic with exacerbations, remitting

Treatment: Psychotherapy (especially CBT), anxiolytics, and antidepressants.

7.6 Obsessive-compulsive disorders

Description: Characterized by obsessive thoughts and compulsive behaviors.

Examples: OCD.

Age of Onset: Adolescence or early adulthood.

Course: Chronic with exacerbations, remitting

Treatment: CBT, SSRIs.

7.7 Stress-related disorders

Description: A reaction to acute or chronic stressors.

Examples: Acute stress reaction, adjustment disorder, PTSD.

Age of Onset: Any age following a traumatic or stressful event.

Course: Varies; PTSD can be chronic if untreated.

Treatment: Psychotherapy, medication for comorbid symptoms.

7.8 Dissociative disorders

Description: Disruption and discontinuity in the normal integration of consciousness, memory, identity, or emotions.

Examples: Dissociative identity disorder, functional neurological disorders.

Age of Onset: Most commonly in childhood.

Course: Chronic, can improve with therapy.

Treatment: Psychotherapy is the mainstay.

7.9 Eating disorders

Description: Disorders marked by unhealthy relationships with food and body image.

Examples: Anorexia nervosa, bulimia.

Age of Onset: Adolescence or early adulthood.

Course: Chronic, with potential for recovery with treatment.

Treatment: Multimodal with nutritional, psychotherapeutic, and sometimes pharmacological interventions.

7.10 Disorders of bodily distress or bodily experience

Description: Primarily medically unexplained bodily symptoms that cause distress.

Examples: Somatic symptom disorder, illness anxiety disorder.

Age of Onset: Varies.

Course: Typically chronic.

Treatment: Psychotherapy, physical rehabilitation approaches.

7.11 Substance-related disorders

Description: Problems related to the use of alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants, tobacco, or other substances.

Examples: Acute intoxication, withdrawal, addiction.

Age of Onset: Typically adolescence or early adulthood.

Course: Chronic, remitting

Treatment: Detoxification, counseling, medications to reduce craving or withdrawal symptoms.

7.12 Neurocognitive disorders

Description: Disorders that affect cognitive function.

Examples: Dementia, delirium.

Age of Onset: Dementia in older age; delirium can occur at any age, more often in elderly.

Course: Dementia is progressive; delirium is acute and often reversible.

Treatment: Address underlying cause for delirium, symptomatic treatment, and support for dementia.

7.13 Personality disorders

Description: Enduring patterns of behavior, cognition, and inner experience that deviate from cultural expectations.

Examples: Borderline personality disorder.

Age of Onset: Symptoms often begin in adolescence.

Course: Chronic, chronic with diminishing symptoms (BPD)

Treatment: Psychotherapy, especially DBT for BPD.