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Centre for Integrative Psychiatry

WEAVE 100 / PAPER III

Child, Forensic and Special Populations

One hundred ten-mark questions, solved as answer maps

MD Psychiatry theory. DNB revision fits too.



ILLUSTRATED REVIEW EDITION

weave.clinic

Dr. Wilfred Dsouza · Dr. Niharika Reddy

WEAVE

A NOTE ON WHO MADE THIS

Weave, Centre for Integrative Psychiatry

Weave is a psychiatry practice and a publishing house for the things clinicians and families actually need to read. Two consultant psychiatrists run it, online across India and in person in Mumbai.

WHAT WEAVE DOES	Integrative psychiatry, online and in Mumbai, and a free library for residents, clinicians and families.
WHO RUNS IT	Dr. Niharika Reddy and Dr. Wilfred D'souza, Consultant Psychiatrists.
WHAT THAT MEANS HERE	This book is free because the practice pays for it. There is nothing to buy on any page of it.

WEAVE 100 - PAPER III

Child, Forensic and Special Populations

One hundred ten-mark questions, solved as answer maps

THE WEAVE 100 SERIES

TITLE

Weave 100, Paper III: Child, Forensic and Special Populations

Book three of Weave 100, one hundred solved ten-mark questions for each paper of the MD psychiatry written examination.

WRITTEN BY

Dr. Wilfred Dsouza and Dr. Niharika Reddy

PUBLISHED BY

Weave, Centre for Integrative Psychiatry · weave.clinic

EDITION

First compiled 2026. Free to read, share and print for study.

First edition (R1), August 29, 2026.
Illustrated edition, September 2026. Original answer maps with 181 selected plates. Page references updated for this edition.

SOURCES

Question records were read from the published papers and archives of the boards named on the back cover. Board names appear throughout because the count is only meaningful with them. No board has endorsed this book and none was asked to.

The clinical content is written for doctors and doctors in training. It is a study and revision aid, not a substitute for current guidelines or clinical judgement. Verify doses, thresholds and statutory detail against the current references and your local protocols before any clinical use.

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THE HUNDRED, IN WEIGHT ORDER

01 **Criminal and civil forensic psychiatry** III-01 to III-10 · 10 slots · 11.3% 10

02 **Intellectual disability and learning disorders** III-11 to III-20 · 10 slots · 10.9% 32

03 **Ethics, consent and child protection** III-21 to III-30 · 10 slots · 10.7% 60

04 **Childhood emotional, tic, attachment and elimination disorders** III-31 to III-40 · 10 slots · 10.2% 90

05 **Mental health legislation and disability law** III-41 to III-49 · 9 slots · 9.6% 112

06 **ADHD and disruptive behaviour disorders** III-50 to III-58 · 9 slots · 9.5% 138

07 **Geriatric, consultation-liaison and transcultural psychiatry** III-59 to III-66 · 8 slots · 8.7% 166

08 **ECT and neurostimulation** III-67 to III-74 · 8 slots · 7.9% 199

09 **Emergency psychiatry** III-75 to III-81 · 7 slots · 6.5% 224

10 **Perinatal and women's mental health** III-82 to III-88 · 7 slots · 6.3% 241

11 **Autism spectrum disorder** III-89 to III-93 · 5 slots · 4.6% 275

12 **Child assessment, pharmacotherapy and interventions** III-94 to III-97 · 4 slots · 3.2% 288

13 **Normal child development** III-98 to III-100 · 3 slots · 0.7% 308

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HOW TO USE THIS BOOK

One question, one page

Every page after the weightage chapter is one question and its answer map. Nothing continues onto a second page, so a map can be read in the time you have rather than the time it deserves. Five blocks, always in the same order.

1	**Question band**	The slot number, the question as a board set it, and three chips: the mark split, the area, and where the question has been seen.
2	**Skeleton**	Three to five rows. The mark column sums to ten, so you can see the allocation before you read a word of content.
3	**Body**	Two to four components, chosen for the question: a comparison table, a flowchart, a plate, typed lines, at most one pitfall box.
4	**What earns the marks**	Three or four things an examiner ticks. Each one names something that is on the page above it.
5	**Links**	The related slots in this book, and the Weave Sprint day that teaches the underlying topic in full.

The colour code

Structure	The shape of the answer: headers, rules, table heads, the question band. When a line is indigo it is telling you how the answer is organised.
Key number	A figure to carry exactly: a mark split, a threshold, a count, a cut-off. Amber means memorise the number, not just the shape of it.
Trap	The mistake the examiner is waiting for. When a line is red it is warning you off an error that looks right until it costs you the mark.

Two ways to work. Read an area straight through, banner first, to see how the boards have carved it up. Or use the ten sets at the back: each is ten questions and one hundred marks, drawn one from each rank decile, so a set is a paper-shaped sitting rather than ten easy questions or ten hard ones.

The chips are traceable. A recurrence chip names the boards and gives a count against a stated denominator. If it says three of seventy-eight sittings, that is three sittings out of the seventy-eight this book counted, and the boards are listed by name so you can check.

THE WEIGHTAGE CHAPTER, PAGE ONE OF THREE

Where the marks have gone

Nothing in this book is a prediction. It is a count of 78 sittings from 8 examining boards, and a statement of where those boards have put their marks in Paper III.

Thirteen areas, weighted. The university boards are pooled by how much each is trusted, DNB is held out and given a fixed thirty percent, and the resulting weight becomes a share of one hundred and then a whole number of slots. The ledger of which boards were counted, how their papers reached us, and how far each one is trusted, is on the page opposite.

AREA, IN WEIGHT ORDER	UNIV POOL	DNB	WEIGHT	SHARE	SLOTS
01 Criminal and civil forensic psychiatry	0.239	0.301	0.257	11.34%	10
02 Intellectual disability and learning disorders	0.212	0.333	0.248	10.94%	10
03 Ethics, consent and child protection	0.201	0.343	0.243	10.72%	10
04 Childhood emotional, tic, attachment and elimination disorders	0.172	0.370	0.232	10.20%	10
05 Mental health legislation and disability law	0.181	0.302	0.217	9.58%	9
06 ADHD and disruptive behaviour disorders	0.212	0.223	0.215	9.48%	9
07 Geriatric, consultation-liaison and transcultural psychiatry	0.087	0.452	0.196	8.65%	8
08 ECT and neurostimulation	0.214	0.096	0.178	7.86%	8
09 Emergency psychiatry	0.209	0.000	0.147	6.45%	7
10 Perinatal and women's mental health	0.204	0.000	0.143	6.30%	7
11 Autism spectrum disorder	0.120	0.067	0.104	4.59%	5
12 Child assessment, pharmacotherapy and interventions	0.033	0.162	0.072	3.16%	4
13 Normal child development	0.024	0.000	0.017	0.73%	3

Univ pool is the trust-weighted verdict of the seven university boards; DNB is the national paper, held out. Weight = 0.70 times the pool plus 0.30 times DNB. Share is that weight as a fraction of Paper III. Slots are the share turned into whole questions by largest remainder, with a floor of two and a cap of twenty; Paper III reached neither.

THE WEIGHTAGE CHAPTER, PAGE TWO OF THREE

How the hundred were picked

BOARD	SITTINGS COUNTED	HOW THE PAPERS REACHED US	TRUST
RGUHS	12	Hand transcription and public mirrors of the printed papers	0.806
KUHS	9	Official university portal PDFs	0.600
TN-MGRMU	35	Public archive of the printed papers, exact sitting dates recovered	0.480
KNRUHS	3	Official university portal PDFs	0.300
MUHS	2	Two watermark-confirmed papers, read by OCR. A third-party recurrence compilation was tested against them, matched none, and was removed from the sitting count	0.267
NTRUHS	2	Mirror text of the printed papers	0.160
WBUHS	2	Public archive of the printed papers	0.180
DNB	10	Official NBE material; 32 of 40 files verified by checksum against the board's own published path	fixed 0.30

Trust is how far a board sets the university pool: its standing, its number of sittings, and the quality of its evidence. DNB sits outside the pool. A third-party compilation claiming thirteen further MUHS sittings was tested against the only confirmed MUHS papers inside its own window, matched none of them, and was removed from this ledger; its topic distribution still contributes to area mass at reduced quality.

1 Count the sittings

78 sittings from 8 boards, each weighted so that it halves roughly every six years and is reduced again when the paper reached us as a mirror, an archive or a transcription rather than an official file.

2 Weight the areas

Each board reads each area twice: breadth, how often it examines there, and mark share, how much of its marks land there. The two are averaged, the boards are pooled by trust, and DNB is held out at a fixed thirty percent.

3 Turn weight into slots

The thirteen weights become shares of one hundred, then whole slots by largest remainder, with a floor of two and a cap of twenty so no area disappears and none swallows the book.

4 Score every eligible question

Four components: weighted recurrence (45 per cent), recency (30), how many boards have asked it (15), and how well it is shaped as a ten-mark question (10). Normalised across all four papers, so one score means one thing everywhere.

5 Fill the slots

The highest scorers in each area, up to that area's slot count, near-duplicates merged first. All 100 were filled from questions actually set: 5 anchor, 14 high, 5 recurrent, 76 single-appearance.

THE WEIGHTAGE CHAPTER, PAGE THREE OF THREE

What this book cannot promise

A frequency count is a strong prior, not a prophecy. Here is exactly what that sentence costs, stated before you rely on it.

It does not predict a paper. Nothing here says what your board will set. It says where the marks have gone across 78 sittings, which is a different claim and a smaller one. A board that changes its examiner, its syllabus or its habits can leave every number in this book behind in one sitting.

Most questions were seen once. Of the 224 selectable Paper III questions in the record, 196 appeared in a single sitting. That is not a defect in the counting, it is what happens when eight boards set different papers: the same TOPIC returns constantly while the same QUESTION rarely does. So the selection is driven by AREA weight, where the signal is dense, and each map prints a band rather than a frequency claim about its own question.

The band on a map is a description, not a forecast. Anchor means this question has come back across boards and years. Single means it was set once in the record we hold. A single-appearance question is here because its AREA is heavy, and it is a fair worked example of that area, which is the only thing it is offered as.

Nothing here is invented. All 100 slots in this book are questions a board actually set. Where a paper in this series cannot fill its slots from observed questions, the shortfall is authored to syllabus and labelled as such on the map. Paper III has no such slots.

The record is uneven, and openly so. Two of the eight boards set papers in a legacy structure that does not map onto the modern four, so their sittings are counted against all of their papers rather than one. Two more contribute only two sittings each. The trust column on the first page of this chapter is where that unevenness is priced in, and it is the number to argue with if you want to argue with the weighting.

No board has endorsed this. Board names appear on every page because a count that hides its sources is not a count. None of them was asked, and none of them is responsible for anything in this book.

AREA 01 OF 13 · P3-A08

Criminal and civil forensic psychiatry

10	11.3%	III-01	III-10
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

ANCHOR 1 · HIGH 2 · RECURRENT 1 · SINGLE 6

REVISION ORDER

Start with testamentary capacity and do not leave it until all three of its slots read the same way. McNaughton and the expert-witness slot next, because they share their structure. Ganser and adoption last.

WHAT IS IN THIS AREA

Capacity and the will (four slots), criminal responsibility and the psychiatrist in court, risk of violence, adoption, and Ganser syndrome as the forensic differential. Testamentary capacity alone takes three of the ten, which is the single strongest question-level signal in this paper.

III - 01

Testamentary capacity [10]

10 CRIMINAL AND CIVIL FORENSIC PSYCHIATRY

KNRUHS, KUHS, RGUHS - 3 APPEARANCES, 3 OF 78 SESSIONS

SKELETON

2	The test	A sound disposing mind, and where the test comes from
4	The four limbs	Each limb, what it asks, what defeats it
2	What the statute adds	Sound mind, not a minor, and the execution rules
2	The psychiatrist	Contemporaneous, documented, and never the judge

THE DEFINITION

Testamentary capacity is the mental ability to make a valid will: a sound disposing mind at the moment of execution. The classical test is Banks v Goodfellow, 1870, which Indian courts continue to apply alongside Section 59 of the Indian Succession Act 1925.

LIMB	WHAT THE TESTATOR MUST DO	WHAT DEFEATS IT
The act	Understand that he is making a will and what it does	Dementia, delirium, intoxication
The property	Know in general terms what he owns	Not an exact valuation
The claims	Recall those who have a claim on his bounty	Amnesia, severe neglect of family
No perverting disorder	Be free of any delusion that shapes the disposition	A delusion that does not touch the will is no bar

The two amber cells are where most answers overreach: capacity is not perfect knowledge, and mental illness is disqualifying only when it operates on this disposition.

- **The statute and the moment.** Section 59 requires a person of sound mind who is not a minor; execution requires signature and two attesting witnesses. Capacity is judged at the time of execution, so a lucid interval suffices, and a valid will is not undone by later deterioration.

WHAT THE TEST DOES NOT COVER

Undue influence, coercion and fraud are separate grounds that void a will even where capacity is intact. Nor does the psychiatrist decide validity: the court does, and suspicious circumstances shift the burden to the propounder.

WHAT EARNS THE MARKS

- **All four limbs, attributed to Banks v Goodfellow.**
- **Capacity fixed to the moment of execution,** with the lucid interval named.
- **The delusion qualifier.** It must operate on the disposition.
- **Undue influence kept separate from capacity.**

SEE ALSO Slot III - 03 assessing testamentary capacity **SPRINT**

Day 25, Mental health legislation and forensic psychiatry

WEAVE 100+ / PAPER III • 1.1

Testamentary capacity

LEGAL ACTS APPENDIX • III Q1 / Q3 / Q10 • definition, assessment and report

1 DEFINITION & FOUR ABILITIES

Definition	Mental ability to make a valid will **at the time of execution**. Task-specific and time-specific.
ACT	Understand **making a will and its effects**.
ASSETS	Know the broad extent of property; **exact valuation is unnecessary**.
CLAIMS	Appreciate people who may reasonably expect consideration and explain the disposition.
DISTORTION	No mental disorder or delusion that **distorts the disposition**. Diagnosis alone does not prove incapacity.

2 INDIAN LEGAL ANCHORS

Banks v Goodfellow	Classical four-part test, **1870**.
Succession Act §59	Adult of sound mind may make a will; **lucid intervals** can permit a valid will.
§61: free agency	Fraud, coercion or importunity that destroys free agency invalidates the will. Assess **undue influence separately**.
§63: execution	Unprivileged-will formalities include **two attesting witnesses**. Check personal-law applicability; this is not the capacity test.

3 ASSESS IN PRACTICE

Prepare	Clarify referral, timing and legal question; interview privately, with **consent and communication support**.
Examine	MSE, cognition, delirium, intoxication, psychosis and mood. Ask the person to explain the proposed will **in their own words**.
Corroborate	Review assets, intended beneficiaries, prior wills, medical records and collateral; check pressure and inconsistencies.
Optimise	Treat reversible impairment; choose best time. **A low cognitive score is not the decision.**

4 REPORT: FIVE ESSENTIALS

1–2	Instructions, date and setting; information sources and records.
3–4	Findings, verbatim answers and reasoning **against each ability**; consider alternatives.
5	Clear opinion at the relevant time; limitations, uncertainty and reassessment needs. **Court decides validity.**

ACT • ASSETS • CLAIMS • DISTORTION

Indian Succession Act 1925 §§59,61,63; Banks v Goodfellow (1870).

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Testamentary capacity. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-01.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III • 1.2

Civil capacity: marriage, money and care

LEGAL ACTS APPENDIX • Supplement • III Q 1, Q 3, Q 10, Q 61 legal component

1 THE PRINCIPLE	
Capacity	**Decision-specific and time-specific**. Diagnosis, disability certificate, age or admission alone does not prove incapacity. Support communication and assess the actual task.
Report	State legal question, date, sources, mental state, relevant abilities, opinion and limitations. **Court makes legal determination**.
2 MARRIAGE & DIVORCE • HMA 1955	
§5(ii)	At marriage: incapacity to consent from unsoundness; or qualifying mental disorder rendering unfit for marriage/procreation; or recurrent attacks of insanity. **Epilepsy removed as a criterion**.
§12(1)(b)	Contravention of §5(ii) makes marriage **voidable**, not automatically void. Judicial annulment and statutory conditions matter.
§13(1)(iii)	Divorce: incurable unsoundness OR mental disorder of such kind/extent that petitioner cannot reasonably be expected to live with respondent.
Psychiatrist	Assess course, severity, function and treatment—not diagnosis alone. Applicable personal law/Special Marriage Act must be identified; HMA does not govern every marriage.
3 PROPERTY, CONTRACTS & WILLS	
Contract Act §12	At transaction: understand contract and form a **rational judgment of its effect on one's interests**. Lucid intervals can matter.
Succession Act §59	Adult of sound mind may make a will; assess nature/effect, property, claims of beneficiaries and disorder affecting disposition. **See 1.1 for Q 1/3/10 full answer**.
Property support	RPwD §13 protects equal legal/property/financial rights. Guardianship requires appropriate legal process and defined scope.
4 GUARDIANSHIP & DEMENTIA	
RPwD §14	Limited guardianship where adequate support is insufficient: specific purpose/time and joint decisions based on will/preferences.
National Trust	LLC framework for its specified developmental disabilities. **Not a default dementia guardianship Act**. See 47.2.
Dementia	Assess separately consent, money, wills, safety and exploitation; advance planning when capable. Cognitive screen alone is insufficient for legal conclusions.
Minor guardianship	Guardians and Wards Act / applicable personal law: child welfare; distinguish from adult supported decisions.
5 ETHICAL SAFEGUARDS	
Protect autonomy	Private interview, check coercion/conflict of interest, reasonable supports, contemporaneous records and review.
Avoid overreach	A psychiatrist's certificate does not itself dissolve marriage, transfer property or appoint a guardian.

HMA 1955 §§5, 12, 13; Indian Contract Act 1872 §12; Indian Succession Act 1925 §59; RPwD 2016 §§13–14.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Civil capacity: marriage, money and care. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-01.

Credits and references: retained within the illustration.

III - 02

Discuss about the various admission procedures used for mentally ill criminal persons. What are the criteria for Fit to stand trial? [5+5]

5 + 5 | CRIMINAL AND CIVIL FORENSIC PSYCHIATRY | DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 **Who is covered**	Undertrial, convicted, and the acquitted unsound
3 **The routes**	In order, with the actor and the authority at each
3 **Fitness criteria**	The five abilities, from Pritchard onward
2 **What follows unfitness**	Not acquittal: postponement, with review

STEP	WHAT HAPPENS	WHO ACTS	AUTHORITY
1	Unsoundness suspected before or during trial	Magistrate or Court of Session	**Inquiry is mandatory**
2	Examination and opinion on fitness	Civil surgeon or psychiatrist	On the court's reference
3	Trial postponed; bail with security, or safe custody	The court	Custody in a mental health establishment
4	Prisoner found mentally ill while in custody is transferred	Prison medical officer	**A prison mental health establishment per State**
5	Fitness restored, trial resumes; if acquitted as unsound, safe custody with review	Court, then the State Government	Periodic review and release

The procedure sits in the criminal code's chapter on accused persons of unsound mind, carried forward with renumbering into the Bharatiya Nagarik Suraksha Sanhita 2023; the custodial provisions sit in the Mental Healthcare Act 2017.

- **Fit to stand trial.** The accused must be able to understand the charge, follow the course of the proceedings, know that he may challenge a juror or a witness, comprehend the evidence, and instruct his counsel. Fitness is about the present; insanity is about the time of the act.

WHAT THE PROCEDURE DOES NOT COVER

Unfitness is not a verdict and not an acquittal: it postpones the trial, which resumes on recovery. Nor does it decide criminal responsibility, which is judged on the accused's state at the time of the offence.

WHAT EARNS THE MARKS

- **The routes given as a sequence with the deciding authority at each.**
- **All five fitness abilities.** Four out of five is a mid-band answer.
- **Present fitness distinguished from responsibility at the time of the act.**
- **The prison establishment provision,** which most answers omit entirely.

SEE ALSO Slot III - 08 the McNaughton rule **SPRINT** Day 25, Mental health legislation and forensic psychiatry

WEAVE 100+ / PAPER III • 2.1

Forensic admission and fitness for trial

LEGAL ACTS APPENDIX • III Q 2 • admission 5 + fitness 5

1 THREE DIFFERENT QUESTIONS

Responsibility	Mental state **at the alleged act**: BNS §22 (formerly IPC §84).
Fitness	Ability **now** to participate in defence: BNSS §§367–378 (formerly CrPC §§328–339).
Treatment	Clinical need and legal authority for care; **a diagnosis answers none of these automatically**.

2 FORENSIC CARE ROUTES

Inquiry / trial	If court suspects unsoundness with inability to defend: **§367 inquiry / §368 trial**, medical examination and specialist assessment; court decides incapacity.
Expert assessment	Government psychiatrist/clinical psychologist assesses; statutory Medical Board appeal available. Report illness/ID, functional ability, treatment and prognosis.
If unfit	For unsoundness with a prima facie case: **postpone and treat**. ID with inability to defend: statutory closure/no-trial route, then §369 care provisions.
§369	Bail can apply even to non-bailable offences if inpatient treatment unnecessary and suitable undertaking given. Otherwise arrange **regular psychiatric care**, with MHCA safeguards.
Other routes	Insanity acquittal: **§§373–374**, safe custody or entrusted care with conditions. Prisoner treatment: **MHCA §103**, lawful court/prison authority and safeguards.

3 FITNESS: FUNCTIONAL ASSESSMENT

Understand	Nature of charge, purpose of proceedings, possible consequences, roles of judge/prosecutor/defence counsel.
Participate	Follow evidence, give a coherent account, identify relevant facts/witnesses, make reasoned decisions and instruct counsel.
Communicate	Meaningful confidential communication with lawyer; interpreter, communication aids and reasonable accommodations.
Assess barriers	Psychosis, mania, depression, delirium, ID, dementia, substance effects; distinguish noncooperation from inability. Assess possible feigning without assuming it.

4 METHOD → OPINION → REVIEW

Explain forensic role and confidentiality limits → interview + MSE/cognition + records/collateral

↓

Link **specific symptoms to trial abilities**; document supports tried, limitations, treatment and likely reassessment interval

↓

Report to court → treatment/support → **reassess fitness** → resume proceedings under §§370–371 when appropriate

5 CRITICAL POINT

Court decides	Clinical opinion assists; **psychiatrist does not declare guilt, acquittal or legal fitness conclusively**. A person may be fit now yet have been legally insane at the act.

BNSS 2023 §§367–378; BNS 2023 §22; MHCA 2017 §103. New codes effective 1 July 2024; savings apply.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Forensic admission and fitness for trial. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-02.

Credits and references: retained within the illustration.

III - 03

a) What is testamentary capacity? b) How do you assess it? c) What is role of psychiatrist in it? [3+4+3]

3 + 4 + 3 | CRIMINAL AND CIVIL FORENSIC PSYCHIATRY

DNB - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

3 What it is	A sound disposing mind, in four limbs
4 The assessment	Step by step, each limb put to a question
2 The role	Examiner, recorder, witness, expert
1 The boundary	Opinion on capacity, never on validity

- **What it is.** The mental ability to make a valid will at the moment of execution: to understand the act and its effect, to know the extent of the property, to recall those with a claim, and to be free of any delusion that shapes the disposition. Banks v Goodfellow, 1870.

STEP	WHAT IS DONE	WHO ACTS	CONDITION
1	Clarify who instructed the assessment and tell the testator its purpose	Psychiatrist	**Consent, and no confidentiality assumed**
2	History, medication, sensory state, and collateral from the solicitor	Psychiatrist with family	Reversible causes corrected first
3	Examine each limb by open question, in the testator's own words	Psychiatrist alone with him	Beneficiaries out of the room
4	Cognitive testing, and specific enquiry into any delusion about the heirs	Psychiatrist	Screening test is supportive only
5	Record verbatim answers, ideally contemporaneous with execution	Psychiatrist	**The record is the evidence**

Where the will is already executed and the testator has died, the same limbs are reconstructed from records, witnesses and the solicitor's attendance notes.

- **The role.** To examine and give an opinion; to record it in a form that survives cross-examination; to act as attesting witness or as expert witness, but not both in the same matter without disclosure.

WHAT THE PSYCHIATRIST DOES NOT DO

He does not pronounce the will valid, does not assess undue influence as a legal conclusion, and does not infer incapacity from a diagnosis or from an unfair disposition. An eccentric will made with capacity is a valid will.

WHAT EARNS THE MARKS

- **The four limbs, then an assessment mapped onto them.**
- **Examination alone, beneficiaries excluded,** and verbatim recording.
- **Contemporaneous documentation,** named as the evidence it becomes.
- **The limit of the role,** capacity and not validity.

SEE ALSO Slot III - 10 reporting on capacity to make a will **SPRINT**

Day 25, Mental health legislation and forensic psychiatry

III - 04

Ganser syndrome. [10]

10 CRIMINAL AND CIVIL FORENSIC PSYCHIATRY

KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	Definition	Named for Ganser, 1898, described in prisoners
3	The four features	Approximate answers first, then the other three
3	Differential	Four rivals, each separated on one finding
2	Course and forensic weight	Abrupt recovery, amnesia, and fitness to plead

THE DEFINITION

A dissociative disorder whose cardinal feature is the approximate answer: a reply that is plainly wrong yet demonstrates that the question was understood. Described by Ganser in 1898 in prisoners awaiting trial, and classified as a dissociative rather than a factitious condition.

CONFUSED WITH	WHAT IT LOOKS LIKE	WHAT SEPARATES IT
Malingering	Deliberate false symptoms	**Conscious, goal directed, and improves unobserved**
Factitious disorder	Symptoms produced for the sick role	Motive is care, not release
Pseudodementia	Do not know replies in depression	Mood precedes, and answers are omissions
Delirium	Clouding, disorientation, fluctuation	An organic cause, and no approximate answers

The amber cell is the distinction the examiner is looking for, and it is also the one that cannot be made with certainty at a single interview.

- **The four features.** Approximate answers, the German vorbeireden, talking past the point: asked how many legs a horse has, the patient says five. With them, clouding of consciousness; somatic conversion features; and hallucinations, usually visual and vivid.
- **Where it sits.** ICD places it among the dissociative disorders and DSM among the other specified dissociative disorders, so it is understood as unconsciously produced. That classification is itself the answer to the malingering question, and it is contested.
- **Course and forensic weight.** Abrupt onset in custody or under any severe stress, abrupt recovery with amnesia for the episode, and a real bearing on fitness to plead, which is why it is assessed over time and never on one meeting.

WHAT EARNS THE MARKS

- **The approximate answer defined precisely,** wrong but showing the question was understood.
- **All four features, in order.**
- **Separated from malingering on consciousness and motive,** not asserted.
- **The eponym and the custodial setting,** which is where the syndrome was found.

SEE ALSO Slot III - 02 fitness to stand trial **SPRINT** Day 15, Dissociative and conversion disorders

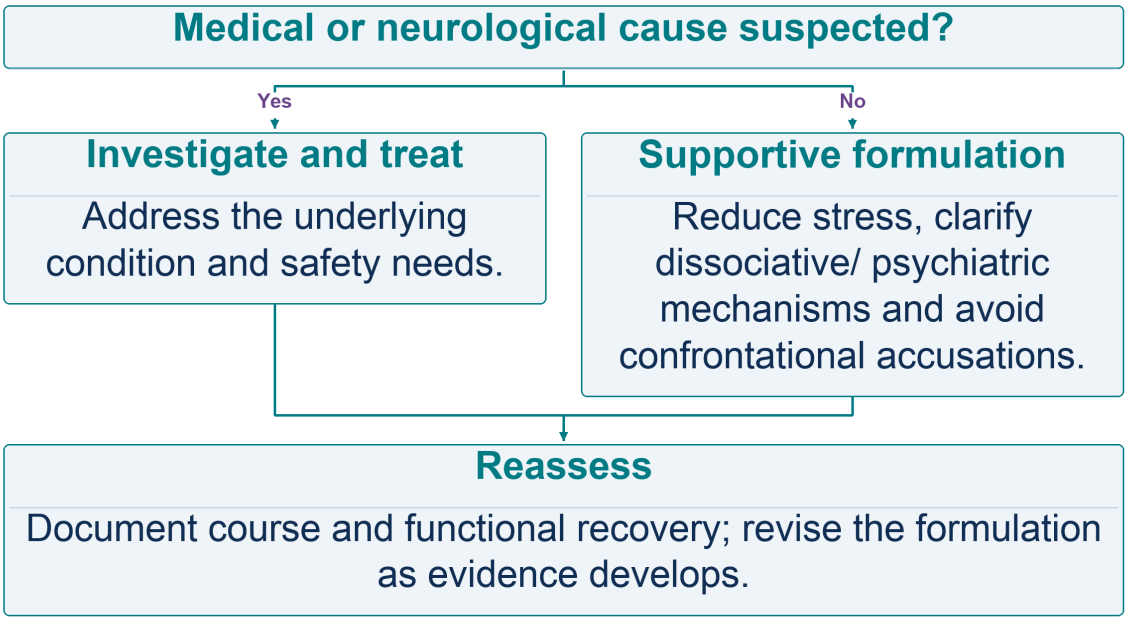
WEAVE 100+ / PAPER III

Ganser syndrome

Approximate answers require a careful differential.

Domain	Revision points
Phenomenology	Near-miss or approximate answers despite apparent understanding; may accompany altered awareness and dissociative features.
Context	Often described around severe stress or forensic settings; not confined to prisoners.
Differential	Delirium, neurological disorder, intellectual disability, psychosis, dissociation, factitious disorder and malingering.
Assessment	Medical/ cognitive examination, chronology, inconsistency and collateral evidence; do not infer motive from one odd response.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 4.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Ganser syndrome. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-04.

Credits and references: retained within the illustration.

III - 05

Write in detail about the Forensic aspects of sexual offenses and its psychiatric manifestation. [10]

10 | ASKED AT 15 MARKS | CRIMINAL AND CIVIL FORENSIC PSYCHIATRY

TN-MGRMU - 3 APPEARANCES, 3 OF 78 SESSIONS

SKELETON

2 **The legal frame**	The penal provisions, and what 2013 changed
3 **The examination**	Steps, consent, timing, and one banned practice
3 **In the survivor**	Acute reaction, then the disorders that follow
2 **In the accused**	What is assessed, and what it does not excuse

STEP	WHAT HAPPENS	WHO ACTS	CONDITION
1	Informed consent for examination, treatment and evidence collection, taken separately	Survivor, or guardian if a child	**Refusal of any part is permitted**
2	Free first aid and treatment, which no hospital may refuse	Any hospital, public or private	Refusal is itself an offence
3	Medical examination and forensic sampling	Registered medical practitioner	As soon as possible, ideally within twenty four hours
4	Report recording findings and the survivor's account, without opinion on consent	Examining doctor	**The per vaginum two-finger test is prohibited**
5	Psychiatric assessment, support and follow-up	Psychiatrist and counsellor	Repeat questioning minimised

The 2013 amendments after the Justice Verma Committee widened the definition of rape, created offences of stalking, voyeurism and disrobing, and imposed the duty of free treatment; a child complainant is dealt with under the POCSO Act 2012.

- **In the survivor.** An acute reaction of fear, numbing and disorganisation, then post-traumatic stress disorder, depression, substance use, sexual dysfunction, self-harm and, in children, developmental and behavioural regression.
- **In the accused.** Assess paraphilic disorder, intellectual disability, psychosis, substance intoxication and personality disorder; then fitness to stand trial and responsibility, which are separate questions.

WHAT THE EXAMINATION DOES NOT DECIDE

It never decides consent, and it never opines on whether the offence occurred: both are for the court. A paraphilic diagnosis is not a defence, and the absence of injury is not evidence that nothing happened.

WHAT EARNS THE MARKS

- **Consent taken separately for each part of the examination.**
- **The prohibited two-finger test, named as prohibited.**
- **Survivor and accused answered separately.**
- **The refusal to opine on consent,** which is the boundary of the role.

SEE ALSO Slot III - 28 the POCSO Act in practice **SPRINT** Day 25, Mental health legislation and forensic psychiatry

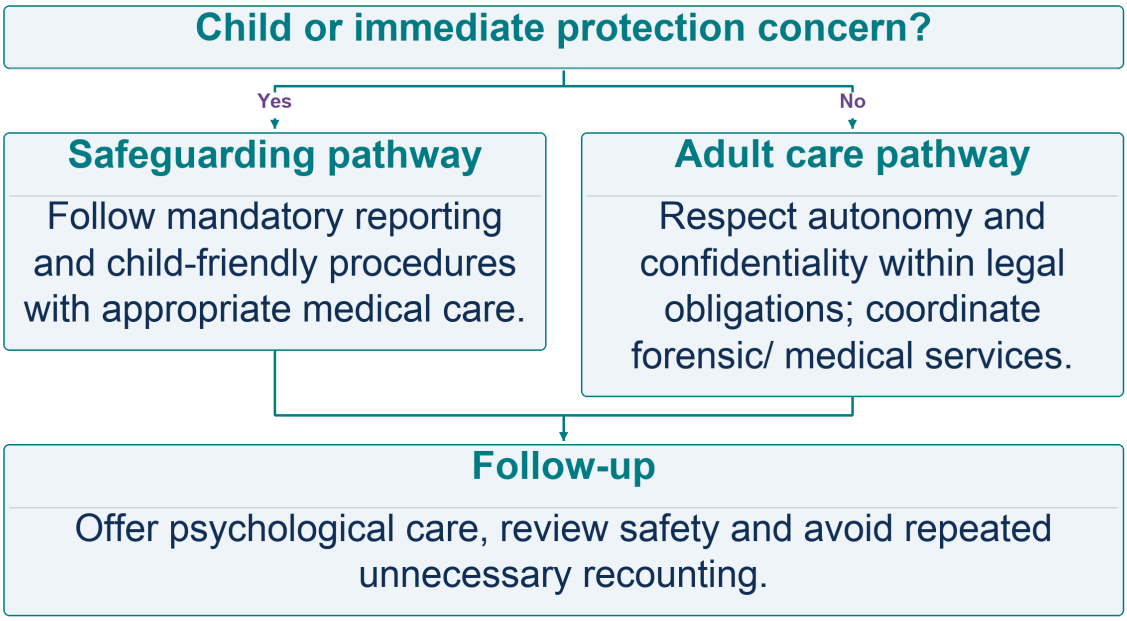
WEAVE 100+ / PAPER III

Sexual offences: psychiatric assessment

Separate care, consent, forensic evidence and legal conclusions.

Domain	Revision points
Immediate priorities	Safety, medical needs, consent and trauma-informed communication.
Assessment	Symptoms, risk, developmental/ cognitive ability, supports and effects of trauma; avoid leading questions.
Forensic role	Document objective findings and verbatim relevant statements; preserve the distinction between history and observation.
Consequences	Acute stress, PTSD, depression, anxiety, dissociation, self-harm and sexual/ relationship difficulties may occur.

DECISION PATHWAY



Weave 100 III-05; POCSO and applicable criminal-law provisions.

III 5.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Sexual offences: psychiatric assessment. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-05.

Credits and references: retained within the illustration.

III - 06

Discuss the assessment of risk for violence. Discuss nonpharmacological and pharmacological management of a patient with high risk of violence. [4+3+3]

4 + 3 + 3 | CRIMINAL AND CIVIL FORENSIC PSYCHIATRY

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

4	**Assessment**	Three factor classes, and the method that beats intuition
3	**Non-pharmacological**	Environment, de-escalation, restraint under law
2	**Pharmacological**	Rapid tranquillisation, then the disorder itself
1	**Afterwards**	Monitor, review, and write the risk plan down



Fig 006.1 Risk factors paired row by row with the intervention each one licenses, so that the static row is seen to buy observation rather than treatment.

- **The method.** Structured professional judgement beats both unaided clinical opinion and a pure actuarial score: a validated checklist completed in full, then a formulation. Historical, clinical and risk-management items are rated, and short-term inpatient risk is tracked with a brief daily checklist.
- **Rapid tranquillisation.** Intramuscular lorazepam alone where the cause is unclear; add or substitute an antipsychotic where psychosis drives it. Do not give intramuscular olanzapine within an hour of a parenteral benzodiazepine. Monitor pulse, blood pressure, respiration, temperature and consciousness.

WHAT EARNS THE MARKS

- **Static, dynamic and protective factors named as three classes.**
- **Structured professional judgement named,** with a validated instrument.
- **De-escalation placed before any drug,** as the figure orders it.
- **Restraint tied to its statutory limits,** not offered as a treatment.

SEE ALSO Slot III - 02 fitness to stand trial **SPRINT** Day 25, Mental health legislation and forensic psychiatry

III - 07

Critically discuss the role of Psychiatrists in the court of law as expert witness in criminal offence committed by the mentally ill. [10]

10 CRIMINAL AND CIVIL FORENSIC PSYCHIATRY

RGUHS, TN-MGRMU - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2 **What an expert is**	Opinion evidence, and the statute that admits it
4 **The steps**	Instruction to testimony, with the duty at each
2 **The two questions**	Fitness now, responsibility then
2 **The critique**	Bias, retrospection, and the limits of the science

- **The expert witness.** An ordinary witness speaks to facts he perceived; an expert may give an opinion, because the law admits opinion on a point of science from a person specially skilled in it. The psychiatrist is the court's helper, not the party's advocate, whoever pays the fee.

STEP	WHAT IS DONE	WHO ACTS	THE DUTY AT THIS STEP
1	Accept the instruction and identify who is asking and for what	Court, prosecution or defence	**Declare any prior treating role**
2	Tell the accused the purpose and that this is not treatment	Psychiatrist	No confidentiality is promised
3	Examine, and gather records, police papers and family accounts	Psychiatrist	Multiple sources, not the in-terview alone
4	Form and write the opinion, with reasoning and alternatives	Psychiatrist	**State the degree of certainty**
5	Testify and be cross-examined	The court	Concede what is not known

The two questions are separate and must be answered separately: fitness to stand trial is about the accused today, and responsibility is about his mind at the moment of the act.

- **The critique.** Retrospective opinion on a mental state months past is inference, not measurement; the adversarial setting invites partisan drift; and the court is never bound by the opinion, which is advisory only.

WHAT THE EXPERT DOES NOT DO

He does not decide guilt, does not opine that the accused is legally insane, and does not treat the person he is assessing. Medical insanity is his field; legal insanity is the court's conclusion drawn from it.

WHAT EARNS THE MARKS

- **Expert opinion distinguished from factual testimony,** with its statutory basis.
- **The warning that confidentiality does not apply,** given before the examination.
- **Fitness and responsibility answered as two questions.**
- **A genuine critique,** since the stem says critically.

SEE ALSO Slot III - 08 the McNaughton rule **SPRINT** Day 25, Mental health legislation and forensic psychiatry

WEAVE 100+ / PAPER III • 7.1

Psychiatrist as expert witness

LEGAL ACTS APPENDIX • III Q7 • role, report, confidentiality and critique

ROLE & LEGAL BASIS	
Duty	**Independent opinion** to assist the court. **Court decides**; opinion is not binding.
Expert evidence	**BSA s39** (old Evidence Act s45).
Two questions	**Fitness NOW**: understand proceedings and assist defence. **Responsibility THEN**: mental state during the act.
Legal test	**BNS s22** (old IPC s84): unsoundness of mind causing inability to know the act's nature, or that it is wrong or contrary to law.

ASSESS & REPORT	
Prepare	Clarify question, dates and authority; **disclose conflicts**.
Assess	Interview + MSE + records + collateral; **reconstruct timeline**.
Report	**Facts → reasoning → opinion → limitations**. Consider alternative explanations.

LIMITS TO CONFIDENTIALITY	
Explain first	**Purpose, recipients and possible court disclosure**.
Authority	**Consent where applicable / lawful order**; document explanation.
Disclose carefully	Stay within **lawful, justified scope**; protect unrelated information.
Remember	**Privacy duties remain**. MHCA s23 allows specified exceptions.

COURTROOM CONDUCT	
Presentation	**Punctual, professionally dressed, prepared**; devices silent.
Respect	Address court courteously; **listen, do not interrupt**.
Testimony	**Truthful, clear, within expertise**; explain jargon.
Cross-examination	**Pause; clarify ambiguity**. Correct false premises; qualify misleading yes/no questions.
Objection	**Stop and await the court's direction**.
Uncertainty	**Admit limits and errors**; do not guess or argue.
Independence	**No partisanship**. Respect never means changing evidence to please anyone.

CRITICAL APPRAISAL	
Value	Links psychiatric evidence to the **legal question**.
Limits	**Retrospective uncertainty, incomplete records, bias**.
Ethics	**Separate treating and forensic roles** where feasible; disclose overlap.

COURT = Clear • Objective • Unbiased • Respectful • Truthful

India Code: BSA §39; BNS §22; MHCA §23. AAPL forensic assessment guidance (2015).

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Psychiatrist as expert witness. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-07.

Credits and references: retained within the illustration.

III - 08

Discuss the McNaughton's rule. [10]

10 CRIMINAL AND CIVIL FORENSIC PSYCHIATRY

KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 The origin	The 1843 case, and the question the Lords answered
3 The rule	Defect of reason, disease of mind, two alternatives
3 In India	The penal provision, the burden, and the case law
2 Criticism and rivals	What the rule leaves out, and the tests that answer it

- **The rule, 1843.** Daniel McNaughton, intending to kill the Prime Minister, killed his secretary and was acquitted as insane. The Lords answered: to establish the defence it must be clearly proved that, at the time of the act, the accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of his act, or, if he did know it, that he did not know that what he was doing was wrong.

STEP	WHAT MUST BE SHOWN	WHO MUST SHOW IT	STANDARD OR NOTE
1	A defect of reason arising from disease of the mind	The accused	**At the time of the act, not at trial**
2	Either not knowing the nature and quality of the act	The accused	The first alternative
3	Or not knowing that it was wrong, or contrary to law	The accused	**India adds contrary to law**
4	Proof to the civil standard, the presumption of sanity displaced	The accused	Preponderance of probabilities
5	Verdict of acquittal by reason of unsoundness, then safe custody	The court	Not a simple release

In India the rule is enacted as Section 84 of the Indian Penal Code, now Section 22 of the Bharatiya Nyaya Sanhita, and the courts have repeatedly held that legal insanity, not medical insanity, is what excuses.

- **Criticism, and the rivals.** It is a purely cognitive test: it excuses the man who did not know, never the man who knew and could not stop. Hence the irresistible impulse test, the Durham product test, and the Model Penal Code's substantial capacity test, none of which India has adopted.

WHAT THE RULE DOES NOT COVER

Volition, emotion and diminished responsibility, which English law added by statute and India has not. Intoxication is dealt with separately, and a diagnosis by itself proves nothing: the illness must have produced the specified defect at the specified moment.

WHAT EARNS THE MARKS

- **The rule quoted with both alternatives,** not paraphrased into one.
- **Section 84 named, with the Sanhita renumbering noted.**
- **Legal insanity against medical insanity,** the line Indian courts insist on.
- **The cognitive limit and one named rival test.**

SEE ALSO Slot III - 07 the psychiatrist as expert witness **SPRINT**

Day 25, Mental health legislation and forensic psychiatry

WEAVE 100+ / PAPER III • 8.1

McNaughton rule

LEGAL ACTS APPENDIX • III Q8 • original rule → current Indian application

1 ORIGINAL RULE • 1843

Origin	Daniel M'Naghten killed **Edward Drummond**, mistaking him for Robert Peel; rules followed the acquittal.

At the time of the act: disease of mind → defect of reason

Does not know the **nature and quality** of the act	OR does not know that the act is **wrong**

2 INDIA: BNS 2023 §22

Legal test	Unsoundness of mind at the act → unable to know its **nature**, OR that it is **wrong or contrary to law**. Either limb suffices.
Old → current	**IPC §84 → BNS §22**; core test retained. Diagnosis or impaired self-control alone is insufficient.

3 BURDEN OF PROOF

Accused	**BSA §108** (old Evidence Act §105): establish exception on **preponderance of probabilities**.
Prosecution	Offence proved **beyond reasonable doubt**. Dahyabhai (1964): defence evidence may raise doubt about an offence ingredient even without establishing the exception.

4 APPLY: RESPONSIBILITY THEN ≠ FITNESS NOW

Reconstruct	Before–during–after behaviour, witnesses, records, symptoms and **their relationship to the act**.
Expert / court	Explain functional incapacity and uncertainty; **court decides**. Assess trial fitness separately.
After acquittal	**BNSS §§373–374** (old CrPC §§334–335): record whether act occurred; if committed, safe custody OR relative/friend care under safeguards.

5 CRITICAL APPRAISAL

Strength	Clear cognitive standard tied to the act.
Limitations	Narrow cognitive focus; retrospective evidence, bias and missing records. Emotional or volitional impairment alone does not meet the test.
Comparators	Irresistible impulse: control; Durham: product of illness; MPC: substantial capacity. **Not India's §22 test.**

TIME • MIND • KNOWLEDGE

BNS §22; BSA §108; BNSS §§373–374; M'Naghten (1843); Dahyabhai (1964). Codes: 1 Jul 2024; savings apply.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

McNaughton rule. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-08.

Credits and references: retained within the illustration.

III - 09

Adoption. [10]

10 CRIMINAL AND CIVIL FORENSIC PSYCHIATRY

KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	Definition	A permanent transfer of parentage, in law
3	The legal routes	Two statutes, two different things they do
3	Eligibility and process	Who may adopt, who is adoptable, who decides
2	Psychiatric aspects	Telling, attachment, and what follows placement

THE DEFINITION

Adoption is the process by which a child is permanently separated from his biological parents and becomes the lawful child of his adoptive parents, with all the rights, privileges and responsibilities that attach to a biological child. It is a change of status, not a placement.

ROUTE	WHAT IT PROVIDES	WHO IT SERVES
Juvenile Justice Act 2015	Full adoption, secular and available to all	The general route, through the central adoption authority
Hindu Adoptions and Maintenance Act 1956	Full adoption under personal law	Hindus, Buddhists, Jains and Sikhs
Guardians and Wards Act 1890	Guardianship only, ending at majority	Not adoption, and confers no inheritance

Under the 2015 Act a child is declared legally free for adoption by the Child Welfare Committee, prospective parents are registered and home-studied, and the adoption order is now passed by the District Magistrate.

- **Eligibility, in outline.** Physically, mentally and financially fit parents in a stable relationship of at least two years; at least twenty five years between child and parent; a single woman may adopt any child, a single man may not adopt a girl; the permitted composite age of the parents falls as the child's age rises.
- **Psychiatric aspects.** Disclosure told early and repeatedly rather than once; attachment difficulty and developmental delay after institutional care; identity questions in adolescence; grief in the adoptive parents where infertility preceded; and a raised rate of referral, which reflects both risk and help-seeking.

WHAT EARNS THE MARKS

- **Adoption defined as a change of legal status,** not as care of a child.
- **Guardianship separated from adoption,** which is the commonest confusion.
- **The two firm numbers,** the twenty five year gap and the single man rule.
- **Disclosure and attachment,** which is where the psychiatrist actually contributes.

SEE ALSO Slot III - 27 the Juvenile Justice Act SPRINT Day 25, Mental health legislation and forensic psychiatry

WEAVE 100+ / PAPER III • 9.1

Adoption

LEGAL ACTS APPENDIX • III Q9 • JJ/CARA route; separate personal-law routes

1 DEFINITION & ELIGIBILITY

Definition	**Permanent legal parenthood**: rights and responsibilities of a parent–child relationship; not merely placement.
Health / safety	Physically, mentally, emotionally and financially capable; no life-threatening condition; **no conviction or accusation of child-rights violation**.
Couple	**Both spouses consent**; stable marriage ≥2 years. Specified relative/step-parent exceptions apply.
Single applicant	Woman: either gender. **Single man: cannot adopt a girl.**
Age / family	Minimum **25-year parent–child gap**; age ceilings below. Couples with ≥2 children: special-needs/hard-to-place route, except relative/step-child adoption.

2 MAXIMUM AGE AT REGISTRATION

Child age	Couple: combined	Single parent
Up to 2 years	85	40
>2–4 years	90	45
>4–8 years	100	50
>8–18 years	110	55

3 JJ / CARA PATHWAY

Registration → **home study** → referral / matching

↓

Acceptance → pre-adoption foster care → **District Magistrate order** → follow-up

4 SAFEGUARDS & OTHER ROUTES

Child status	Orphaned, abandoned or surrendered child must be declared **legally free for adoption by CWC**. Relative/step-child routes differ.
Other laws	JJ/CARA: all religions. **HAMA 1956**: separate personal-law rules. Guardians and Wards Act provides guardianship, not full adoption.
Exceptions	Relative/step-parent adoptions have specified exceptions to age and two-year marriage criteria. Eligibility still requires **child-specific suitability**.

5 PSYCHIATRIST'S ROLE

Assess	Readiness, realistic expectations, functioning, relationships, support, safeguarding and parenting capacity. **Diagnosis alone is not disqualification.**
Support	Attachment, development, behavioural concerns, adoption loss/identity and **age-appropriate disclosure**; support child and parents.

THE CHILD'S BEST INTERESTS COME FIRST

JJ Act 2015 (amended 2021) §§57–58,61; Adoption Regulations 2022 reg5; HAMA 1956.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Adoption. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-09.

Credits and references: retained within the illustration.

III - 10

A psychiatric patient is referred to you to determine if he has the capacity to make a will. What steps you will take to know his capacity to make a will and how will you report. [5+5]

5 + 5 | CRIMINAL AND CIVIL FORENSIC PSYCHIATRY | DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

1 **Clarify the referral**	Who asks, why now, and what is being disposed
4 **The steps**	In order, with the condition attached to each
3 **The report**	Six headings, and the opinion in one sentence
2 **Limits**	What the report must decline to say

STEP	WHAT IS DONE	WHO ACTS	CONDITION
1	Confirm the instruction, and explain to the patient that this is an assessment, not treatment	Psychiatrist	**No confidentiality is promised**
2	Optimise first: correct delirium, sensory impairment, sedation, pain	Treating team	Assess at his best, not his worst
3	Take history, records and collateral, including the solicitor's instructions	Psychiatrist	Beneficiaries interviewed separately
4	Test the four limbs by open question, and screen cognition	Psychiatrist, patient alone	**Record the answers verbatim**
5	Re-examine on a second occasion where the state fluctuates	Psychiatrist	As close to execution as possible

The report: identifying data and instruction; sources used; the examination and the verbatim answers; findings on each of the four limbs; the opinion with its reasoning; and the limits of that opinion.

- **The opinion.** One plain sentence saying whether, in your opinion and on the balance of probabilities, the patient had testamentary capacity at the time of examination, with the reasons that led there and the alternative you rejected.

WHAT THE REPORT DOES NOT COVER

It does not declare the will valid, does not rule on undue influence, and does not certify capacity for any other decision or any other date. Capacity is decision-specific and time-specific, and the report should say so in terms.

WHAT EARNS THE MARKS

- **Optimising the patient before testing him,** which most answers skip.
- **Verbatim recording,** because the record is what the court reads.
- **A report with named headings,** not a narrative letter.
- **The stated limits,** which is the second half of the question.

SEE ALSO Slot III - 01 testamentary capacity **SPRINT** Day 25, Mental health legislation and forensic psychiatry

WEAVE 100 · PAPER III · legacy-6.1

WEAVE 100+ / PAPER III • Q6 [4+3+3]

Aggression: assess, calm, protect

Set the stage • Treat the driver • Build and record the plan

1 — ASSESS WHILE SECURING SAFETY	
Immediate	**Call trained help**; protect others, keep exits clear. Check ABC, vitals, SpO2, glucose, attention and injury; consider delirium, hypoxia, pain, intoxication and withdrawal.
Risk	**WHAT harm • WHOM • WHEN • CIRCUMSTANCES?** Check threats, intent, means and collateral. **Historical:** past violence. **Dynamic:** agitation, substances, symptoms. **Protective:** support and engagement.
Formulate	Example: assault toward neighbour, next few hours, if they meet while agitation and perceived threat persist. Brøset supports short-term reassessment; no score guarantees prediction.

2 — SET THE STAGE: DE-ESCALATE	
Approach	**One calm speaker**; space, short sentences, listen and validate distress. Reduce noise/audience, offer choices, address needs and set respectful limits. Continue throughout.
Least restriction	**Offer oral medication** if feasible. Explain treatment; assess capacity and lawful consent/emergency authority. Aim for calm and engagement, not unconsciousness.

3 — TREAT THE DRIVER	
Cause	**Psychosis/mania:** antipsychotic plus disorder treatment. **Alcohol/benzodiazepine withdrawal:** benzodiazepine-based protocol. **Stimulant agitation:** benzodiazepine often appropriate. **Delirium:** urgently treat cause; avoid routine benzodiazepines except withdrawal.
Caution	**Alcohol/opioid/sedative intoxication:** respiratory depressants may worsen breathing. Choose by cause, prior response, physical health and medicines already given.

4 — RAPID TRANQUILLISATION / “CHEMICAL RESTRAINT”	
When	Urgent medication when oral treatment is unsuitable and serious agitation/danger persists. Not every sedative prescription is chemical restraint; intent and indication matter.
Adult examples	**IM lorazepam 2 mg OR IM haloperidol 5 mg + IM promethazine 25–50 mg**. Individualise; lower doses in frailty; separate child/pregnancy protocols.
Safety	**No ECG, cardiac disease or prolonged QT**: avoid haloperidol–promethazine (NICE). Lorazepam only if respiratory status permits. **Avoid concomitant IM olanzapine and parenteral benzodiazepines**. Review response and cumulative dose before repeating; no injection stacking. Resuscitation equipment ready.

5 — PHYSICAL RESTRAINT: MHCA 2017 §97	
Legal threshold	**Only means to prevent imminent, immediate harm**; **psychiatrist-in-charge authorises**. Shortest necessary duration. Never punishment, deterrence or a response to staff shortage.
Safe use	**Trained team only**; protect airway, breathing, circulation and dignity. Avoid prone restraint; no neck/chest/abdominal pressure. Ongoing direct supervision; check vitals, limbs and distress; release as soon as safe. No chains.
Legal record	Immediately record reason, alternatives, method and duration. Inform nominated representative **within 24 h** of EVERY episode; **monthly report** to Mental Health Review Board.

6 — MONITOR, REVIEW, PREVENT	
Monitor	After IM treatment: consciousness, respiratory rate, SpO2, pulse, BP, temperature and hydration. At least hourly (NICE); **every 15 min** if sedated/asleep, intoxicated, physically unwell, harmed during restriction or maximum dose exceeded. More frequent monitoring if unstable; urgent medical response for deterioration.
Plan	**Reassess risk**, check injuries, debrief patient/staff when calm. Record drugs/times/response and adverse effects. Treat underlying illness; document triggers, early warnings, protective measures, named responsibilities and review date.

INDIA: SECLUSION / SOLITARY CONFINEMENT IS PROHIBITED.

A voluntarily used quiet room is different. MHCA 2017 §§95,97.

Adult clinician revision • Individualise doses; follow local protocols. Sources: IPS 2023; NICE NG10; MHCA 2017.

6.1 • Updated 19 September 2026 • Adult dose examples are not a universal prescribing protocol.

Aggression assessment and management. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Criminal and civil forensic psychiatry.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Narcoanalysis, polygraph and BEAP

Investigative techniques are not reliable substitutes for proof.

Domain	Revision points
Narcoanalysis	Drug-facilitated interview may increase suggestibility and confabulation; it is not a truth serum.
Polygraph	Records physiological arousal; arousal is not specific to deception.
BEAP / brain mapping	Physiological recognition-related responses do not independently prove guilt or the full event.
Selvi (2010)	Involuntary administration violates constitutional protections. Consent and safeguards matter for voluntary testing.
Evidence distinction	Test responses are not simply admissible confessions; subsequently discovered material has a separate legal analysis.

CLINICAL ETHICS

Assess coercion, consent, medical risk and confidentiality; do not promise scientific certainty.

COURT ROLE

Separate the person's medical fitness from the legality, reliability and admissibility of the procedure.

Supreme Court: Selvi v State of Karnataka (5 May 2010); Weave Sprint day 25.

Narcoanalysis, polygraph and BEAP. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Criminal and civil forensic psychiatry.

Credits and references: retained within the illustration.

AREA 02 OF 13 · P3-A02

Intellectual disability and learning disorders

10	10.9%	III-11	III-20
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

ANCHOR 1 SINGLE 9

REVISION ORDER

Definition and classification first: five of the ten slots open with them. Certification and IDEAS next, because they repeat verbatim in the legislation area. The named syndromes and the test list last.

WHAT IS IN THIS AREA

Definition and classification of intellectual disability (three slots), disability certification and its regulations (two), specific learning disorder and scholastic backwardness, the intelligence tests used in India, Fragile X, and stereotypic movement disorder.

III - 11

Fragile X syndrome. [10]

10 INTELLECTUAL DISABILITY AND LEARNING DISORDERS

KNRUHS, NTRUHS, RGUHS - 4 APPEARANCES, 4 OF 78 SESSIONS

SKELETON

2	The genetics	Gene, repeat, methylation, and the protein lost
2	Physical phenotype	Face, ears, jaw, testes, joints, valve
4	Behaviour and cognition	The named cluster, and the autism overlap
2	Diagnosis and care	The right test, then what actually helps the family

THE DEFINITION

The commonest inherited cause of intellectual disability, and the commonest single-gene cause of autism. An expanded CGG repeat in the FMR1 gene on the long arm of the X chromosome silences the gene by methylation once the full mutation is reached. Loss of its protein removes a brake on synaptic signalling, leaving long thin immature dendritic spines.

DOMAIN	FULL MUTATION, MALE	FEMALE AND PREMUTATION	WHAT SETTLES IT
Repeat size	Over 200 repeats, methylated, gene silent	55 to 200 is a premutation, gene still active	Repeat sizing, not a karyotype
Face and body	Long face, large ears, prominent jaw; after puberty large testes and lax joints	Milder or absent, by X inactivation	Suggestive only
Cognition	Mild to moderate disability, verbal better than visuospatial	Learning difficulty or normal range	Variable, so test the gene
Carrier illness	Not applicable	Tremor and ataxia in older men, early ovarian failure in women	Premutation, not full mutation

Amber cells are the two facts that decide the answer: size the repeat, and keep premutation illness separate from the syndrome itself.

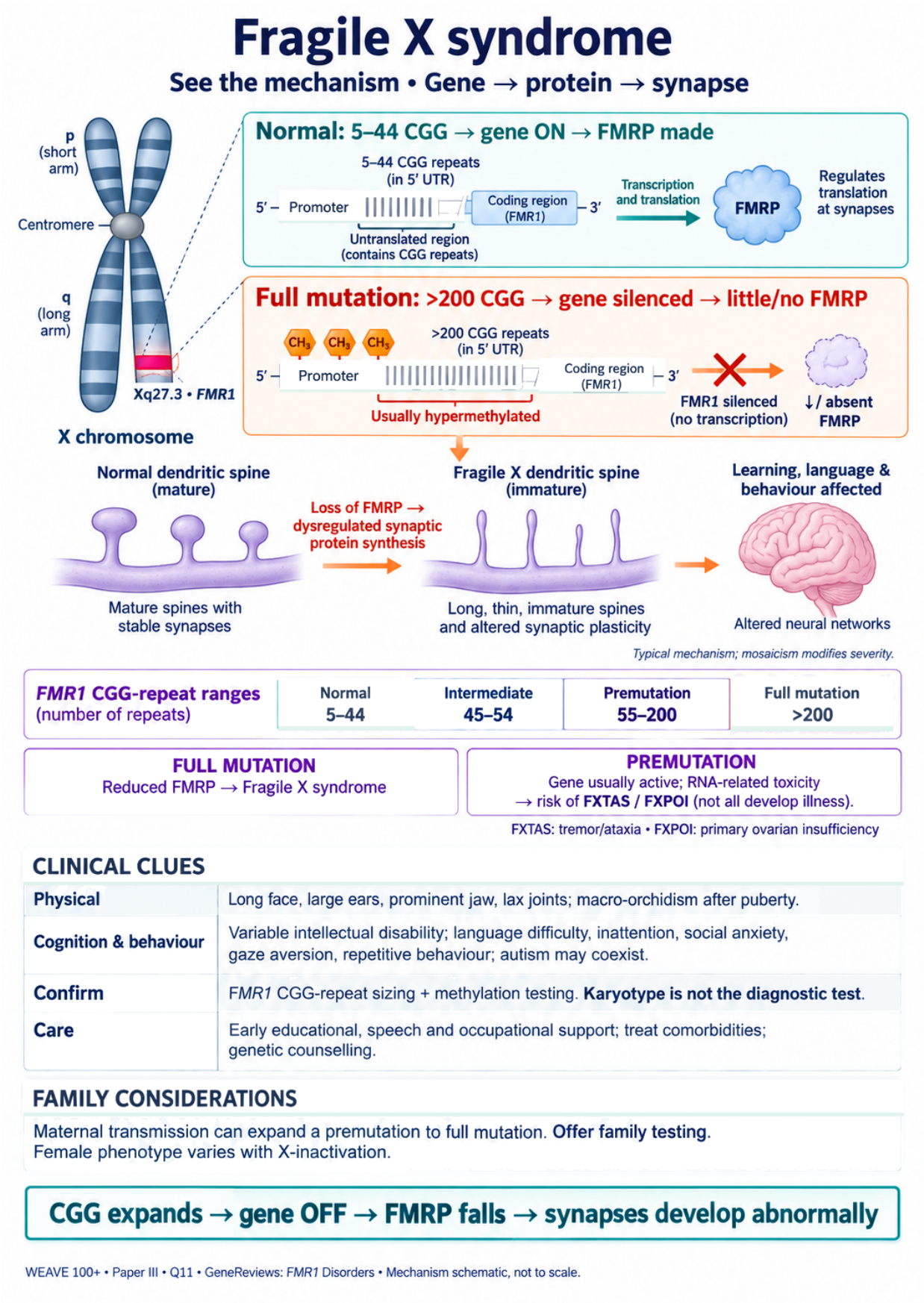
- **The behavioural cluster.** Gaze aversion with social interest preserved, hand flapping and hand biting, shyness and social anxiety, hyperactivity and inattention, perseverative repetitive speech, sensory hyperarousal and tantrums on change. Autism is diagnosed in a substantial minority.
- **Diagnosis and management.** Order FMR1 repeat testing, not a karyotype. No treatment corrects the defect. Early intervention, speech and occupational therapy, a stimulant for inattention and a serotonin reuptake inhibitor for anxiety, plus predictable low-stimulus routines.
- **The family, not just the child.** Anticipation runs through the transmitting mother, so counsel and offer cascade testing. Certify under the Rights of Persons with Disabilities Act 2016 once intellectual disability is established.

WHAT EARNS THE MARKS

- **Gene, repeat threshold and methylation in one line.** Saying X-linked without the repeat is a half mark.
- **The premutation row.** Tremor ataxia and ovarian failure belong to carriers, and most answers never separate them.
- **Repeat testing named as the test.** Ordering a karyotype is the classic wrong answer here.

SEE ALSO Slot III - 12 aetiology of intellectual disability Slot III - 89 clinical features of autism

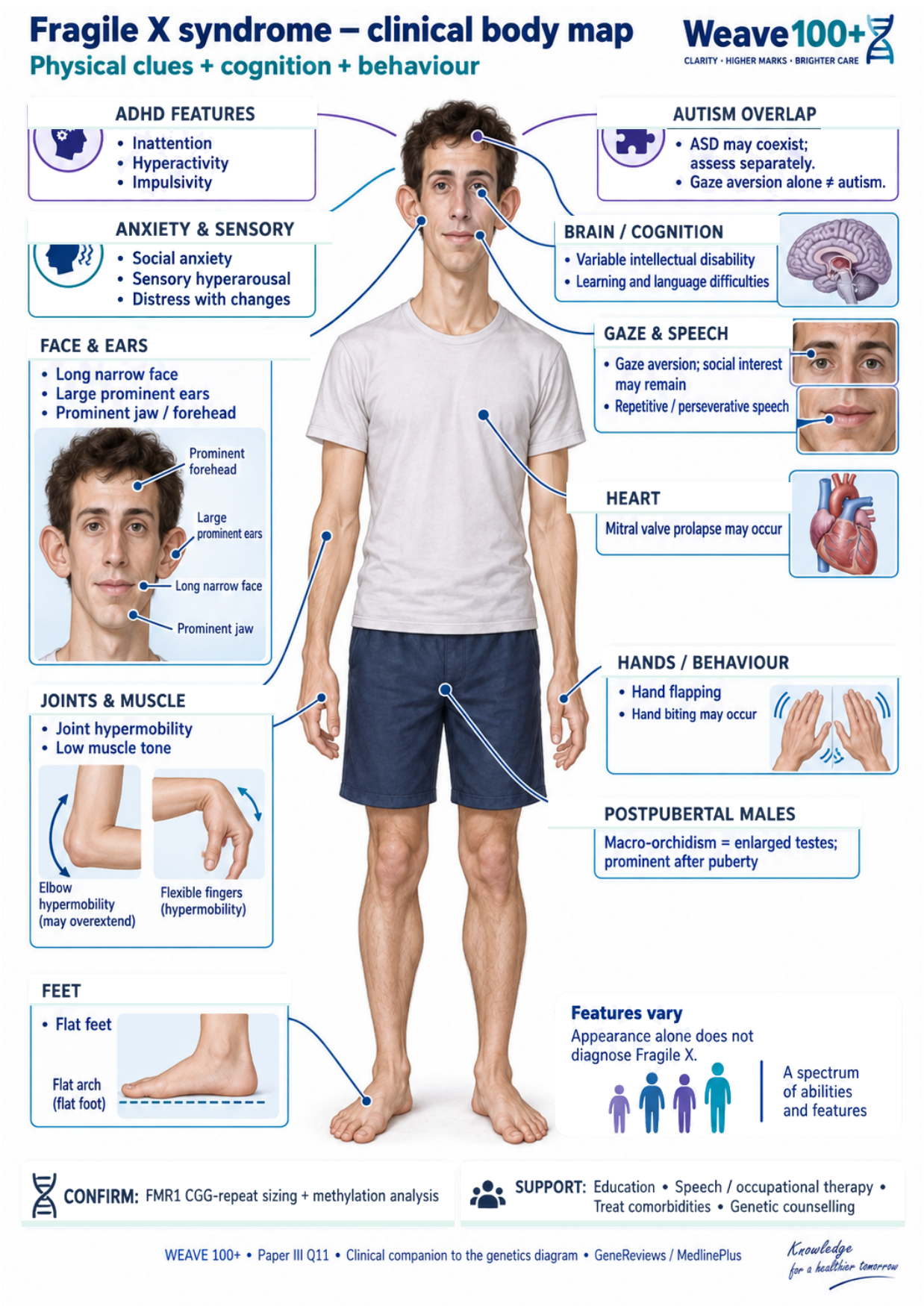
WEAVE 100 · PAPER III · legacy-11.1



Fragile X syndrome. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-11.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · legacy-11.2



Fragile X clinical body map. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-11.

Credits and references: retained within the illustration.

III - 12

Provide classification of Intellectual disability (Mental retardation) based on etiology. [10]

10 INTELLECTUAL DISABILITY AND LEARNING DISORDERS

KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

1	The axis	State it: when the insult acted, not how severe
4	Prenatal	Genetic and acquired kept apart, with examples
3	Perinatal and postnatal	In order, and which of them India can prevent
2	Honest limits	Severity is a second axis; many causes go unfound

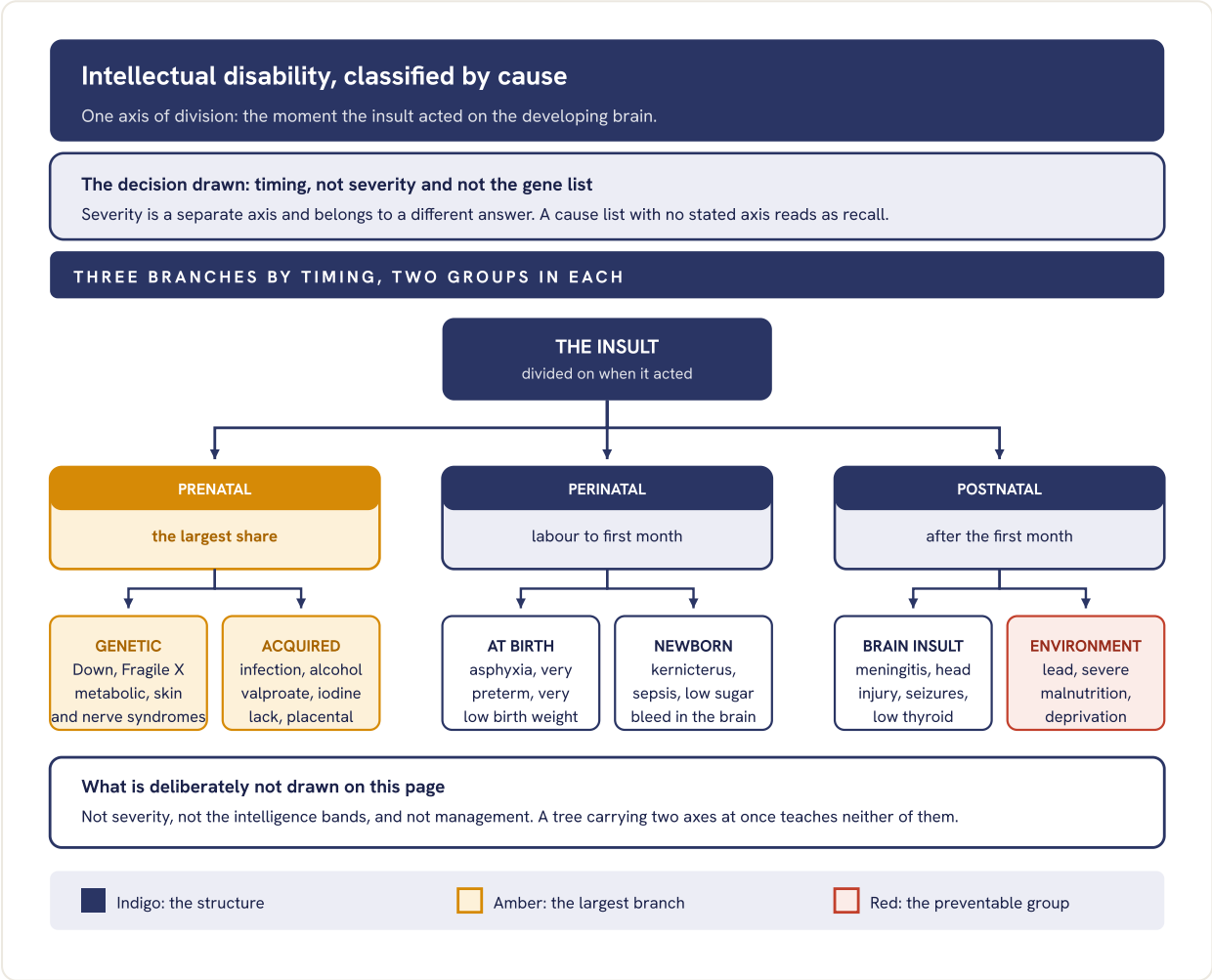


Fig 012.1 Aetiology divided on the timing of the insult, with a genetic and an acquired group inside each branch. The red chip marks the causes public health can remove.

- **What India can prevent.** Iodine fortification, rubella immunisation, folic acid, anaemia and nutrition programmes, skilled birth attendance and newborn resuscitation, newborn screening for low thyroid, lead control, and deworming. Newborn and early childhood screening runs through the national child health screening programme.
- **The honest limit.** No cause is found in roughly a third to a half of cases, and the yield falls further as severity falls. Chromosomal microarray and exome sequencing raise it, but neither is routinely available across Indian districts.

WHAT EARNS THE MARKS

- **The axis stated in one line before the tree.** Timing, and only timing.
- **Genetic separated from acquired inside the prenatal branch.** Merging them is the commonest structural loss.
- **Every branch of the plate reproduced,** with at least two named examples in each.
- **The unfound-cause line.** It reads as command of the field rather than a memorised list.

SEE ALSO Slot III - 11 Fragile X syndrome Slot III - 14 definition and certification

Slot III - 16 neurodevelopmental disorders and prevention

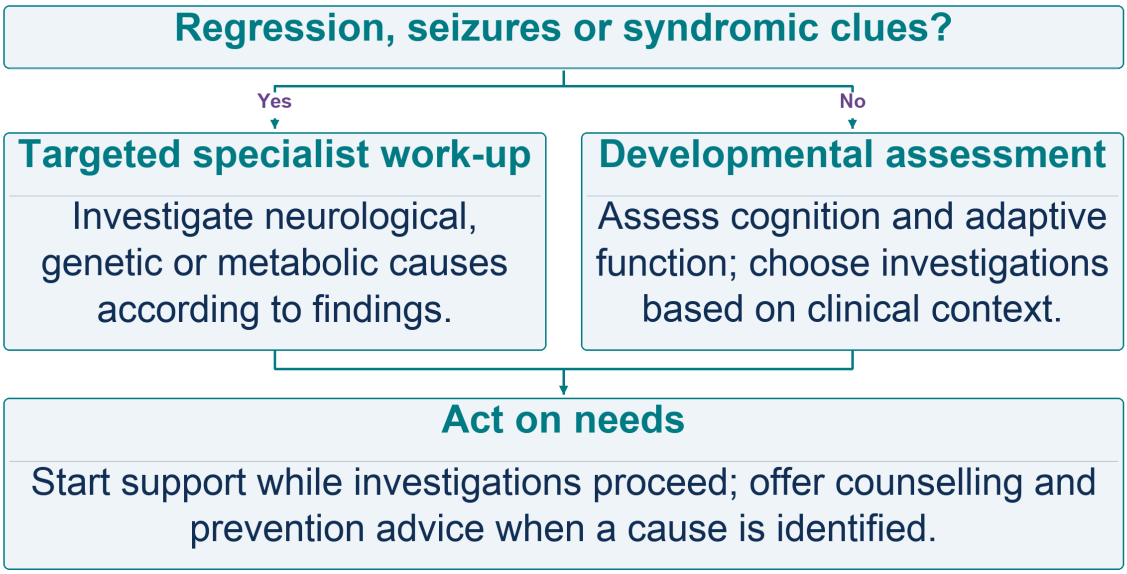
WEAVE 100+ / PAPER III

Intellectual disability: causes and work-up

Organise causes by timing; tailor tests to the clinical phenotype.

Domain	Revision points
Prenatal	Genetic/ chromosomal conditions, metabolic disorders, infections, teratogens and fetal exposures.
Perinatal	Prematurity and significant hypoxic/ ischaemic or other birth-related injury.
Postnatal	CNS infection, trauma, toxic exposure, severe malnutrition and other acquired brain insults.
History/ examination	Developmental trajectory, regression, family history, dysmorphology, growth, neurological signs, hearing and vision.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 12.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Intellectual disability: causes and work-up. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-12.

Credits and references: retained within the illustration.

III - 13

Enumerate common disability certifications in psychiatry. Discuss existing certification regulations. How to assess specific learning disability (SLD)? What are the assistance provided by the Government for a SLD patient? [2+4+2+2]

2 + 4 + 2 + 2 | INTELLECTUAL DISABILITY AND LEARNING DISORDERS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	What is certifiable	The psychiatry entries in the schedule, named
4	The route	Who applies, who assesses, which scale, how long
2	Assessing learning disability	Exclusions first, then the index and the age rule
2	What the child gets	Exam provisions, reservation, schemes

- **Certifiable in psychiatry.** Of the twenty-one disabilities specified by the Rights of Persons with Disabilities Act 2016, five are ours: mental illness, intellectual disability, specific learning disabilities, autism spectrum disorder, chronic neurological conditions.
- **The instrument decides the number.** Mental illness scores on the Indian Disability Evaluation and Assessment Scale; intellectual disability on an intelligence test with an adaptive scale; learning disability on the NIMHANS Index. Benchmark disability begins at forty percent.

STEP	WHAT HAPPENS	WHO ACTS	CONDITION OR INTERVAL
1	Application with identity and address proof	Parent or guardian, on the national disability identity portal	Any time after the assessable age
2	Assessment against the 2018 gazette guidelines	Notified medical authority, as a board	Board must include the relevant specialist
3	Scoring on the prescribed instrument	Psychiatrist, clinical psychologist, special educator	**Percentage, not a diagnosis alone**
4	Certificate and identity card issued; appeal lies against the percentage	Certifying authority, then the district appellate authority	**Permanent if the condition is; otherwise reassessed**

WHAT THE ACT DOES NOT COVER

A certificate is an entitlement document, not a diagnosis and not a treatment order: rights to care come from the Mental Healthcare Act 2017 instead. Learning disability is not certified before about eight years and the third class, because the achievement gap cannot be measured earlier, and no certificate waives a course's core competency requirement.

WHAT EARNS THE MARKS

- **Five psychiatry entries named from the schedule,** not a general statement that mental illness is covered.
- **One instrument tied to each condition.** The scale is what turns a diagnosis into a percentage.
- **Steps in order with the actor at each one,** and the forty percent threshold stated.
- **The exclusions strip.** The age and class rule for learning disability is the line most answers miss.

SEE ALSO Slot III - 14 certification in intellectual disability Slot III - 18 assessment of specific learning disorder

SPRINT Day 25, Mental health legislation and forensic psychiatry

WEAVE 100+ / PAPER III • 13.1

Disability certification in psychiatry

LEGAL ACTS APPENDIX • III Q13 • categories, regulations, SLD assessment and support

1 COMMON CATEGORIES → ASSESSMENT

Mental illness	Clinical assessment + **IDEAS**.
Intellectual disability	Intellectual testing + adaptive functioning; 2024 **disability percentage uses VSMS**.
Specific learning disability	Clinical / intellectual assessment + **NIMHANS or GLAD** battery.
Autism	Clinical diagnosis (AIIMS-modified INCLEN in 2024); **ISAA** disability rating with age-specific rules.
Chronic neurological	Relevant specialist + condition-specific functional assessment.

2 REGULATIONS & CERTIFICATION ROUTE

Framework	**RPwD Act 2016**; Gazette assessment rules **12 March 2024** supersede 2018.
Apply / assess	Person, parent or eligible representative applies through **UDID**. Notified medical authority assesses with prescribed tools.
Rate / issue	Record disability %, issue certificate + UDID; permanent or time-limited **as prescribed**. Review when due; appeal under §59.
Threshold	**≥40% = benchmark disability**. Below 40% does not exclude all rights or certification.

3 SLD: ASSESS IN ORDER

School concerns → developmental, educational and language history

↓

Clinical / neurological, hearing and vision assessment → psychiatric mimics / comorbidity

↓

Intellectual assessment → **NIMHANS / GLAD** → domain profile and support plan

4 SLD CERTIFICATION: 2024 DETAILS

Differentiate	Check adequate learning opportunity; exclude sensory, neurological and global intellectual explanations. **IQ ≥85** is a certification criterion here.
Age / review	Screen at **8 years or Class III, whichever earlier**; certify age **≥8**. Reassess Class X / XII if required; certificate issued at **≥18 is lifelong**.

5 ASSISTANCE & RIGHTS

Education	Benchmark disability: **free education 6–18**; ≥5% seats in government/aided higher education.
Accommodations	Extra time, scribe/assistive support when eligible; **board-specific rules**, not automatic waiver of essential competencies.
Other support	Scholarships, rehabilitation and other schemes: category, income and eligibility rules apply.

DIAGNOSIS ≠ DISABILITY % • CERTIFICATION ≠ TREATMENT ORDER

RPwD Act 2016; Gazette 12 Mar 2024 §§21–23; autism assessment guidelines 2016. VSMS: Vineland Social Maturity Scale.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Disability certification in psychiatry. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-13.

Credits and references: retained within the illustration.

III - 14

Define intellectual disability and give its classification. Discuss disability certification in intellectual disability and the benefits being provided by the Government of India. [1+3+3+3]

1 + 3 + 3 + 3 | INTELLECTUAL DISABILITY AND LEARNING DISORDERS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

1	Definition	Three criteria, and the domain word that carries them
3	Classification	Four grades set by adaptive function, tests named
3	Certification	The steps, in order, with actor and interval
3	Benefits	Money, guardianship, education, employment

- **Definition, three criteria.** Deficits in intellectual function on testing; deficits in adaptive function across the conceptual, social and practical domains; onset in the developmental period. The domain triad is the part most answers drop.
- **Classification.** Mild, moderate, severe and profound, graded on adaptive function rather than the intelligence quotient alone. Indian tests: Binet Kamat, Malin's Intelligence Scale for Indian Children, Seguin Form Board, and the Vineland Social Maturity Scale for social age.

STEP	WHAT HAPPENS	WHO ACTS	CONDITION OR INTERVAL
1	Application on the national disability identity portal	Parent or legal guardian	From about three years, once testing is valid
2	Intelligence testing with an adaptive behaviour scale	Clinical psychologist	**Both, never intelligence alone**
3	Medical board assessment against the 2018 guidelines	Notified medical authority	Percentage recorded on the certificate
4	Certificate and identity card issued; guardianship applied for where capacity is absent	Certifying authority, then the local level committee	**Permanent, since the condition is lifelong**

Benefits follow at forty percent: disability pension, income tax relief under Sections 80DD and 80U, National Trust health insurance, four percent of government posts, five percent of higher education seats, aids, scholarships, travel concession.

WHAT THE ACT DOES NOT COVER

Intellectual disability is not a mental illness under the Mental Healthcare Act 2017 unless a mental illness coexists, so that Act's admission machinery does not follow from this certificate. Guardianship is not a nominated representative, and a percentage is not a capacity finding.

WHAT EARNS THE MARKS

- **All three definition criteria, with the three adaptive domains named.**
- **Grading tied to adaptive function,** with at least two Indian tests named.
- **Steps in order with the actor at each,** and the forty percent threshold before any benefit is listed.
- **The exclusions strip.** Separating the two Acts is what marks a top answer here.

SEE ALSO Slot III - 13 disability certification in psychiatry Slot III - 15 severity grades and pension schemes Slot III - 17 diagnosis and psychosocial management

WEAVE 100+ / PAPER III / Q14

Intellectual disability

Definition • Classification • Certification • Government benefits | 1 + 3 + 3 + 3 marks

1 DEFINITION Significant deficits in intellectual functioning AND adaptive functioning, beginning during the developmental period.

Adaptive domains: conceptual (language, learning) • social (judgment, relationships) • practical (daily living, self-management).

2 CLASSIFICATION | 3 marks

DSM-5-TR: adaptive functioning

Mild, moderate, severe and profound. Severity reflects everyday functioning and support needs, not IQ alone.

Severity	Typical support profile*
Mild	Support for complex daily tasks
Moderate	Regular help with daily activities
Severe	Extensive support in daily life
Profound	Pervasive support for care and safety

*Illustrative profiles, not stand-alone diagnostic criteria; assess all three adaptive domains across settings.

ICD-10: historical IQ classification

Category	IQ band
F70 Mild	50–69
F71 Moderate	35–49
F72 Severe	20–34
F73 Profound	<20

IQ: know what the number means

Traditional ratio IQ = (mental age ÷ chronological age) × 100. Modern tests usually report age-normed scores.

IQ score ≠ disability percentage.

ICD-11: disorders of intellectual development; assess intellectual and adaptive functioning with developmental onset.

Poor schooling or specific learning disability alone does not establish intellectual disability.

3 CERTIFICATION | 3 marks

India: 2024 notified assessment rules

History + developmental/clinical assessment → screen hearing, vision, epilepsy and other comorbidities → psychological testing.

Intellectual tests: Binet–Kamat (BKT), MISIC or other prescribed tests. Adaptive assessment: Vineland Social Maturity Scale (VSMS).

VSMS score → disability percentage

Category	VSMS	Disability
Mild	55–69	50%
Moderate	36–54	75%
Severe	21–35	90%
Profound	0–20	100%

Separate borderline band: VSMS 70–84 → 25%. It is not a fifth DSM-5-TR ID severity level.

Notified medical board → certificate + UDID

Chair: Medical Superintendent / CMO / Civil Surgeon / notified equivalent. Members: paediatric specialist (physician for age >18), psychiatrist, clinical or rehabilitation psychologist.

Age and validity: do not write "always permanent"

Age / degree	Certification or review
≥1 year	Minimum completed age
<5 years	Temporary GDD; valid to age 5
After age 5: <80%	Renew at ages 10 and 18
After age 5: ≥80%	Reassess at age 18
Issued at ≥18	Valid lifelong

4 BENEFITS | 3 marks

≥40% = benchmark disability. Each benefit has its own eligibility rules; certification does not automatically confer every benefit.

Education | RPwD Act §§31–32

Free education at ages 6–18 for children with benchmark disability. At least 5% seats in government / government-aided higher education.

Employment | RPwD Act §§33–34

At least 4% overall reservation in government jobs. ID shares the 1% allocation for clauses (d) + (e); eligibility depends on identified posts and applicable rules.

Pension | IGNDPS

Central scheme: BPL, age 18–79, severe / multiple disability with ≥80% disability. State pension rules and additional amounts vary.

Tax deductions | exam + current numbering

1961 Act: 80DD = eligible dependent; 80U = self. Old regime: Rs 75,000; severe disability (≥80%): Rs 1,25,000. Not both for the same person's disability.

From 1 April 2026: 2025 Act §§127 (dependent) and 154 (self). Earlier tax years retain 1961 Act rules; tax-regime restrictions still apply.

Niramaya | National Trust

Health cover up to Rs 1 lakh, reimbursement basis, with sublimits. Eligible National Trust disabilities require a valid disability certificate + UDID card / enrolment number.

Services and guardianship

National Trust services include early intervention, day care and residential / respite support, subject to scheme rules. Guardianship through the Local Level Committee when required.

Diagnosis ≠ disability % ≠ incapacity. A certificate does not automatically create guardianship.

Sources: DSM-5-TR; WHO ICD-10; Gazette 12 Mar 2024 §21; RPwD Act 2016 §§31–34; National Trust; NSAP / PIB; CBDT.

Q14.1 • Verified 19 Sep 2026 • GDD: global developmental delay • UDID: Unique Disability ID • Source links: accompanying SOURCES.md

Intellectual disability: classification, certification and benefits. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-14.

Credits and references: retained within the illustration.

III - 15

Define intellectual disability according to DSM-5. Compare various degrees of severity of intellectual disability. What are the various benefits and pension schemes for persons with intellectual disability in India? [1+5+4]

1 + 5 + 4 | INTELLECTUAL DISABILITY AND LEARNING DISORDERS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

1 Definition	Three criteria, then name the axis of grading
5 The grid	Four grades across the three adaptive domains
2 Pension and insurance	The named schemes, with the qualifying threshold
2 Other benefits	Tax, reservation, education, aids, travel

THE DEFINITION

Onset in the developmental period, with deficits in intellectual function on clinical assessment and standardised testing, together with deficits in adaptive function limiting independence across the conceptual, social and practical domains. Severity is set by adaptive function, not by the intelligence quotient.

GRADE	CONCEPTUAL	SOCIAL AND PRACTICAL	WHAT SETTLES IT
Mild	Academic difficulty from school age; abstract thinking, money and time weak	Immature judgment, easily led; self-care intact, needs help with complex tasks	Lives independently with intermittent support
Moderate	Primary school academics at best; slow acquisition throughout	Simple spoken language; self-care learned with long teaching and reminders	Needs daily prompting; supervised unskilled work
Severe	Little grasp of written language, number, quantity or time	Single words and phrases; supported for every daily activity	Supervision at all times
Profound	Understanding is of the physical world; may match and sort objects	Very limited symbolic communication; motor and sensory impairment common	Dependent for all personal care

Amber cells are the support statements. Grading on support need rather than on a test score is the change from the earlier manuals, and saying so is itself a mark.

- **Pension and insurance.** Benefits begin at forty percent. The national social assistance disability pension covers adults below the poverty line, with state pensions alongside. National Trust insurance covers intellectual disability, autism, cerebral palsy and multiple disability.
- **The rest of the package.** Tax relief under Sections 80DD and 80U, four percent of government posts and five percent of higher education seats, scholarships, aids and appliances, travel concession, and guardianship through the local level committee.

WHAT EARNS THE MARKS

- **A grid, not four paragraphs.** The comparison has to be readable across a row.
- **Adaptive function named as the grading axis** before the grid begins.
- **The forty percent threshold stated once,** before any scheme is listed.
- **Schemes named,** not described as government help in general terms.

SEE ALSO Slot III - 14 definition and certification Slot III - 17 diagnosis and psychosocial management

III - 16

a) What are the neurodevelopment disorders in children? b) What are the preventive measures of neurodevelopment disorders? c) Discuss schizophrenia as a neurodevelopment disorder. [2+3+5]

2 + 3 + 5 | INTELLECTUAL DISABILITY AND LEARNING DISORDERS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	The six families	Named as a group, with the shared feature stated
3	Prevention	Primary, secondary, tertiary, with Indian programmes
3	The evidence	Obstetric, premorbid, structural, genetic
2	The model and its limit	Two hits, and what the model does not explain

FAMILY	MEMBERS	CORE DEFICIT
Intellectual	Intellectual disability, global developmental delay	Reasoning and adaptive function
Communication	Language, speech sound, fluency, social pragmatic	Producing or using language
Autism spectrum	One category, severity graded on support	**Social communication plus repetitive behaviour**
Attention deficit	Inattentive, hyperactive impulsive, combined	Regulating attention and activity
Specific learning	Reading, written expression, mathematics	**One skill, intelligence in range**
Motor	Coordination, stereotypic movement, tic disorders	Acquiring or controlling movement

- **Prevention in three tiers.** Primary: folic acid, salt iodisation, rubella immunisation, no alcohol or valproate in pregnancy, nutrition programmes, genetic counselling, skilled birth attendance. Secondary: newborn thyroid screening, national child health screening, developmental surveillance. Tertiary: early intervention, remediation, inclusive schooling.

SCHIZOPHRENIA AS A NEURODEVELOPMENTAL DISORDER

Four lines of evidence. Obstetric complications, prenatal famine and prenatal infection raise risk. Premorbid milestone delay, lower childhood intelligence and poor social adjustment precede onset by years. Ventricular enlargement is present at first episode, with disordered cytoarchitecture and no gliosis, so a developmental lesion and not a degenerative one. Risk genes overlap with autism, and excessive adolescent pruning supplies the second hit.

- **What the model does not explain.** Why onset waits for late adolescence in most cases, why some patients have no premorbid abnormality at all, and why the illness can progress after onset. Say this, and the answer reads as understanding rather than recall.

WHAT EARNS THE MARKS

- **Six families, one member each, and the shared feature stated:** a deficit in acquiring a function, never in losing one.
- **Prevention split into three tiers,** with named Indian programmes rather than general advice.
- **Four separate lines of evidence for the schizophrenia part,** then the limit of the model.

SEE ALSO Slot III - 12 aetiology of intellectual disability

Slot III - 55 neurobiology of attention deficit hyperactivity disorder

WEAVE 100+ / PAPER III

Neurodevelopment and prevention

Early vulnerability interacts with development and later exposures.

Domain	Revision points
Disorder families	Intellectual, communication, autism, attention, learning and motor-development conditions.
Before/ during pregnancy	Genetic counselling when indicated, maternal health, nutrition, infection prevention and avoidance of harmful exposures.
Infancy/ childhood	Safe perinatal care, screening, sensory correction, early intervention, education and protection from adversity.
Schizophrenia model	Genetic liability and early developmental influences may interact with adolescent maturation and later stressors.

MODEL LIMIT

A neurodevelopmental model does not imply every exposed child develops schizophrenia or that every case has a visible childhood abnormality.

PREVENTION

Reduce avoidable risks and improve functioning; do not promise prevention of all neurodevelopmental disorders.

Weave Sprint Paper III; see source register

III 16.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Neurodevelopment and prevention. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-16.

Credits and references: retained within the illustration.

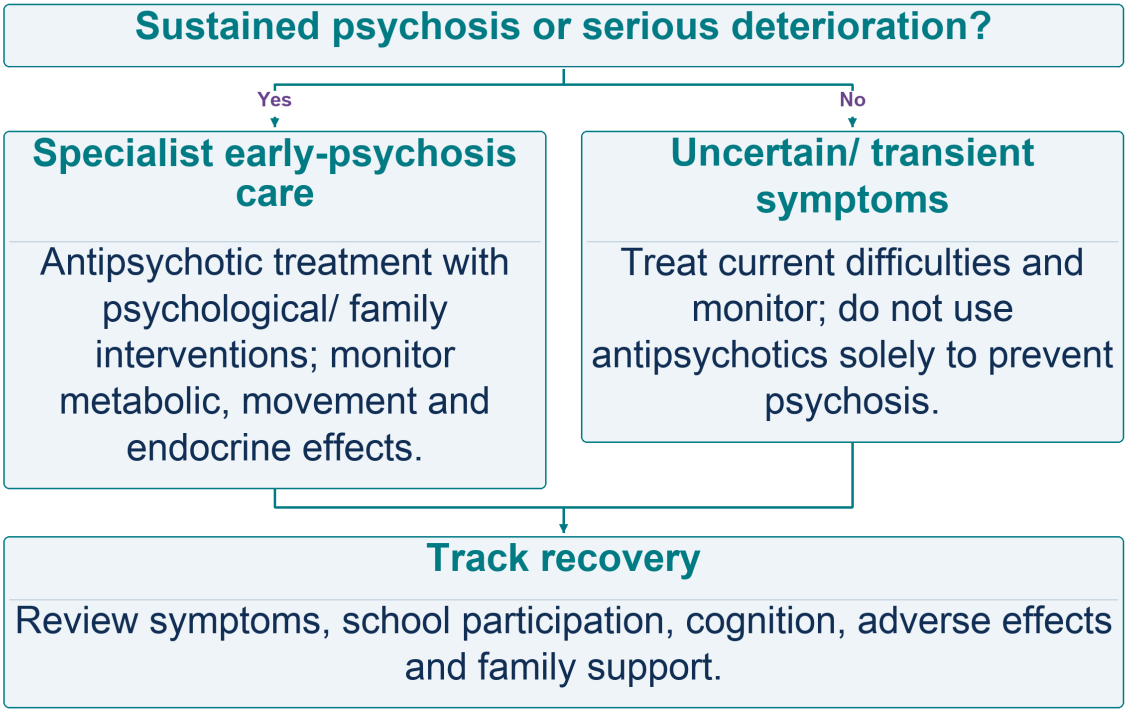
WEAVE 100+ / PAPER III

Childhood-onset schizophrenia

A longitudinal developmental assessment comes before the label.

Domain	Revision points
Phenomenology	Persistent psychotic symptoms with deterioration; distinguish fantasy and developmentally typical experiences.
Differential	Mood disorder, autism, trauma/ dissociation, substances, epilepsy and other medical causes.
Assessment	Child and caregiver interviews, school trajectory, neurological examination, risk and targeted investigations.

DECISION PATHWAY



Weave Sprint child psychiatry; NICE CG155 recommendations.

III 16.3 • Supplement • Source links and qualifications: SOURCES.md

Childhood-onset schizophrenia. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-16.

Credits and references: retained within the illustration.

III - 17

a) How to diagnose Mental retardation? b) Enumerate any four intelligence tests used commonly for child and adolescent. c) What are the principles for psycho social management of persons with intellectual disability? d) What are the benefits offered by Government of India for person with intellectual disability? [2+2+4+2]

2 + 2 + 4 + 2 | INTELLECTUAL DISABILITY AND LEARNING DISORDERS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	**Making the diagnosis**	Three criteria, then the workup that finds the cause
2	**Four tests**	Named, with the age band each covers
4	**Psychosocial principles**	The flowchart: assess, teach, shape, protect
2	**Government benefits**	The threshold, then the named schemes

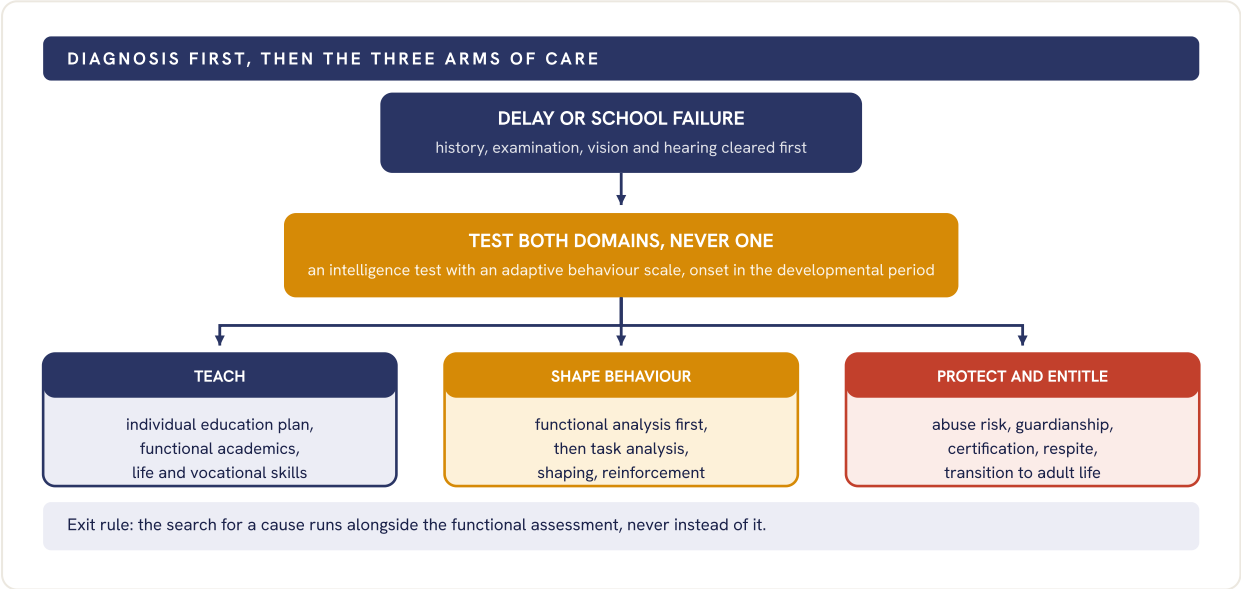


Fig 017.1 Diagnosis made on both domains together, then the three arms of psychosocial care, with the search for a cause carried along the foot.

- **Four tests, with their range.** Binet Kamat, three years upward; Malin's Intelligence Scale for Indian Children, six to fifteen; Wechsler Intelligence Scale for Children, Indian adaptation; Seguin Form Board for younger and non-verbal children. Adaptive function is rated separately, commonly on the Vineland Social Maturity Scale.
- **Benefits, at forty percent.** Disability pension, National Trust insurance and guardianship, tax relief under Sections 80DD and 80U, four percent of posts, five percent of seats, aids, travel concession.

WHAT EARNS THE MARKS

- **Both domains tested, written as the diagnostic step.** Resting on the intelligence quotient alone loses here.
- **Four tests named with their age bands,** the adaptive scale kept separate.
- **Functional analysis before any behavioural technique,** and the forty percent threshold before the benefits.

SEE ALSO Slot III - 14 definition and certification Slot III - 15 severity grades and pension schemes

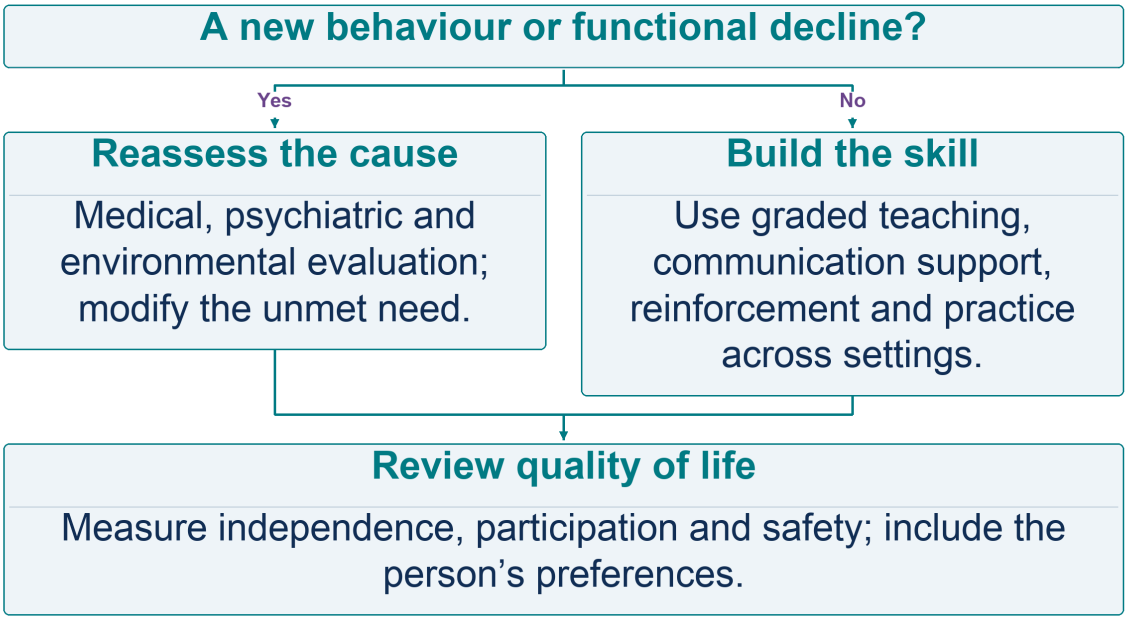
WEAVE 100+ / PAPER III

Intellectual disability: psychosocial care

Support function and participation throughout life.

Domain	Revision points
Early intervention	Communication, play, motor and adaptive skills; include hearing/ vision and family needs.
Education	Individualised goals, accessible teaching, school accommodations and supported inclusion.
Behaviour	Look for pain, communication barriers, environmental demands and mental illness before labelling behaviour.
Adulthood	Daily living, relationships, supported employment, decision support and caregiver respite.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 17.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Intellectual disability: psychosocial care. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-17.

Credits and references: retained within the illustration.

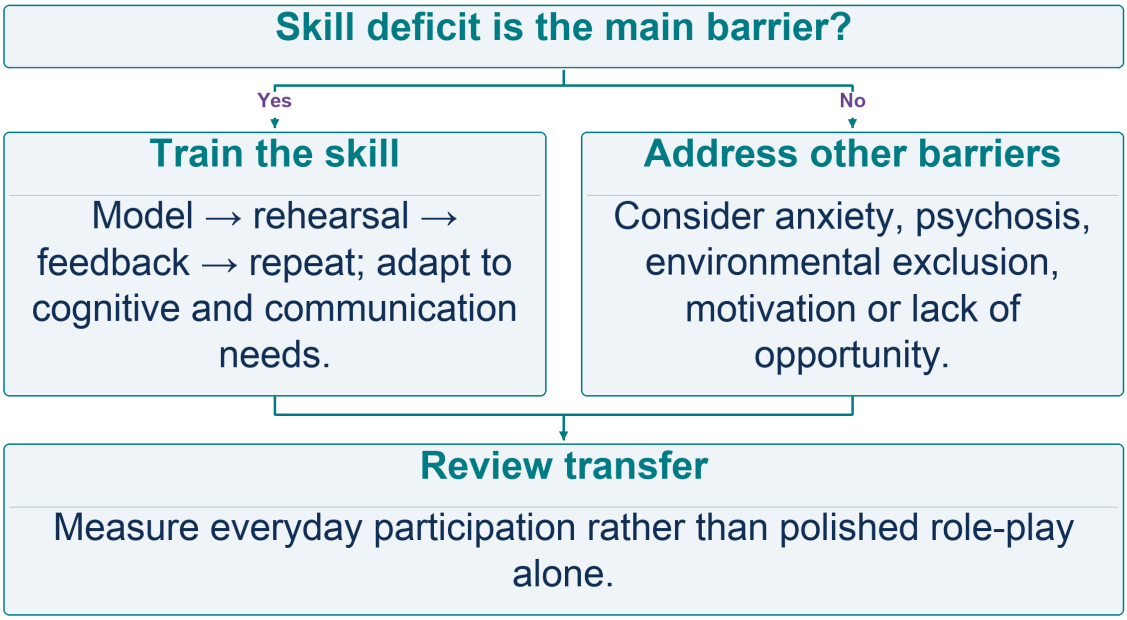
WEAVE 100+ / PAPER III

Social skills training

Teach a specific interpersonal skill through practice and feedback.

Domain	Revision points
Choose a target	A meaningful situation: greeting, requesting help, assertiveness or resolving a disagreement.
Model	Demonstrate the skill and explain its observable components.
Rehearse	Role-play with graded difficulty; give specific positive and corrective feedback.
Generalise	Practise in real settings, review barriers and reinforce successful use.

DECISION PATHWAY



SCOPE

Selection is diagnosis- and goal-specific; do not assume routine social skills training is recommended for every psychotic disorder.

Weave Sprint Paper III; see source register

III 17.3 • Supplement • Source links and qualifications: SOURCES.md

Social skills training. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-17.

Credits and references: retained within the illustration.

III - 18

Enumerate the causes of Scholastic backwardness. Discuss in detail about the epidemiology, clinical features, assessment and management of Specific Learning Disorder. [10]

10 | ASKED AT 15 MARKS | INTELLECTUAL DISABILITY AND LEARNING DISORDERS

TN-MGRMU - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

3	Causes of backwardness	Six groups, each with the clue that points to it
2	Epidemiology and features	Prevalence range, the three types, what travels with them
3	Assessment	Exclude, then test, then the Indian index
2	Management	Remediate, accommodate, certify, treat what coexists

GROUP	CAUSES	THE CLUE THAT POINTS THERE
Cognitive	Intellectual disability, learning disorder, borderline intelligence	All subjects, or only one
Sensory and medical	Vision, hearing, epilepsy, sedating drugs, anaemia, worms	Copying, repetition, drowsiness
Mind and mood	Attention deficit, autism, depression, anxiety, bullying, substance use	A dated fall in the record
Home and school	Poverty, labour, migration, violence; teaching, class size, language	The whole class fails

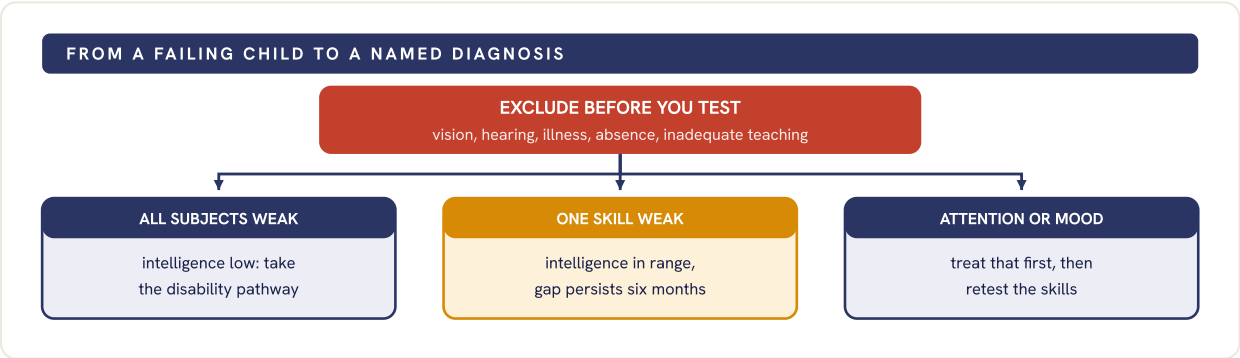


Fig 018.1 Exclusion first, then the three profiles a failing child resolves into. Only the amber lane is a learning disorder.

- **Epidemiology and features.** Indian school surveys report roughly five to fifteen percent, the spread reflecting the instrument rather than the population. Three types: reading, written expression, mathematics.
- **Assessment and management.** Achievement testing with an intelligence test, then the NIMHANS Index for certification from about eight years. Multisensory remediation, exam accommodations, and progress judged on curriculum based measurement.

WHAT EARNS THE MARKS

- **Causes grouped, not listed flat,** each group with the clue that points to it.
- **The exclusion step written before any testing.**
- **Prevalence as a range with the reason for it,** then remediation and accommodation named separately.

SEE ALSO Slot III - 13 assessing specific learning disability Slot III - 20 impairment in written expression

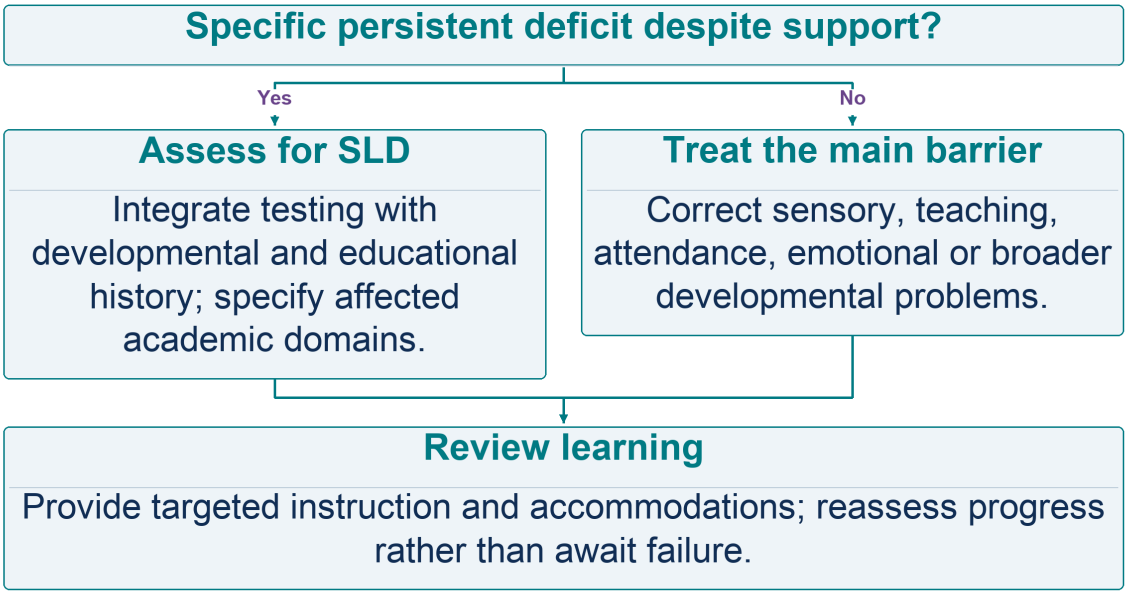
WEAVE 100+ / PAPER III

Scholastic backwardness and SLD

Poor school performance is a presentation, not a diagnosis.

Domain	Revision points
Learning profile	Reading, spelling/ writing and mathematics; onset, persistence and response to teaching.
Alternative causes	Hearing/ vision problems, intellectual disability, language difficulty, poor instruction, absence and psychosocial adversity.
Comorbidity	ADHD, anxiety, depression, autism and motor difficulties may compound the problem.
Assessment	Child, parent and teacher information; schoolwork, language context and standardised achievement testing.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 18.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Scholastic backwardness and SLD. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-18.

Credits and references: retained within the illustration.

III - 19

Define Stereotypic Movement Disorder as per DSM-5. How would you differentiate it from body-focused repetitive behavior disorders? Discuss the management of Stereotypic Movement disorder. [2+4+4]

2 + 4 + 4 | INTELLECTUAL DISABILITY AND LEARNING DISORDERS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 Definition	Criteria, then the two specifiers that change management
4 The grid	Domain by domain, with the discriminators marked
2 Behavioural management	Function first, then the technique that fits it
2 Drugs and protection	Only for self injury, and only with a review date

THE DEFINITION

Repetitive, seemingly driven and apparently purposeless motor behaviour, such as rocking, hand waving, head banging or self biting, beginning in the early developmental period, interfering with activity or causing self injury, and not better explained by a substance, a neurological condition or another mental disorder. Specify with or without self injurious behaviour.

DOMAIN	STEREOTYPIC MOVEMENT	BODY-FOCUSED REPETITIVE BEHAVIOUR	WHAT SETTLES IT
Onset	Early developmental period, often before three	Around puberty, sometimes later	**Onset before three years**
Form	Rhythmic, bilateral, whole body or limb	Focused grooming of hair, skin or nails	**Rhythm against grooming**
Product	Purposeless, nothing removed	Tissue removed or damaged	Follows from form
Urge	Occurs when engrossed or stressed; distractible	Premonitory urge, then relief	**A named urge first**
What works	Reinforcement based behaviour work, enrichment	Habit reversal training	The retrospective test

- **Management, in order.** Treat pain and medical drivers first: dental disease, otitis, constipation, reflux, eye disease in the blind child. Then a functional analysis. Then reinforcement of a competing behaviour, response interruption and redirection, enrichment and sensory work, and parent training. Protective equipment is short term and reviewed, never a substitute for the analysis.
- **Drugs.** No drug treats the stereotypy itself. Where self injury is severe, risperidone or aripiprazole have the best evidence, borrowed from irritability trials in autism, with metabolic monitoring. Restraint used without a functional analysis increases the behaviour it is meant to stop.

WHAT EARNS THE MARKS

- **The self injury specifier named in the definition.** It is what changes the management plan.
- **A grid, with onset, form and urge marked as the discriminators,** and tics named as the third confusable.
- **Pain and medical causes searched before behaviour is analysed.**
- **Drugs placed last and tied to self injury only.**

SEE ALSO Slot III - 31 tics and Tourette syndrome Slot III - 39 pica

WEAVE 100+ / PAPER III

Repetitive movements and behaviours

Phenomenology guides the differential.

Domain	Revision points
Tics	Brief, rapid, recurrent movements/ vocalisations; often urge and temporary suppressibility.
Stereotypies	More patterned or rhythmic, often early onset; may occur with excitement or self-regulation.
Compulsions	Repetitive acts/ mental rituals linked to obsessions, rules or distress reduction.
BFRBs	Hair pulling/ skin picking and related body-directed habits; assess triggers, awareness and damage.
Clinical context	Development, medication exposure, neurological signs, impairment and self-injury matter.

TREAT THE FUNCTION

Behavioural approaches differ: tic-focused CBIT, habit reversal or exposure/ response prevention are not interchangeable labels.

SAFETY

Assess pain, injury and neurological causes; do not suppress harmless self-regulatory behaviour solely because it looks unusual.

Weave Sprint Paper III; see source register

III 19.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Repetitive movements and behaviours. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-19.

Credits and references: retained within the illustration.

III - 20

a) What are Specific Learning Disorder? b) What are various types of Specific Learning Disorder. c) Write steps in assessment and management of Specific Learning Disorder with impairment in written expression. [2+3+5]

2 + 3 + 5 | INTELLECTUAL DISABILITY AND LEARNING DISORDERS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 **Definition**	Persistence, the six-month rule, and the exclusions
3 **The three types**	With the sub-skills each specifier names
3 **Assessment steps**	The flowchart: clear, test, profile, certify
2 **Management steps**	Teach the skill, then remove the barrier

THE DEFINITION

Difficulty learning and using an academic skill, present despite targeted help, persisting at least six months, well below that expected for age. Not better explained by intellectual disability, uncorrected vision or hearing, another disorder, adversity, the language of instruction, or inadequate teaching.



Fig 020.1 The writing profile split into its three failing components. Remediation teaches the skill, accommodation removes the barrier, and the child needs both.

- **The three types.** Reading: word accuracy, rate, comprehension. Written expression: spelling, grammar and punctuation, clarity of organisation. Mathematics: number sense, arithmetic facts, calculation, reasoning. Severity is graded mild, moderate or severe.
- **Steps that get skipped.** Test oral language too, since weak spoken language produces weak writing. Certify from about eight years for exam provisions: extra time, a scribe where the hand is the problem, spelling not penalised outside a spelling paper.

WHAT EARNS THE MARKS

- **The six-month persistence rule and the exclusion list.** A definition without them is half a definition.
- **Three specifiers with their sub-skills,** not three bare names.
- **The failing component identified before any remedy is chosen.**
- **Remediation separated from accommodation,** with the exam provisions named.

SEE ALSO Slot III - 18 scholastic backwardness and assessment Slot III - 13 assessing specific learning disability

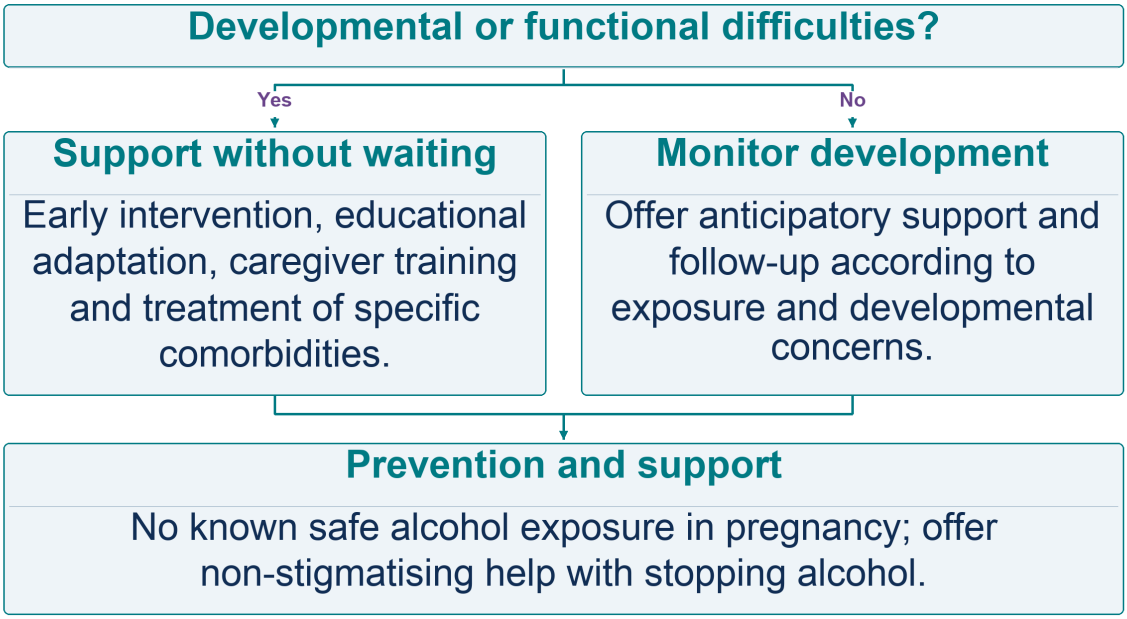
WEAVE 100+ / PAPER III

Fetal alcohol spectrum disorders

Prenatal exposure can affect growth, brain development and adaptive function.

Domain	Revision points
Spectrum	FASD is an umbrella; fetal alcohol syndrome is one defined presentation. Facial features are not universal.
Clinical pattern	Learning, attention, executive function, emotional regulation and adaptive difficulties; assess growth and dysmorphology.
Assessment	Sensitive exposure history, developmental assessment and multidisciplinary differential diagnosis.

DECISION PATHWAY



Weave Sprint day 21; CDC FASD treatment resources.

III 12.2 • Supplement • Source links and qualifications: SOURCES.md

Fetal alcohol spectrum disorders. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Intellectual disability and learning disorders.

Credits and references: retained within the illustration.

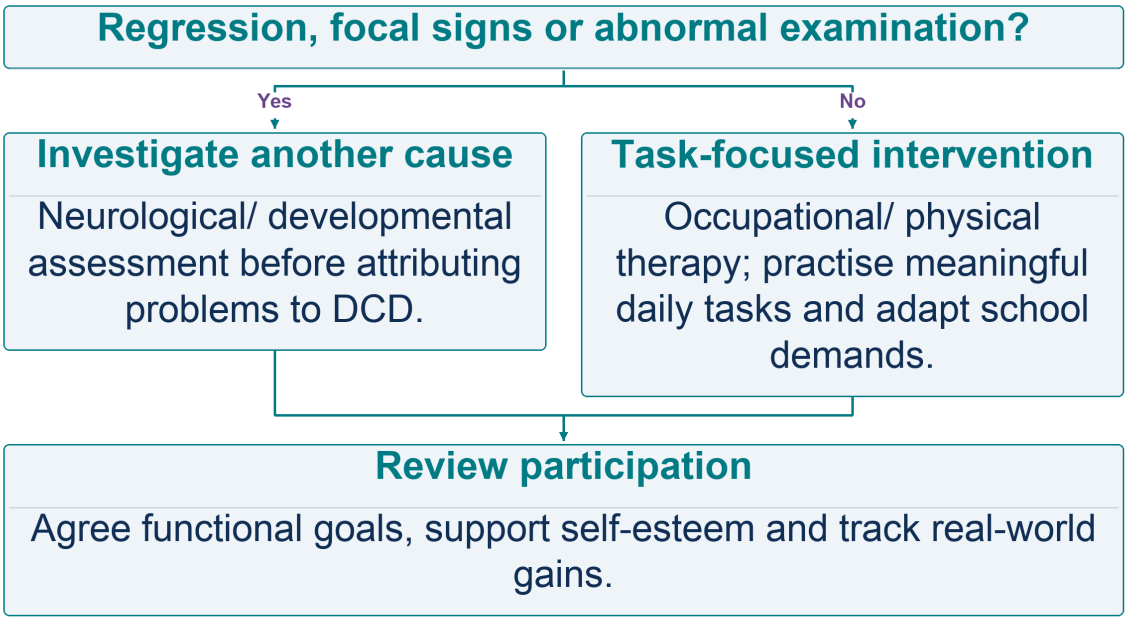
WEAVE 100+ / PAPER III

Developmental coordination disorder

Motor skill difficulty must interfere with everyday function.

Domain	Revision points
Diagnostic frame	Motor acquisition/ execution below age expectations; early onset and functional interference.
Manifestations	Clumsiness, slow dressing, handwriting difficulty, awkward ball skills and avoidance of sport.
Exclusions	Assess vision and neurological disease; interpret performance relative to intellectual/ developmental level.
Comorbidity	ADHD, learning difficulties and emotional effects may coexist.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 16.2 • Supplement • Source links and qualifications: SOURCES.md

Developmental coordination disorder. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Intellectual disability and learning disorders.

Credits and references: retained within the illustration.

NEURODEVELOPMENTAL DISORDERS

16.5 • Weave 100+ Paper III • Q16(a) • Six families: risks and defining clinical features

1 INTELLECTUAL DEVELOPMENTAL DISORDER

Intellectual disability • global developmental delay (GDD)

RISKS / ASSOCIATIONS

Genetic: Down syndrome, fragile X; metabolic disorders.
Prenatal: alcohol exposure or infection.
Brain injury: hypoxic–ischaemic injury in some cases.

CLINICAL FEATURES

Intellectual + adaptive deficits: conceptual, social, practical.
Severity follows adaptive function, not IQ alone.
GDD: <5 years; multiple delays; reliable testing not possible.

2 COMMUNICATION DISORDERS

Language • speech sound • fluency • social pragmatic

RISKS / ASSOCIATIONS

Familial/genetic contributions; causes vary by subtype.
Developmental language disorder: **gene–environment** influences; often **no single identifiable cause**.

CLINICAL FEATURES

Language: vocabulary, grammar, comprehension.
Speech sound: intelligibility. **Fluency:** stuttering.
Pragmatic: social language use; no ASD repetitive pattern.

6 MOTOR DISORDERS

Coordination • stereotypic movement • tics

RISKS / ASSOCIATIONS

DCD: prematurity is a risk association.
Tics: genetic + environmental contributions.
Stereotypies can co-occur with ASD or ID.

CLINICAL FEATURES

Developmental coordination disorder (DCD): poor coordination impairs everyday motor skills.
Stereotypies: repetitive, driven movements that impair function or cause injury.
Tics: sudden, rapid, non-rhythmic acts/sounds.

Neurodevelopmental disorders

SHARED RISK THEMES

Genetic susceptibility
Prenatal / early-life influences

Contributions vary by disorder and child

No single universal cause

3 AUTISM SPECTRUM DISORDER

Social communication + repetitive patterns

RISKS / ASSOCIATIONS

Genetic contribution; family history.
Fragile X / tuberous sclerosis in some cases.
Older parental age: risk association.

CLINICAL FEATURES

Social-communication deficits AND restricted/repetitive behaviour or interests.
Sameness, sensory differences, stereotypies.
Intellectual/language impairment may coexist.

5 SPECIFIC LEARNING DISORDER

Reading • written expression • mathematics

RISKS / ASSOCIATIONS

Familial/genetic vulnerability; multifactorial.
Language difficulties increase learning risk.
Poor teaching alone does not establish SLD.

CLINICAL FEATURES

Academic skills substantially below age expectations.
≥6 months despite targeted help.
Not better explained by ID; **no normal-IQ requirement**.

4 ADHD

Inattention and/or hyperactivity–impulsivity

RISKS / ASSOCIATIONS

Strong familial/genetic contribution.
Environmental risks include **early lead exposure**.
Prenatal exposure associations are **not deterministic**.

CLINICAL FEATURES

Developmentally excessive symptoms ≥6 months.
Several before age 12; ≥2 settings; functional impairment.
Inattentive, hyperactive–impulsive or combined presentation.

Developmental onset does not exclude regression: loss of skills warrants assessment.

Sources: APA • NIH/NIDCD • CDC • Canadian Paediatric Society (DCD) | Source notes: 19 Sep 2026
Q16(a) overview only. Prevention (3 marks) and the schizophrenia model (5 marks) remain separate.

Neurodevelopmental disorders - Six-family overview with shared risks. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Intellectual disability and learning disorders.

Credits and references: retained within the illustration.

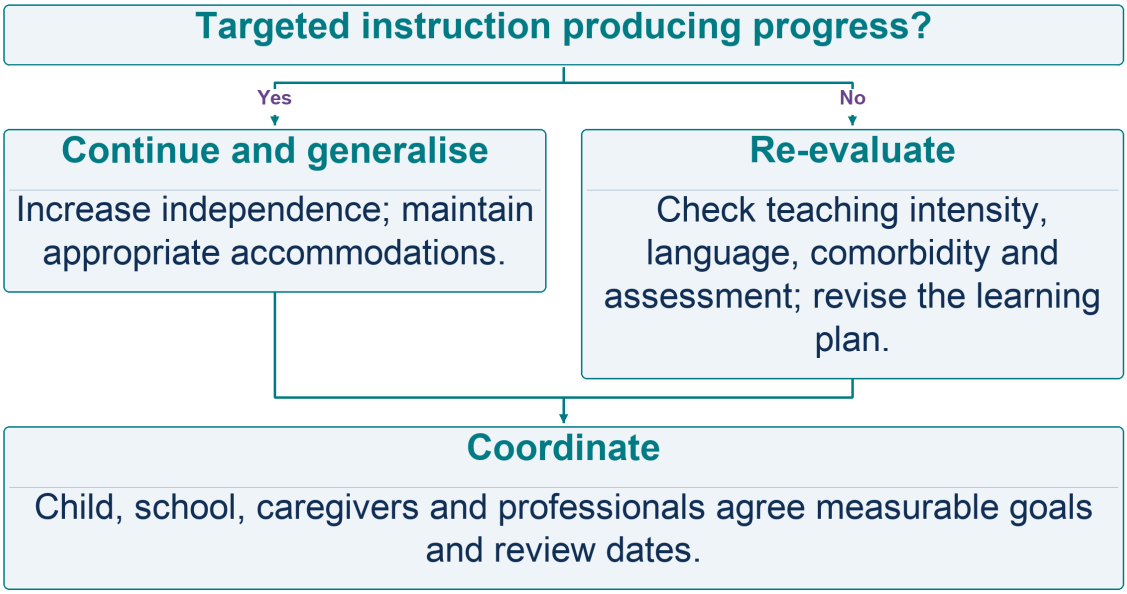
WEAVE 100+ / PAPER III

SLD: domains and support

Match intervention to the skill that is difficult.

Domain	Revision points
Reading	Word accuracy, rate/ fluency or comprehension; targeted explicit reading instruction.
Written expression	Spelling, grammar, punctuation or organisation; structured writing instruction and appropriate assistive tools.
Mathematics	Number sense, facts, calculation or reasoning; explicit, sequenced teaching and practice.
Accommodations	Extra time, accessible material and alternative response formats when indicated; distinguish from changing learning goals.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 18.2 • Question-linked revision • Source links and qualifications: SOURCES.md

SLD: domains and support. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Intellectual disability and learning disorders.

Credits and references: retained within the illustration.

BEHAVIOURAL MANAGEMENT — A REUSABLE ANSWER MAP

19.2 • Q19 stereotypic movement disorder | Cross-reference: Q17 intellectual disability • Q31 tics • Q90 autism

1 AGREE THE TARGET AND GOAL

Patient/family priorities: safety, distress and everyday functioning.
Is the behaviour harmful, distressing or functionally interfering?

→ **NO → SUPPORT / ACCOMMODATE**

Harmless self-regulation need not stop.
Explain, adapt surroundings, review needs.

YES → assess; immediate danger also enters safety branch

2 ASSESS DRIVERS, FUNCTION AND BASELINE

Development + communication: adapt to ability; **treat pain/illness, sleep problems and comorbidities**; assess triggers.
ABC: antecedent → observable behaviour → consequence. Test the function; do not infer it from appearance.
Possible functions: **sensory/automatic reinforcement • attention • escape • access** to items/activities.
Baseline: frequency, duration, intensity and functional impact; define one measurable, observable target.

3 FIRST-LINE SUPPORT FOR EVERY ACTIVE PLAN

Modify triggers: predictable routines, manageable demands, meaningful activity and matched sensory supports.
Build communication: accessible requests; teach replacement skills; agree one consistent parent–teacher–carer plan.

FUNCTION / LIMITED AWARENESS | **LEARNABLE REPETITIVE HABIT / TIC** | **INJURY / HIGH RISK AT ANY STAGE**

A FUNCTION + REINFORCEMENT

ASD / ID challenging behaviour:
use a **function-led replacement plan**.
FCT: teach a request for the same outcome (help, break, attention or access).
Sensory function: safe matched activity.
Positive reinforcement: individualised, prompt; coordinate carers and settings.
DRA: reinforce an adaptive alternative.
DRI: reinforce an incompatible action.
DRO: reinforce absence over an interval; use selectively; **never withhold basic care**.
Teach skills: prompts, shaping, chaining; fade prompts; **safe redirection** if needed.

B HRT / CBIT — MATCH INDICATION

HRT = habit reversal training
Adapt to developmental/awareness capacity; if limited, use the **function-led branch**.
1 Awareness: triggers, urges, early signs.
2 Competing response: a safe action incompatible with the target behaviour.
3 Social support + generalisation practice.
Tics → CBIT: HRT + functional changes and relaxation.
Primary stereotypies: adapted awareness, competing response + reinforcement.

BFRB: hair pulling / skin picking → HRT + stimulus control. IPS CPG 2020
Gold applies only to this BFRB recommendation.

C SAFETY + TARGETED ADJUNCTS

Severe injury / immediate danger → wound/pain care; **specialist team**; least restrictive safety plan; frequent review.
Restrictions: last resort + legal safeguards.
No punishment / aversives / blanket ignoring of dangerous behaviour.
Medication is not routine for primary stereotypies or core autism features.
Treat comorbidity. Severe behaviour: if psychosocial care fails / cannot be delivered, **specialist medicine + monitoring + care plan**.
Autism irritability evidence ≠ stereotypy-specific drug evidence.

4 REVIEW THE MEASURABLE OUTCOME — NOT JUST "LESS MOVEMENT"

Better function / less harm? YES → generalise skills across settings; gradually fade prompts and reinforcement.
NO / worse → reassess pain, function, feasibility and implementation; revise the plan. Do not escalate punishment.

FCT: functional communication training • DRA/DRI/DRO: differential reinforcement • CBIT: comprehensive behavioural intervention for tics
NICE NG11 / CG170 • CDC tic guidance • Johns Hopkins stereotypy programme • IPS CBT CPG 2020 (BFRB only) • Checked 19 Sep 2026

Behavioural management - Reusable assessment and intervention chart. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Intellectual disability and learning disorders.

Credits and references: retained within the illustration.

AREA 03 OF 13 · P3-A09

Ethics, consent and child protection

10	10.7%	III-21	III-30
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

HIGH 1 SINGLE 9

REVISION ORDER

Learn the four principles once, properly: they carry three slots and they frame the consent slot as well. Then the abuse and POCSO group, which shares a management spine. Boundaries last, and it is short.

WHAT IS IN THIS AREA

The four principles of ethics and their application (three slots), informed consent, boundary violations, and child sexual abuse with POCSO and the Juvenile Justice Act (four slots between them).

III - 21

Discuss the long-term consequences of child sexual abuse. [10]

10 ETHICS, CONSENT AND CHILD PROTECTION

KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 The frame	Not one syndrome; outcome is the rule, not the exception
4 Domain by domain	Psychiatric, developmental, interpersonal, physical
2 Mechanism	Why the sequelae are so wide, said in one line
2 What modifies it	The factors that make outcome better or worse

THE FRAME

There is no single post-abuse syndrome. Child sexual abuse is a non-specific risk factor of large effect, raising the likelihood of many adult disorders rather than producing one. A minority remain asymptomatic, and saying so is part of an accurate answer.

DOMAIN	WHAT APPEARS IN ADULT LIFE	THE CLINICAL MARKER
Psychiatric	Depression, post-traumatic stress disorder, anxiety, substance use, eating disorder	**Self-harm and suicide attempt rates rise sharply**
Personality and affect	Emotional dysregulation, dissociation, chronic shame, borderline pattern	Complex trauma presentation
Interpersonal	Insecure attachment, difficulty with trust and intimacy, revictimisation	**Revictimisation is the most robust finding**
Sexual and reproductive	Sexual dysfunction, early sexual activity, unplanned pregnancy	Often unvolunteered unless asked
Physical and social	Chronic pain, functional gastrointestinal disorder, poorer education and work outcome	Presents to medicine, not psychiatry

The amber rows are the two an examiner expects by name; the physical row is the one that shows the answer was learned from patients rather than a list.

- **Why so wide.** Abuse acts through disrupted attachment, altered stress response, traumatic sexualisation, stigmatisation and betrayal, and each of those routes has its own downstream disorders.
- **What modifies outcome.** Worse with penetrative and repeated abuse, an abuser close to the child, and disbelief on disclosure. Better with early disclosure that is believed, one supportive caregiver, and treatment received.

WHAT EARNS THE MARKS

- **Non-specificity stated at the top,** with the asymptomatic minority acknowledged.
- **Consequences given by domain,** not as an undifferentiated list.
- **A mechanism offered,** which separates the top band.
- **Moderators in both directions,** protective as well as adverse.

SEE ALSO Slot III - 25 assessment and management of abuse **SPRINT** Day 24, Child psychiatry

III - 22

Discuss principles of ethics and their implications for clinical practice. [10]

10 ETHICS, CONSENT AND CHILD PROTECTION

DNB, NTRUHS - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2	The four principles	Named, with the tradition they come from
4	What each demands	One concrete clinical act per principle
2	When they collide	No hierarchy; the collision is the work
2	The Indian frame	The code that actually binds a practitioner here

THE DEFINITION

Medical ethics is the systematic study of what a doctor ought to do. The working framework is the four principles of Beauchamp and Childress: respect for autonomy, beneficence, non-maleficence and justice, with veracity, fidelity and confidentiality as derived duties.

PRINCIPLE	WHAT IT DEMANDS AT THE BEDSIDE	HOW IT IS BREACHED IN PRACTICE
Autonomy	Informed consent, truth-telling, respecting a refusal	Consent taken as a signature, not a conversation
Beneficence	Acting in the patient's interest, not the family's or your own	Treating to relieve the relatives' distress
Non-maleficence	Weighing harm, monitoring, stopping what is not working	Polypharmacy continued without review
Justice	Fair use of scarce time, beds and money; no discrimination	Preferring the articulate or the paying patient

The four have no fixed rank. An answer that names a hierarchy is wrong; an answer that shows the collision being reasoned through is what is being marked.

- **The collision.** Autonomy against beneficence is the daily conflict of this specialty: the patient who refuses treatment he needs. It is resolved by testing capacity, not by overriding the refusal, and by using the least restrictive option that answers the risk.
- **The Indian frame.** Principles are argued, but a practitioner here is bound by the Medical Council code of ethics regulations of 2002, still the operative code, and by the rights chapter of the Mental Healthcare Act 2017.

WHAT EARNS THE MARKS

- **All four named and attributed.**
- **A concrete clinical act under each,** which is the implications half of the question.
- **The absence of a hierarchy, stated.**
- **An Indian instrument named,** not a purely Western answer.

SEE ALSO Slot III - 30 scope of the principles in mental health Slot III - 24 informed consent SPRINT Day 26, Forensic ethics, consent and legal procedure

WEAVE 100+ / PAPER III • 22.1

Ethics in psychiatric practice

LEGAL ACTS APPENDIX • III Q 22, Q 30 • Q 23 clinical-ethics half

1 FOUR PRINCIPLES → CLINICAL APPLICATION

Autonomy	Respect informed choices; support capacity, consent and refusal. **Psychosis is not automatic incapacity**.
Beneficence	Promote wellbeing through appropriate, evidence-based care and recovery goals agreed with the person.
Non-maleficence	Minimise treatment, coercion, confidentiality and boundary harms; monitor adverse effects.
Justice	Fair access, non-discrimination, reasonable accommodation and responsible use of resources.

2 PROFESSIONAL DUTIES

Fidelity / honesty	Trustworthiness, truthful explanation, competence, clear limits and referral when needed.
Confidentiality	Private consultation and secure records; explain limits, disclose only what is necessary under lawful exceptions.
Respect / dignity	Non-stigmatising language, cultural awareness, participation and protection of vulnerable persons.

3 COMMON PSYCHIATRIC CONFLICTS

Refusal / risk	Assess decision-specific capacity, supports and urgency; use **least restrictive lawful intervention**, document reasons and review.
Family involvement	Seek permission when capable; share proportionately. Family concern does not create unlimited entitlement to records.
Dual loyalty	Treatment versus employer/court/institution demands; declare role, consent/confidentiality limits and conflicts.
Boundaries	Avoid sexual exploitation, harmful dual relationships, financial conflicts and inappropriate self-disclosure; see 29.1.
Resource allocation	Prioritise fairly; avoid discrimination by diagnosis, social status, disability or ability to pay.

4 PRACTICAL ETHICAL METHOD

Define problem → clinical facts + person's values + legal duties

↓

Identify options and competing principles → consult/supervise when needed

↓

Choose proportionate, least harmful lawful option → explain → **document and review**

5 LAW & RESEARCH

Law is a floor	MHCA/RPwD rights, POCSO reporting and consent law shape practice. Ethical care also requires empathy, competence and accountability.
Research	Separate clinical care from recruitment; voluntary informed consent, fair selection and independent review. **See 23.1 for drug-trial safeguards**.

MHCA 2017; RPwD 2016; ICMR National Ethical Guidelines 2017; NMC Code of Medical Ethics 2002.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Ethics in psychiatric practice. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-22.

Credits and references: retained within the illustration.

III - 23

Describe the applications of ethics in mental health. What are the ethical issues to be considered in a drug trial? [5+5]

5 + 5 | ETHICS, CONSENT AND CHILD PROTECTION | DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	Why psychiatry is different	Capacity, coercion and stigma, all at once
3	The applications	Five settings where the principles actually bite
3	Trial ethics	Consent, vulnerability, placebo, compensation
2	The Indian regulation	Which committee, which guideline, which registry

SETTING	THE ETHICAL QUESTION	HOW IT IS ANSWERED
Involuntary care	Whose judgement replaces the patient's	**Capacity test, least restrictive option, review**
Confidentiality	What may be told to a family that provides the care	Consent, and disclosure limited to what is needed
Risk to a third party	Whether to warn	**Weighed case by case; not an Indian statutory duty**
Boundaries and dual roles	Treating and assessing the same person	Declare the role before the interview
Telepsychiatry and records	Identity, privacy and the limits of remote care	Follow the 2020 telemedicine guidelines

Psychiatry differs because the illness can impair the very faculty consent depends on, and because the setting can be coercive even when nobody intends it to be.

- **In a drug trial.** Independent ethics committee approval before enrolment; capacity assessed for consent, and assent with a legally acceptable representative where it is absent; an independent witness or audiovisual recording for vulnerable participants; placebo only where no proven treatment is being withheld to the participant's harm; free treatment for adverse events and compensation for trial-related injury; the right to withdraw without any loss of usual care.
- **The Indian regulation.** The national ethical guidelines for biomedical and health research, the New Drugs and Clinical Trials Rules 2019, a registered ethics committee, and prior registration of the trial in the national registry.

WHAT EARNS THE MARKS

- **Why psychiatry is a special case,** stated before the list.
- **Applications given as settings,** each with its resolution.
- **Capacity for research consent treated separately** from capacity for treatment.
- **Compensation and registration,** which are the Indian specifics.

SEE ALSO Slot III - 24 informed consent SPRINT Day 26, Forensic ethics, consent and legal procedure

WEAVE 100+ / PAPER III • 23.1

Drug-trial ethics in psychiatry

LEGAL ACTS APPENDIX • III Q 23 • ethics 5 + trial issues 5; use 22.1 for first half

1 ETHICAL BASIS	
Principles	Autonomy, beneficence, non-maleficence and justice; **scientific validity and social value** are ethical prerequisites.
Oversight	Independent **registered Ethics Committee**; applicable CDSCO permissions, approved protocol and prospective trial registration.

2 CONSENT IN A VULNERABLE SETTING	
Information	Investigational nature, randomisation/placebo, procedures, risks, benefits, alternatives, compensation, privacy and contacts; understandable language.
Capacity	Assess research-specific capacity; mental illness does not automatically exclude participation or justify proxy consent.
If impaired	Legally authorised representative only within permitted framework, added safeguards and assent where possible; respect objection and **re-consent if capacity returns**.
Voluntary	No loss of ordinary care for refusal/withdrawal; avoid excessive inducement, authority pressure and therapeutic misconception.

3 DESIGN & PARTICIPANT PROTECTION	
Risk–benefit	Minimise burden; fair inclusion/exclusion; justify vulnerable recruitment. Include only scientifically necessary procedures.
Placebo / washout	Ethically justify; avoid serious/irreversible harm, unnecessary withdrawal and denial of effective care; rescue and stopping criteria.
Monitoring	Adverse events, suicidality, relapse, capacity changes and protocol deviations; appropriate independent safety monitoring.
Privacy	Coded data, controlled access, proportionate sharing and consent for future use where required.

4 INDIA: NDCTR 2019 & ICMR	
Injury / SAE	Prompt SAE reporting, medical management and compensation for trial-related injury/death under applicable rules. **Sponsor/investigator duties cannot be waived by consent**.
Transparency	Register prospectively in **CTRI**, disclose conflicts/funding, publish results honestly and retain auditable records.
Post-trial	Plan continuity, referral and post-trial access as required; explain arrangements during consent.
MHCA §99	Interventional research without capacity but **without resistance**: concerned **State Authority permission**, NR consent and statutory safeguards; EC approval alone is insufficient.

5 EXAM CRITIQUE	
Main tension	Generate useful evidence without exploiting dependency, fluctuating capacity, institutionalisation or financial vulnerability.
Clinical separation	Treating role and recruiting role can conflict; independent consent support and clear boundaries help.

ICMR National Ethical Guidelines 2017; New Drugs and Clinical Trials Rules 2019 (CDSCO); MHCA 2017 §99.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Drug-trial ethics in psychiatry. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-23.

Credits and references: retained within the illustration.

III - 24

What is informed consent? What are the various components of informed consent? Discuss its relevance in the patients with psychotic disorders as compared to medical disorders. [1+3+6]

1 + 3 + 6 | ETHICS, CONSENT AND CHILD PROTECTION

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

1 Definition	A process, not a signature
3 The components	Five, each of which can fail on its own
4 The comparison	Domain by domain, with what settles each
2 What follows	When capacity is absent, the law supplies the route

- **Informed consent.** A voluntary agreement to a specific intervention by a person with the capacity to decide, given after disclosure of its nature, benefits, risks and alternatives, including the alternative of no treatment. Five components: disclosure, understanding, capacity, voluntariness, and the authorisation itself.

DOMAIN	PSYCHOTIC DISORDER	MEDICAL DISORDER	WHAT SETTLES IT
Capacity	May be impaired, and may fluctuate within the day	Usually intact unless delirium or pain	**Test the four abilities, do not assume**
Understanding	Thought disorder and poor insight distort it	Limited by literacy and anxiety	Ask the patient to say it back
Voluntariness	Ward setting and family pressure are coercive	Pressure is mostly time and cost	**Who benefits if he agrees**
Refusal	Refusal is read as illness, wrongly	Refusal is respected readily	**An unwise choice is not incapacity**
If capacity is absent	Nominated representative, advance directive, supported admission	Next of kin, emergency doctrine	The Mental Healthcare Act 2017 supplies the route

Amber cells are the discriminators. The last one carries the most marks: the same refusal is treated differently in the two settings, and that asymmetry is what the question is really asking about.

- **The Indian standard.** Disclosure is judged by what a reasonably competent practitioner would tell, not by what a particular patient would want to know, and consent covers only the procedure consented to.

WHAT EARNS THE MARKS

- **Consent as a process, in the first line.**
- **All five components named.**
- **A grid, not two paragraphs,** with discriminators marked as discriminators.
- **The refusal asymmetry,** which is the heart of the six-mark part.

SEE ALSO Slot III - 43 capacity under the Act SPRINT Day 26, Forensic ethics, consent and legal procedure

WEAVE 100+ / PAPER III • 24.1

Informed consent and mental capacity

LEGAL ACTS APPENDIX • III Q 24 • definition 1 + components 3 + comparison 6

1 DEFINITION	
Informed consent	**Voluntary, competent authorisation** of a specific intervention after adequate understandable information and opportunity to decide. A signature alone is insufficient.

2 ESSENTIAL COMPONENTS	
Capacity	Decision/time-specific understanding, appreciation, reasoning and communication assessed clinically; apply relevant statutory test.
Disclosure	Nature/purpose, expected benefits, material risks, alternatives including no treatment, costs where relevant and questions.
Understanding	Plain language, interpreter/visual support and **teach-back**; correct misconceptions.
Voluntariness	No coercion, deception or undue influence. Right to refuse/withdraw, with consequences explained.
Authorisation	Specific agreement and documentation; consent to examination/admission is not blanket consent to every treatment.

3 PSYCHOTIC vs MEDICAL DISORDERS	
Same presumption	Both retain autonomy unless the relevant ability is impaired. **Diagnosis does not decide capacity**.
Psychosis	Delusions about treatment, disorganisation or severe mood symptoms may impair a particular decision; insight score alone is insufficient.
Medical illness	Delirium, hypoxia, pain, shock, sedatives or cognitive disorder can impair capacity equally; do not assume all medical patients are capable.
Support / review	Treat reversible barriers, choose best time, repeat explanation, allow support person. Reassess fluctuating capacity and each new decision.

4 MHCA & SPECIAL SITUATIONS	
§4	Statutory wording uses **understand OR appreciate consequences OR communicate**. Do not silently substitute a different conjunctive legal test.
If lacks capacity	Use lawful supported-decision/NR route and valid AD where applicable; review capacity. Family signature alone does not legitimise all interventions.
Emergency	Urgent necessary treatment follows applicable emergency law; MHCA §94 has defined scope/time limits. **No emergency ECT under §94**.
Minors / research	Appropriate guardian permission plus developmentally suitable assent; research requires separate safeguards. See 49.1/23.1.

5 RECORD THE PROCESS	
Document	Decision, information given, questions/teach-back, abilities, supports, choice, participants, consent/refusal and review plan.
Conclusion	Protect meaningful choice while ensuring proportionate care when capacity is genuinely impaired.

MHCA 2017 §§4, 10, 86–90, 94–95; NMC Code 2002; ICMR ethical guidance 2017.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Informed consent and mental capacity. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-24.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III • 24.2

MTP Act 1971: psychiatric relevance

LEGAL ACTS APPENDIX • Supplement • III Q 24, Q 25–28 • amended 2021

1 STATUTORY GROUNDS • §3	
Risk	Continuing pregnancy risks the woman's life or **grave injury to physical/mental health**, or substantial risk of serious fetal abnormality.
Presumptions	Pregnancy alleged to result from rape: presumed grave mental-health injury. **Contraceptive failure of any woman/partner** also supports the statutory mental-health presumption.
Context	Actual/reasonably foreseeable environment matters; assess without moral judgment or diagnosis-based assumptions.

2 GESTATION → AUTHORISED OPINION	
Up to 20 weeks	**One eligible registered medical practitioner**, acting in good faith on statutory grounds.
>20 to 24 weeks	**At least two eligible RMPs**; prescribed categories under Rule 3B and relevant judicial interpretation.
Beyond 24 weeks	Gestational limit does not apply for **substantial fetal abnormalities diagnosed by Medical Board** under §3(2B).
Emergency §5	Separate exception when immediate termination is necessary to **save the pregnant woman's life**. Not a general distress exception.

3 RULE 3B: PRESCRIBED CATEGORIES	
Vulnerability	Sexual assault/rape/incest survivors; minors; specified marital-status change during pregnancy; major physical disability.
Other categories	Mental illness including ID in the Rule's wording; specified fetal malformation; government-declared humanitarian/disaster/emergency settings.
Interpretation	Apply current judicial interpretation on reproductive autonomy and unmarried women; **do not deny solely because unmarried**.

4 CONSENT, SETTING & PRIVACY	
§3(4)	Adult pregnant woman's consent; guardian's written consent for **under 18 or statutory mentally ill person**. MTP definition excludes ID; do not confuse this with Rule 3B eligibility.
No substitute	Husband/partner consent is **not required**. Protect participation and assess coercion; do not equate disability with inability to choose.
Where / who	Government hospital or approved place under §4; eligible RMP requirements. Psychiatrist's opinion does not substitute for the statutory RMP/Board.
§5A	Protect name and particulars; disclosure only to a person authorised by law. POCSO obligations also apply where relevant.

5 PSYCHIATRIST'S ROLE	
Assess / support	Mental-health risk, capacity, coercion, trauma, supports and preferences; accurate records, timely referral and continuing care.
Keep tests separate	MHCA capacity, MTP consent wording and Rule 3B categories are **different legal questions**; resolve uncertainty through appropriate specialist/legal review without avoidable delay.

MTP Act 1971 §§2–5A (amended 2021); MTP Rules 2021 Rule 3B; SC X v.Principal Secretary(2022).

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

MTP Act 1971: psychiatric relevance. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-24.

Credits and references: retained within the illustration.

III - 25

Discuss the assessment and management of a case of child sexual abuse. [5+5]

5 + 5 | ETHICS, CONSENT AND CHILD PROTECTION | DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	First contact	Believe, do not interrogate, and report
3	Assessment	Medical, psychiatric and safety, in that order
3	Early management	Protect, treat, and prepare for the process
2	Longer term	Trauma-focused therapy and the family's own work

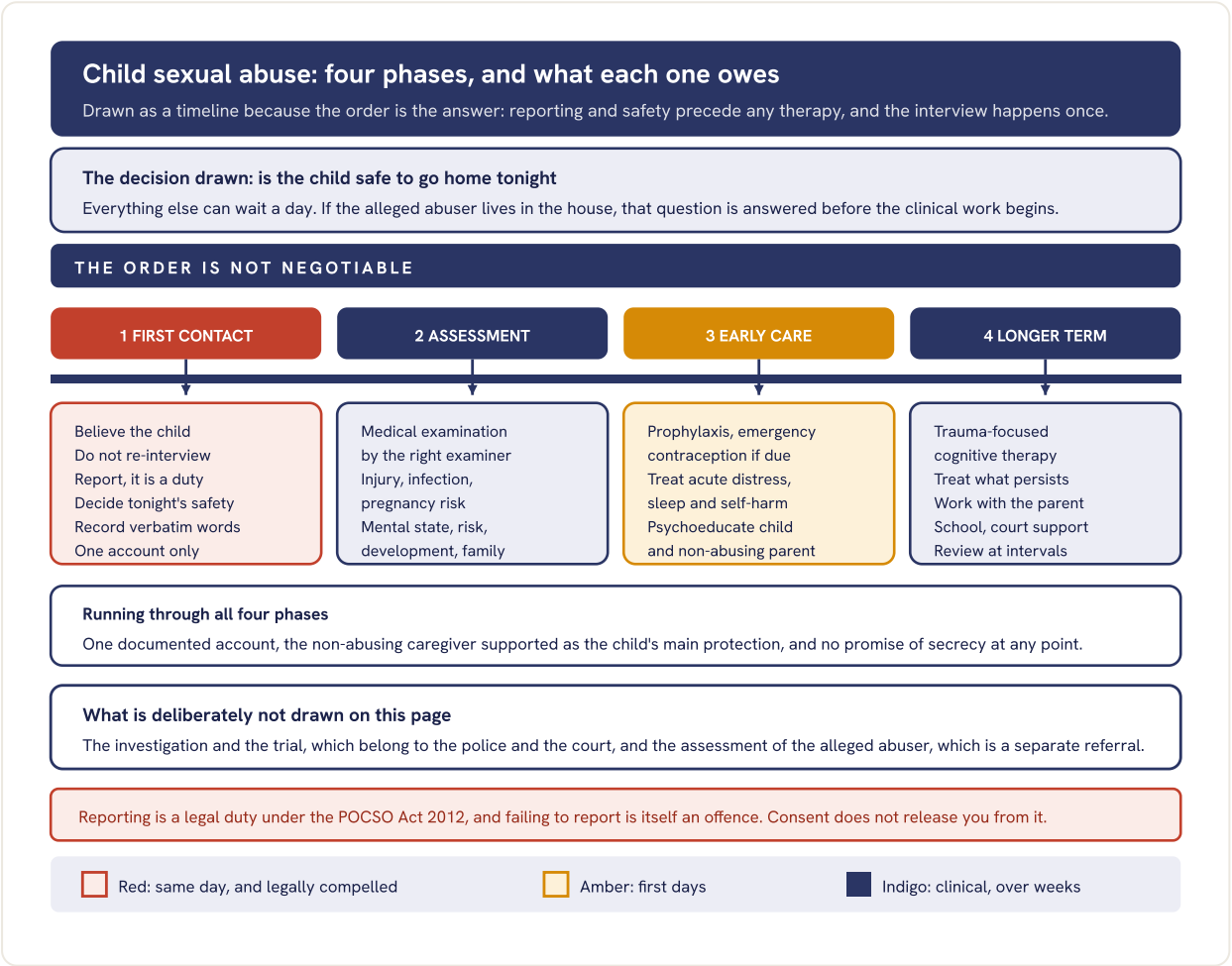


Fig 025.1 The four phases on one timeline, with the legally compelled same-day actions in red so that reporting and safety are never displaced by the therapy that follows them.

- **The one interview rule.** Every repetition costs accuracy and re-traumatises. Take one account in the child's own words, record it verbatim, and leave the forensic interview to the trained examiner rather than repeating it yourself.

WHAT EARNS THE MARKS

- **Safety and reporting placed before clinical work,** as the plate orders them.
- **Medical and psychiatric assessment kept as separate strands.**
- **The non-abusing caregiver named as the protective factor,** and worked with.
- **Trauma-focused cognitive therapy named,** not therapy in general.

SEE ALSO Slot III - 26 management under the POCSO Act Slot III - 21 long-term consequences **SPRINT** Day 24, Child psychiatry

WEAVE 100+ / PAPER III • 25.1

Child sexual abuse: assessment and care

LEGAL ACTS APPENDIX • III Q 25, Q 26, Q 28 • clinical answer + POCSO

1 DEFINE & ESTABLISH SAFETY	
Definition	Involving a child in sexual activity they cannot comprehend, consent to, or are not developmentally prepared for; includes **contact, non-contact and online exploitation**.
Immediate needs	Separate from unsafe access to alleged perpetrator; treat injuries, suicidality and acute medical emergencies; involve safe caregiver/CWC as indicated.

2 ASSESSMENT • CHILD-CENTRED, NOT INTERROGATION	
History	Developmentally appropriate **open questions**; avoid leading questions, repeated detailed narration or pressure to disclose. Record spontaneous words verbatim.
Context	Timing, ongoing access, coercion, threats, safety, family response; coordinate trained forensic interview to reduce duplication.
Mental state	Fear, shame, guilt, dissociation, sleep disturbance, PTSD symptoms, depression/anxiety, self-harm, behaviour and school changes. Assess development and supports.
Medical / forensic	Refer appropriate trained service for examination, evidence and chain of custody. Normal examination **does not exclude abuse**; preserve dignity and consent.

3 POCSO DUTIES	
Report	§19: **SJPU/local police** on knowledge/apprehension; explain mandatory reporting without blaming the child.
Child-friendly care	Trusted person; interpreters/disability accommodations; no repeated coercive interviewing. Medical care without waiting for FIR (§27).
Documentation	Objective findings, source of each account, consent/assent, referral, reporting and safety actions. Protect identity and access to records.

4 MANAGEMENT	
Acute	Supportive, validating response: **not the child's fault**. Safety plan; address pain/injury; time-sensitive STI/HIV and pregnancy care through appropriate protocols.
Psychological	Psychoeducation, routine and school support; help caregiver respond calmly. **Trauma-focused CBT when indicated**; avoid compulsory single-session debriefing.
Comorbidity	Treat diagnosed PTSD, depression, anxiety or other disorders; medicines target indicated disorders, not the abuse experience itself.
Follow-up	Review safety, symptoms, functioning and engagement; coordinate social, school, child-protection and legal support.

5 LONG-TERM CONSEQUENCES • Q 21 BRIDGE	
Possible outcomes	PTSD, depression/anxiety, self-harm, substance problems, sexual/interpersonal difficulties, somatic symptoms and educational disruption.
Qualify	Outcomes are **heterogeneous, not inevitable**; severity, chronicity, other adversity and protective relationships matter. Use 21.1 for broader adversity context.

WHO Responding to children/adolescents sexually abused (2017); POCSO 2012; MoHFW sexual-violence guidance.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Child sexual abuse: assessment and care. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-25.

Credits and references: retained within the illustration.

III - 26

Discuss management of a child presenting with history of sexual abuse, especially in the background of the POCSO Act. [10]

10 | ETHICS, CONSENT AND CHILD PROTECTION | DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 **The duty that starts it**	Mandatory reporting, and the penalty for silence
4 **The statutory steps**	In order, with who acts and by when
2 **Clinical care alongside**	It runs in parallel, never afterwards
2 **Child-friendly protections**	The provisions written to spare the child

- **Where it begins.** The Act makes reporting mandatory for any person who knows or apprehends that a sexual offence against a child has been committed, and failure to report is itself punishable. It is gender neutral, and a child is anyone below eighteen.

STEP	WHAT HAPPENS	WHO ACTS	TIME LIMIT OR CONDITION
1	Information given to the police or the child welfare unit, recorded in simple language	Any person who knows, doctor included	**A duty, not a discretion**
2	Child produced before the welfare committee, care and protection arranged	Police and Child Welfare Committee	Within twenty four hours
3	Medical examination, with a woman doctor for a girl and a trusted adult present	Registered medical practitioner	Free, and possible without a police report
4	Statement recorded by the Magistrate, at the child's home or a place of his choice	Magistrate, with a support person	**Recorded once, not repeatedly**
5	Trial in a designated Special Court, in camera, the child never facing the accused	Special Court	Evidence and trial are time-bound

The Act presumes the accused's culpable mental state, which reverses the usual burden; that is a feature of the statute and not a matter for the doctor's opinion.

- **Clinical care, in parallel.** Injury and infection treatment, emergency contraception where indicated, acute distress and self-harm risk, then trauma-focused cognitive behavioural therapy, work with the non-abusing caregiver, and school liaison. Court preparation is part of treatment, not separate from it.

WHAT THE ACT DOES NOT COVER

It does not make the doctor an investigator: no opinion on whether the offence occurred, no repeated interviewing, and no promise of confidentiality once reporting is triggered. Adolescent consensual activity below eighteen also falls within the Act, which is a recognised and unresolved difficulty.

WHAT EARNS THE MARKS

- **Mandatory reporting named first,** with the offence of not reporting.
- **The steps in order, with the actor at each.**
- **Clinical care shown running in parallel,** not after the legal process.
- **The child-friendly provisions,** which is where the Act earns its name.

SEE ALSO Slot III - 28 features of the POCSO Act **SPRINT** Day 24, Child psychiatry

WEAVE 100+ / PAPER III • 26.1

POCSO Act: child-friendly justice

LEGAL ACTS APPENDIX • III Q 26, Q 28 • legal framework; pair with 25.1

1 SCOPE & OFFENCES

Child	**Every person below 18**, irrespective of gender. A child's apparent agreement does not legalise a POCSO sexual offence.
Offences	Penetrative sexual assault; sexual assault without penetration; sexual harassment; use of children for pornography; abetment/attempt.
Aggravation	Specified authority/trust relationships, institutional settings and other listed circumstances attract aggravated categories. Do not infer category from diagnosis alone.

2 REPORTING • §§19–21

Knowledge of an offence OR apprehension it is likely → **report to SJPU / local police**

↓

Record disclosure accurately; explain reporting and privacy limits; **do not wait for proof or conduct your own investigation**

↓

Police arrange urgent care/protection where needed and report to **CWC / Special Court within 24 h**

3 CHILD'S STATEMENT • §§24–26

Place / officer	At home or a place of choice; as far as practicable **woman police officer, at least SI**, without uniform.
Protection	No contact with accused; **no overnight detention in police station**. Trusted person present.
Communication	Interpreter/translator, special educator or expert for disability; communication aids; audio-video recording where possible.

4 MEDICAL EXAMINATION • §27

Access	Examination can occur **without FIR or complaint**. Urgent care must not depend on police paperwork.
Safeguards	Girl examined by **woman doctor**. Parent/trusted person present; if unavailable, woman nominated by medical institution head.
Consent / dignity	Explain each step; obtain appropriate consent and child's assent, minimise repetition, document objectively. **No two-finger or virginity test**.

5 SPECIAL COURT & CLINICAL IMPLICATIONS

Process	Child-friendly, in-camera proceedings; protect identity; avoid aggressive questioning and repeated calling. Evidence within 30 days and trial within 1 year **as far as possible** (§35).
Psychiatrist	Safety and trauma assessment; clear records; support treatment and recovery; expert opinion within competence. **Symptom presence/absence neither proves nor disproves abuse**.
Limits	Good-faith reporting protection; failure to report can be punishable, but child exempt. Never promise absolute secrecy.

POCSO Act 2012 (amended 2019) §§2–23, 24–27, 33–37, 42A; MoHFW medico-legal sexual-violence guidance.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

POCSO Act: child-friendly justice. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-26.

Credits and references: retained within the illustration.

III - 27

Juvenile justice act. [10]

10 ETHICS, CONSENT AND CHILD PROTECTION

KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	**Two children, two systems**	In conflict with law, and in need of care
2	**The two bodies**	One for each category, and who sits on them
4	**The steps**	Apprehension to disposal, including the 2015 change
2	**The psychiatrist's part**	The preliminary assessment, and what it is not

- **Two categories, two systems.** A child in conflict with law, who is below eighteen and alleged to have committed an offence, goes to the Juvenile Justice Board, a magistrate sitting with two social workers. A child in need of care and protection goes to the Child Welfare Committee. The Act's premise is care and reintegration, not punishment.

STEP	WHAT HAPPENS	WHO ACTS	CONDITION
1	Child apprehended and produced, never lodged in a police lock-up or jail	Special juvenile police unit	**Within twenty four hours**
2	Inquiry into the offence, the child kept out of the adult system	Juvenile Justice Board	Ordinarily completed in four months
3	For a heinous offence by a child of sixteen to eighteen, a preliminary assessment	Board, with a psychologist or expert	**Capacity, understanding of consequences, circumstances**
4	Board may transfer such a case to be tried as an adult	Children's Court	Only after that assessment
5	Disposal: counselling, community service, group home, or a place of safety	Board or Court	No death penalty, no life without release

The 2015 Act replaced the 2000 Act mainly to create this transfer route after public pressure; the same Act also carries the adoption provisions and the central adoption authority.

- **The preliminary assessment.** It asks whether the child had the mental and physical capacity to commit the offence, the ability to understand its consequences, and the circumstances in which it happened. It is not a trial, not a finding of guilt, and not a psychiatric diagnosis.

WHAT THE ACT DOES NOT COVER

Sexual offences against children, which go to the POCSO Act 2012 and its Special Court, and mental illness in the child, which goes to the Mental Health Care Act 2017. Nor does it validate the assessment it asks for: there is no established instrument for judging a sixteen year old's criminal maturity.

WHAT EARNS THE MARKS

- **The two categories separated at the start,** each with its own body.
- **The sixteen to eighteen transfer route,** which is the Act's defining feature.
- **The three limbs of the preliminary assessment.**
- **An honest word on its weak evidence base.**

SEE ALSO Slot III - 09 adoption **SPRINT** Day 24, Child psychiatry

WEAVE 100+ / PAPER III • 27.1

Juvenile Justice Act 2015

LEGAL ACTS APPENDIX • III Q 27 • with 2021 amendment; adoption link Q 9

1 AIM & WHO IS A CHILD

Child	**Below 18 years**. Rehabilitation, reintegration, best interests, dignity, participation, privacy and institutionalisation as a last resort.
Two pathways	**Child in conflict with law → JJB.** Child in need of care and protection → CWC. Age relates to date of alleged offence.
Institutions	JJB: Principal Magistrate + two social workers, at least one woman. CWC: Chairperson + four members, with required woman/expert representation.

2 CHILD IN CONFLICT WITH LAW

First contact	Special Juvenile Police Unit / Child Welfare Police Officer; produce before Board **within 24 h excluding travel**. No police lock-up or jail.
Bail	Ordinarily release with safeguards; refusal needs statutory reasons involving harmful association, danger or defeat of justice.
Offence classes	Petty: maximum ≤3 years. Heinous: **minimum ≥7 years**. Serious: statutory middle category, including offences with maximum >7 but no minimum or minimum <7.
Board orders	Counselling/admonition, group work, community service, probation or rehabilitative placement as law permits; individual care plan and follow-up.

3 AGE 16–18 + HEINOUS OFFENCE • §15

JJB preliminary assessment: **mental and physical capacity, consequences and circumstances**

↓

May obtain psychologist / psychosocial expert assistance; **assessment is not a trial**

↓

Children's Court independently decides whether adult trial is needed; otherwise juvenile procedure

4 SAFEGUARDS & CARE

No automatic transfer	Age 16–18 plus accusation alone does not mandate adult trial. **No death penalty or life imprisonment without possibility of release**.
Placement / review	Place of safety where applicable; at 21 assess reform and further disposition under statute. Protect education, treatment and reintegration.
CWC route	Assess protection needs; restore safely or arrange foster/sponsorship/institutional care; review individual care plans.

5 PSYCHIATRIST & ADOPTION

Expert role	Development, cognition, mental illness, trauma, substance use and function; report limitations. Do not equate maturity with IQ or predict guilt.
Adoption	JJ/CARA route; **District Magistrate** adoption orders after 2021 amendment. Legal eligibility and child's best interests; see 9.1 for full answer.
Appraisal	Child-centred framework; implementation challenges include specialist access, reliable assessment, delay, stigma and community rehabilitation.

JJ(Care and Protection of Children) Act 2015, amended 2021: §§2, 3, 4, 10–21, 27, 56, 61; Adoption Regulations 2022.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Juvenile Justice Act 2015. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-27.

Credits and references: retained within the illustration.

III - 28

Define child sexual abuse. Discuss important features of the POCSO Act and its implication in psychiatric practice. [3+4+3]

3 + 4 + 3 | ETHICS, CONSENT AND CHILD PROTECTION

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

3 **Definition**	Contact and non-contact, and the two conditions
4 **The Act's spine**	Six features, each with what it changes
2 **For the psychiatrist**	What the Act requires of you specifically
1 **The unresolved part**	One honest limit, named

- **Child sexual abuse.** The involvement of a child in sexual activity that he does not fully comprehend, cannot give informed consent to, or is not developmentally prepared for, and which violates the law or the social taboos of society. It covers contact and non-contact acts, and consent is legally impossible below eighteen.

FEATURE	WHAT THE ACT DOES	WHAT IT CHANGES IN PRACTICE
Gender neutral, under eighteen	Protects any child from any offender	Boys are covered, which older law did not do
Graded offences	Penetrative, aggravated, sexual assault, harassment, pornography	Severity tracks the act and the offender's position
Mandatory reporting	Any person must report; silence is an offence	**Overrides clinical confidentiality**
Child-friendly procedure	Support person, statement recorded once, in camera trial	Reduces repeated retelling
Presumption of guilt	Culpable mental state presumed of the accused	**Reverses the ordinary burden**
Special Court, time-bound	Designated court, evidence and trial within fixed periods	Faster than the general system, in principle

- **For the psychiatrist.** Report on first suspicion; take one account in the child's words and record it verbatim; give no opinion on whether the offence occurred; prepare the child for court as part of treatment; and tell the family at the outset that confidentiality does not survive a disclosure of abuse.

WHAT THE ACT DOES NOT SETTLE

Consensual sexual activity between adolescents falls within it, so a sixteen year old's relationship is an offence, and clinicians are drawn into reporting where no exploitation exists. Courts and law reform bodies have repeatedly noted the problem, and it remains unresolved.

WHAT EARNS THE MARKS

- **A definition with both conditions,** comprehension and developmental readiness.
- **Mandatory reporting named as overriding confidentiality.**
- **The reversed burden,** which few candidates know.
- **The adolescent difficulty,** stated honestly rather than avoided.

SEE ALSO Slot III - 26 management under the Act **SPRINT** Day 24, Child psychiatry

III - 29

Discuss the sexual boundary violations and nonsexual boundary violations that are important in clinical practice in Psychiatry. [5+5]

5 + 5 | ETHICS, CONSENT AND CHILD PROTECTION | DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	Crossing and violation	The distinction the whole answer rests on
4	The non-sexual domains	Where they occur, with an example in each
2	Sexual violations	Absolute, and why the rule outlasts discharge
2	Prevention	The slippery slope, and what interrupts it

THE DISTINCTION

A boundary crossing is a departure from the usual frame that is brief, non-exploitative and may even help: seeing a distressed patient beyond the hour. A boundary violation exploits the patient and serves the therapist's needs. Crossings are judged by context; violations never are.

DOMAIN	THE VIOLATION	WHY IT HARMS
Role	Treating a friend or relative; becoming the patient's business partner	**Objectivity and the right to refuse both go**
Money and gifts	Accepting valuable gifts, loans, investment tips	Creates obligation the patient cannot refuse
Time and place	Repeated late sessions, meetings outside the clinic	The frame that makes therapy safe dissolves
Self-disclosure	Confiding personal problems to the patient	**Reverses the direction of care**
Confidentiality	Using the material socially, or in teaching without consent	Trust cannot be repaired once lost

The amber rows carry the marks because they show the mechanism: a violation is defined by whose needs are served, not by the act's outward appearance.

- **Sexual violations.** Absolutely prohibited, whatever the patient's apparent consent, because the power difference makes consent meaningless. The prohibition does not lapse on discharge; a relationship with a former psychotherapy patient remains unethical, and the conduct is professional misconduct before the State Medical Council.
- **Prevention.** Violations arrive gradually, so the interruption is early: notice the exception being made, document it, keep supervision and personal therapy available, and treat the wish to make an exception for one patient as the signal it is.

WHAT EARNS THE MARKS

- **Crossing separated from violation in the first line.**
- **Non-sexual violations given by domain,** which is the five-mark half.
- **The rule surviving discharge,** stated explicitly.
- **The gradual course,** which is what makes prevention possible.

SEE ALSO Slot III - 22 principles of ethics **SPRINT** Day 26, Forensic ethics, consent and legal procedure

WEAVE 100+ / PAPER III • 29.1

Sexual and nonsexual boundary violations

LEGAL ACTS APPENDIX • III Q 29 • sexual 5 + nonsexual 5

1 DEFINITIONS

Boundary	Limits protecting the therapeutic role, trust and patient's interests. **Power imbalance persists despite apparent agreement**.
Crossing vs violation	A justified, documented departure may be benign; a violation exploits, harms or seriously compromises care. Context and effect matter.

2 SEXUAL VIOLATIONS

Examples	Sexual contact, romantic/sexual solicitation, erotic comments, sexualised messages, unnecessary intimate examination or voyeurism.
Why serious	Exploitation of trust/dependency, retraumatisation, shame, worsening symptoms, avoidance of care and damaged professional trust.
No rationalisation	Patient initiation, transference or alleged consent does not make exploitation therapeutic. Ending care to pursue a relationship does not erase vulnerability.

3 NONSEXUAL VIOLATIONS

Financial	Loans, business dealings, excessive gifts, fee exploitation or referral commissions.
Social / digital	Harmful dual relationships, private social contact, intrusive messages or public social-media disclosure.
Time / space / touch	Repeated special treatment, private meetings without clinical purpose, intrusive touch or compromised privacy.
Self-disclosure	Meeting clinician's emotional needs, burdening the patient, favouritism, excessive dependency or secrecy.

4 PREVENTION

Frame	Clear appointments, fees, contact rules, confidentiality, social-media policy and emergency arrangements.
Reflect	Recognise countertransference, rescue fantasies, secrecy and exceptionalism; seek supervision early.
Document	Clinical rationale for unavoidable boundary crossings; transparent team discussion and patient-centred alternatives.
Examination	Explain need, obtain consent, use appropriate chaperone and preserve dignity.

5 RESPONSE TO A VIOLATION

Ensure safety → listen without blame → assess psychological harm and immediate needs

↓

Document facts; support independent care, complaint/reporting routes and applicable legal duties

↓

Institutional/professional review → prevent recurrence; **do not pressure silence or private settlement**

6 LEGAL FRAME

Accountability	Professional misconduct; depending on facts, criminal/civil liability. POCSO applies to children; employment protections may also apply.
Ethical conclusion	Boundaries protect the patient and the integrity of treatment—not merely the clinician's reputation.

NMC Code of Medical Ethics 2002; POCSO 2012; general professional ethics and clinical boundary principles.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Sexual and nonsexual boundary violations. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-29.

Credits and references: retained within the illustration.

III - 30

What are the principles of Ethics? Describe their scope and application in mental health. [4+3+3]

4 + 3 + 3 | ETHICS, CONSENT AND CHILD PROTECTION

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

4	The principles	Four, plus the derived duties, each defined
3	Scope	Where they reach, and where the law takes over
2	Application	Four situations peculiar to this specialty
1	The limit	What principles cannot do on their own

THE PRINCIPLES

Autonomy, the right to decide for oneself. Beneficence, acting for the patient's good. Non-maleficence, above all doing no harm. Justice, fairness in distributing benefit and burden. From these follow veracity, fidelity and confidentiality, which are duties rather than principles.

WHERE IT APPLIES	THE MENTAL HEALTH QUESTION	WHAT GOVERNS IT HERE
Treatment decisions	Whether the patient may refuse	**Capacity, not diagnosis, decides**
Involuntary admission	Autonomy overridden to prevent harm	Statutory grounds, review, least restriction
Confidentiality	Family, employer, and a third party at risk	**Consent first; disclosure only as far as needed**
Research	Enrolling someone who cannot consent	Representative, assent, ethics committee
Resource use	Who gets the scarce bed or the long appointment	Need, not articulacy or ability to pay

Scope: principles guide, statute compels. Where the Mental Healthcare Act 2017 speaks, it settles the matter; where it is silent, the principles do the work.

- **The limit.** Principles do not rank themselves. They frame the argument and constrain the answer, but the decision in a hard case is made by reasoning through the conflict and recording that reasoning, which is also what protects the clinician afterwards.

WHAT EARNS THE MARKS

- **Four principles defined, not merely listed,** with the derived duties named as derived.
- **Scope answered as a boundary with the law,** which is what scope means here.
- **Applications specific to psychiatry,** not general medical examples.
- **The absence of a ranking,** and documentation as the practical answer.

SEE ALSO Slot III - 22 principles and clinical implications SPRINT

Day 26, Forensic ethics, consent and legal procedure

WEAVE 100+ / PAPER III

Childhood adversity and later outcomes

Risk accumulates through interacting pathways; outcomes are not predetermined.

Domain	Revision points
Adversity	Abuse, neglect, household disruption and other harmful exposures; ask sensitively and only with a care purpose.
Pathways	Threat/ stress regulation, attachment, learning, sleep, health behaviours and social disadvantage.
Possible outcomes	PTSD, depression, anxiety, substance problems, self-harm, relationship difficulties and physical-health burden.
Protection	A safe stable relationship, practical support, timely treatment, school connection and reduced ongoing exposure.

ASSESSMENT

Current safety and the person's needs matter more than an adversity-count score.

AVOID DETERMINISM

Association is not proof of a specific mechanism in an individual; many exposed children show resilience.

Weave Sprint Paper III; see source register

III 21.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Childhood adversity and later outcomes. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Ethics, consent and child protection.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

End-of-life decisions

Distinguish relief of suffering, treatment withdrawal and intentionally causing death.

Domain	Revision points
Withholding / withdrawal	Not starting or stopping burdensome life-sustaining treatment through the applicable decision process.
Palliative care	Active comfort care continues; proportional symptom relief is not abandonment.
Advance medical directive	Records future end-of-life preferences; distinct from a psychiatric advance directive under MHCA.
Indian framework	Common Cause (2018), modified in 2023; subsequent Supreme Court directions require attention.
Psychiatric contribution	Assess capacity, coercion, depression/ delirium and communication needs; do not decide alone.

CURRENT CASE CONTEXT

Harish Rana (2026) addresses withdrawal of life-sustaining treatment and reinforces the need for the court-defined safeguards.

KEEP DISTINCT

A competent refusal of treatment, assisted suicide and active euthanasia are different legal and ethical questions.

Supreme Court: Common Cause (2018/ 2023); Harish Rana landmark-judgment summary (2026).

III 22.2 • Supplement • Source links and qualifications: SOURCES.md

End-of-life decisions. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Ethics, consent and child protection.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III • 22.3

Consumer protection and medical care

LEGAL ACTS APPENDIX • Supplement • III Q 22–24, Q 29–30 • ethics/legal liability

1 LEGAL FRAMEWORK

CPA 2019	Consumer protection includes qualifying healthcare services. **V.P. Shantha(1995)** established medical-service coverage; do not infer a blanket doctor exemption from the 2024 lawyers judgment.
Current qualification	Supreme Court declined the suggested reference on 7 Nov 2024; later decisions continue to cite Shantha. Review live case law for an actual dispute.

2 WHO / WHAT IS COVERED?

Service	Paid medical consultation, diagnosis and treatment may constitute a service; insurer/employer-funded care can qualify.
Free care	Services wholly free to all patients generally excluded under Shantha; mixed paid/free services are treated differently. **Nominal registration alone is not full consideration**.
Deficiency	Fault, inadequacy or shortcoming in the quality/manner of performance required by law or undertaking; medical-negligence analysis needs facts and standard of care.

3 NEGLIGENCE: FOUR LINKS

Duty of care → expected reasonable professional standard

↓

Breach of that standard → causal link → **actual damage**

4 PSYCHIATRIC EXAMPLES & PREVENTION

Consent	Adequate information, capacity/support, specific agreement and record. A signed form does not excuse negligent care.
Assessment	Appropriate physical/mental assessment, risk formulation and differential; avoid diagnostic overshadowing.
Treatment	Reasonable prescribing and monitoring, follow-up, referral and emergency response; document clinical reasoning.
Records / privacy	Accurate contemporaneous notes, clear communication, secure records and lawful disclosure.
Limits	Adverse outcome, relapse or complication **does not itself establish negligence**. Evaluate care against knowledge and resources at the relevant time.

5 REMEDIES & PARALLEL ACCOUNTABILITY

Consumer route	District/State/National Consumer Commissions with statutory jurisdiction; remedies can include compensation and correction of deficiency.
Time	Ordinarily **2 years from cause of action**, delay may be condoned for sufficient cause (§69).
Separate routes	Professional discipline, civil and criminal proceedings have distinct tests. **Criminal negligence is not identical to civil deficiency**.
Clinical response	Preserve records, explain facts respectfully, arrange continuing care and use appropriate institutional/legal process; do not alter notes retrospectively.

Consumer Protection Act 2019 §§2, 39, 69; IMA v.V.P.Shantha 1995; SC order 7 Nov 2024; medical-negligence cases.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Consumer protection and medical care. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Ethics, consent and child protection.

Credits and references: retained within the illustration.

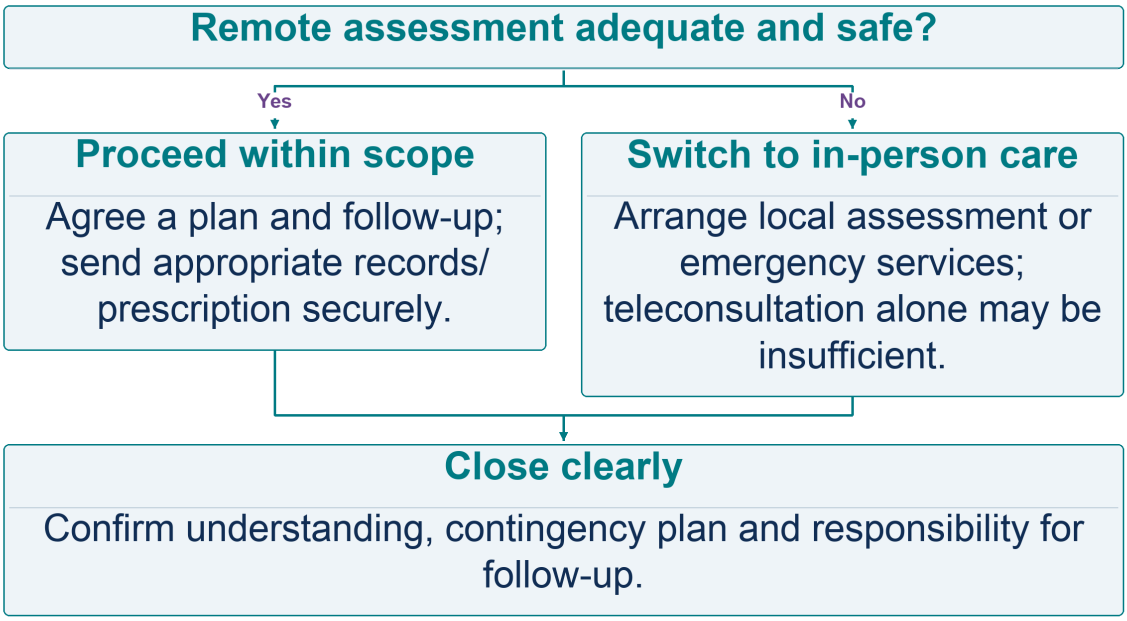
WEAVE 100+ / PAPER III

Telepsychiatry and confidentiality

The same clinical duties apply; distance adds identity and safety checks.

Domain	Revision points
Before consultation	Verify identities, location, privacy, consent and a reachable contact; document the consultation mode.
Confidentiality	Explain limits; disclose only necessary information when a lawful exception applies.
Records	Document assessment, consent, prescription, advice and referral; secure storage and access.
Prescribing	Check current telemedicine medicine lists, consultation type and applicable controlled-drug restrictions.

DECISION PATHWAY



NMC Telemedicine Practice Guidelines 2020; MHCA confidentiality provisions; Weave Sprint day 26.

III 24.3 • Supplement • Source links and qualifications: SOURCES.md

Telepsychiatry and confidentiality. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Ethics, consent and child protection.

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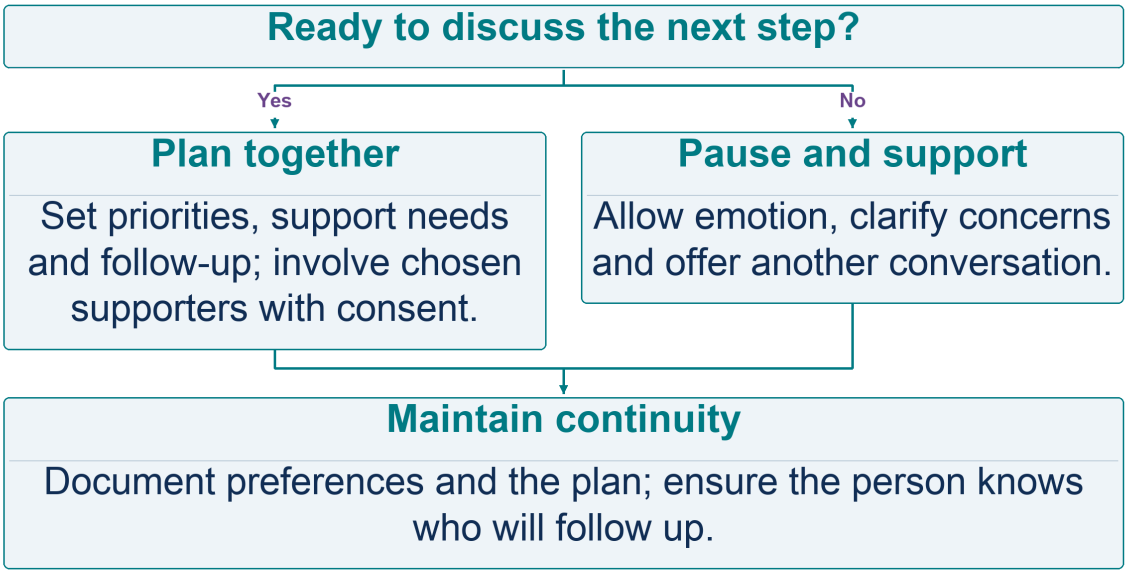
WEAVE 100+ / PAPER III

Relationship and breaking bad news

Clear information works best within a respectful therapeutic relationship.

Domain	Revision points
Setting / perception	Ensure privacy, time and support; ask what the person already understands.
Invitation / knowledge	Ask how much detail they want; give a warning shot, then small chunks in plain language.
Emotion / empathy	Pause, name and acknowledge feelings; avoid premature reassurance.
Strategy / summary	Agree immediate next steps; check understanding and offer written information.

DECISION PATHWAY



BOUNDARY

Empathy does not require false reassurance, promises of cure or disclosure beyond the person's wishes.

Weave Sprint Paper III; see source register

III 24.4 • Supplement • Source links and qualifications: SOURCES.md

Relationship and breaking bad news. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Ethics, consent and child protection.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Transactional analysis

A model of interactions: Parent, Adult and Child ego states.

Domain	Revision points
Parent	Internalised rules, criticism or care; not simply chronological adulthood.
Adult	Here-and-now information processing and reality-based response.
Child	Internalised early feelings and responses; can be spontaneous, adapted or rebellious.
Transactions	Complementary: expected response; crossed: response shifts the interaction; ulterior: overt and covert messages.
Other concepts	Strokes, life positions, scripts and games are used to examine recurring relational patterns.

WORKED EXAMPLE

“You never do anything right” can invite a defensive Child response. An Adult response asks which task needs changing and agrees a concrete action.

EVIDENCE FRAME

Use as a formulation and communication model; do not present its constructs as established neurobiological entities.

Transactional analysis. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Ethics, consent and child protection.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Client-centred therapy

Rogers: therapeutic conditions that support self-directed change.

Domain	Revision points
Empathic understanding	Try to understand the person's experience and communicate that understanding accurately.
Unconditional regard	Respect the person without making acceptance conditional on pleasing the therapist.
Congruence	A genuine, coherent therapeutic presence with appropriate professional boundaries.
Techniques	Reflect feeling and meaning, clarify and summarise; avoid directing the person toward the therapist's preferred solution.
Formulation	Explore incongruence between lived experience and self-concept; support agency and self-understanding.

IN THE ROOM

"Part of you wants change, and another part fears what you might lose." Check whether the reflection fits rather than assume it does.

LIMIT

A nondirective stance does not remove the need for risk assessment, safeguarding or treatment of acute illness.

Weave psychotherapy notes: Client-Centered Therapy; Rogers person-centred framework.

III 29.3 • Supplement • Source links and qualifications: SOURCES.md

Client-centred therapy. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Ethics, consent and child protection.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Existential psychotherapy

Explore how the person lives with choice, limits and meaning.

Domain	Revision points
Core concerns	Death, freedom/ responsibility, isolation and meaninglessness.
Therapeutic work	Examine avoidance, values, choices and ways of relating; use the therapeutic encounter reflectively.
Stance	Curious, collaborative and attentive to lived experience rather than imposing a philosophical answer.
Techniques	Clarification, exploration of dilemmas, values and responsibility; contextualise choices and constraints.
Distinction	Logotherapy particularly emphasises meaning; it is one approach within a broader existential tradition.

IN THE ROOM

“Which commitments still matter to you, even while certainty is unavailable?” Move from abstract discussion to the person’s actual choices.

LIMIT

Do not reframe structural adversity as personal failure or bypass acute risk and symptom treatment.

Weave psychotherapy notes: Existential Therapy; existing Logotherapy appendix.

III 29.4 • Supplement • Source links and qualifications: SOURCES.md

Existential psychotherapy. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Ethics, consent and child protection.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Common factors in psychotherapy

Shared therapeutic processes interact with specific techniques.

Domain	Revision points
Alliance	Agreement on goals, agreement on tasks and a workable emotional bond.
Expectancy / rationale	A credible explanation and realistic hope can support engagement.
Empathy / collaboration	Feeling understood and participating in decisions can improve the treatment process.
Learning and practice	New experiences, skills and behaviour outside sessions help translate insight into change.
Context	Patient preferences, therapist competence, culture, support and treatment fit influence outcome.

AVOID THE FALSE DICHOTOMY

Common factors do not imply that all therapies are equally effective for every condition, or that specific techniques are unnecessary.

REPAIR

Notice alliance ruptures; ask for feedback, clarify disagreement and renegotiate tasks and goals.

Weave psychotherapy foundations; psychotherapy common-factors and alliance literature.

III 29.5 • Supplement • Source links and qualifications: SOURCES.md

Common factors in psychotherapy. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Ethics, consent and child protection.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · new-child-rights



Supplement - Child rights and the psychiatrist. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Ethics, consent and child protection.

Credits and references: retained within the illustration.

AREA 04 OF 13 · P3-A05

Childhood emotional, tic, attachment and elimination disorders

10	10.2%	III-31	III-40
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

ANCHOR 1 · HIGH 2 · RECURRENT 1 · SINGLE 6

REVISION ORDER

Enuresis first and hardest: four of the ten slots, and the pharmacology is the part most answers get wrong. School refusal next. Tourette, anxiety, the mother infant slot and pica after that.

WHAT IS IN THIS AREA

Enuresis in four slots, school refusal in two, Tourette syndrome, childhood anxiety disorders, mother infant relationship disorders, and pica.

III - 31

Etiology, clinical features, differential diagnosis and treatment of Gilles de la Tourette syndrome. [10]

10 ASKED AT 7 MARKS

CHILDHOOD EMOTIONAL, TIC, ATTACHMENT AND ELIMINATION DISORDERS

DNB, KNRUHS, TN-MGRMU - 5 APPEARANCES, 5 OF 78 SESSIONS

SKELETON

2	Aetiology	Genetic, circuit and chemical, in that order
3	Clinical features	The criteria, the urge, the course, the company kept
2	Differential diagnosis	Movement, drug and functional causes separated
3	Treatment	The stepped plate: educate, behaviour, drug, refractory

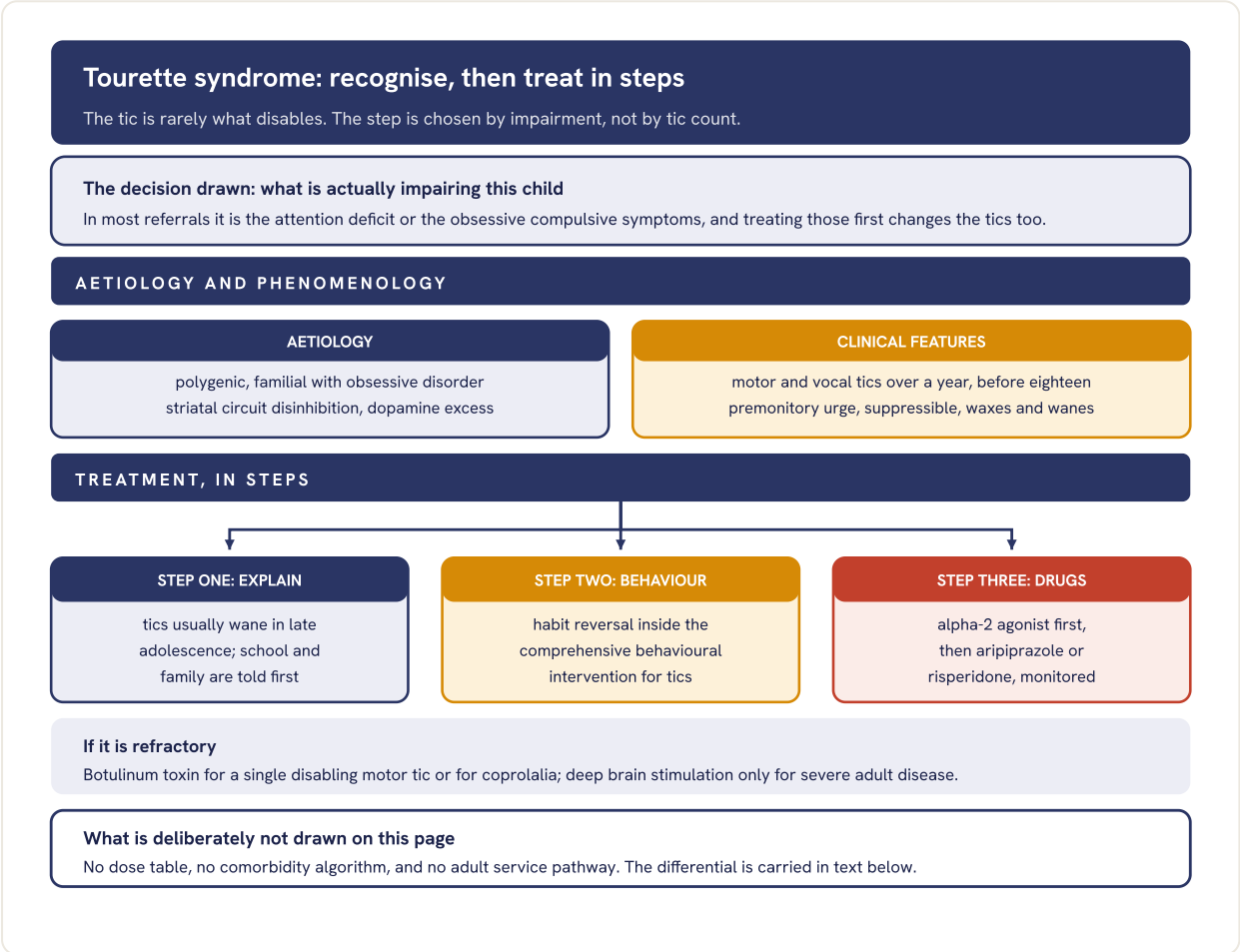


Fig 031.1 Aetiology and phenomenology in one band, then treatment as three steps, with the refractory options held back in a separate strip.

- **The company it keeps.** Attention deficit disorder in about half and obsessive compulsive symptoms in a third to a half, plus anxiety, rage outbursts, learning difficulty and poor sleep. Stimulants do not, on the evidence, worsen tics, so a coexisting attention deficit disorder should still be treated.

- **Differential diagnosis.** Provisional and persistent tic disorders, which do not meet the duration or the combination. Stereotypies, which are rhythmic and start earlier. Chorea in rheumatic fever or Wilson disease. Dystonia and myoclonus. Akathisia and tardive dyskinesia from antipsychotics. Compulsions, which are preceded by a thought rather than a bodily urge. Rapid-onset functional tic-like movements in adolescents.

PITFALL

Suppressibility is not proof of voluntariness. A child who holds tics through a clinic appointment and releases them at home has not been misbehaving, and telling a family otherwise is the commonest harm done in this condition.

WHAT EARNS THE MARKS

- **The premonitory urge named,** with suppressibility explained rather than treated as control.
- **A differential that crosses categories:** movement disorder, drug induced, and functional.
- **Behaviour therapy placed before medication,** with the named intervention.
- **The stimulant point.** Withholding stimulants for fear of tics is the classic wrong answer.

SEE ALSO Slot III - 19 stereotypic movement disorder Slot III - 50 management of attention deficit disorder **SPRINT** Day 23, Child behavioural, emotional & other disorders

WEAVE 100 · PAPER III · selected-31.3

Q31 • TOURETTE SYNDROME

PAPER III • AREA 4 | Recognise tics → classify → treat impairment

"Tics are real, not a choice." Support, understand, help them thrive.

1 PHENOMENOLOGY

Tics: sudden, rapid, recurrent, non-rhythmic movements or vocalisations.

Simple motor tics (e.g. eye blinking, shoulder shrug)	Complex motor tics (e.g. touching sequence)	Simple vocal tics (e.g. throat clearing, sniffing)	Complex vocal tics (e.g. repeating words: echolalia, paillalia)



Eye blinking · Shoulder shrug · Touching sequence · Throat clearing / sniffing · Repeating words (echolalia, paillalia)

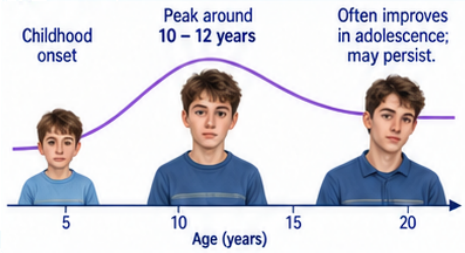
- **Coprolalia is uncommon and NOT** required.
- Often briefly **suppressible; premonitory urge** may precede tics, but is not universal.
- Wax and wane; stress may amplify.

2 DSM-5-TR COMPARISON

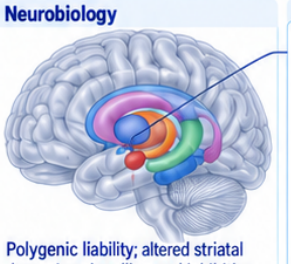
Disorder	Diagnostic criteria (DSM-5-TR)
Tourette syndrome	• ≥2 motor tics and ≥1 vocal tic at some time • Need not coexist • >1 year since first tic
Persistent motor OR vocal tic disorder	• One or more motor **OR vocal tics,** never both • >1 year • >1 year since first tic • Never met Tourette criteria
Provisional tic disorder	• Motor and/or vocal tics • < 1 year • Never met Tourette or persistent tic criteria
All	Onset before 18; exclude substances and other medical causes.

3 COURSE + MECHANISM

Typical course

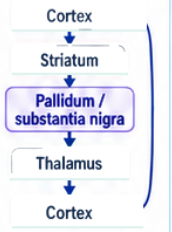


Neurobiology



Polygenic liability; altered striatal dopamine signalling and inhibition.

CSTC motor gating



Key points

- Overlapping, distinct loops in OCD.
- Urge relief = negative reinforcement; not proof of a mesolimbic origin.

4 ASSESS

- History + examination; tic type, course, urge/suppression, pain/injury, school and social impact; YGTSS for severity.
- Screen ADHD, OCD, anxiety, mood and suicidality.
- Diagnosis is clinical; investigate atypical features.

Differential diagnosis (key pointers)

- **Stereotypies:** patterned/rhythmic, often earlier onset
- **Compulsions:** rule/fear-driven
- **Chorea:** flowing
- **Dystonia:** sustained postures
- **Myoclonus:** shock-like
- **Seizures,** drug effects and functional tic-like symptoms.

5 MANAGEMENT — AAN 2019

Educate patient/family/school; agree functional goals; treat comorbidities

Tic-related impairment?

- NO → **Watchful waiting + review; CBIT if motivated**
- YES → **Offer CBIT when available**
  HRT: awareness + competing response + support; address triggers



Still impaired, unavailable or medication preferred?

- NO → **Tics + ADHD: consider α2 agonists → clonidine / guanfacine.** Monitor sedation, BP and pulse; taper gradually.
- YES → **Individualised antipsychotic option: aripiprazole / risperidone.** Lowest effective dose; monitor weight/metabolic effects, movement effects, prolactin as indicated.

Selected focal troublesome tics → botulinum toxin; severe refractory adult cases → specialist multidisciplinary DBS assessment.

Reassess function, tics and adverse effects → adjust / combine / taper when appropriate

Comorbidity management

- **ADHD:** treat when impairing; methylphenidate is not automatically contraindicated.
- **OCD:** CBT with ERP + SSRI.
- Address anxiety and school support.

Tics can be challenging, but with the right support, bright futures are possible.

UNDERSTAND TREAT SUPPORT EMPOWER

Diagnostic frame: DSM-5-TR (2022) · **Management:** AAN (2019) · IPS: dedicated Tourette CPG not verified in this search · Educational revision | 19 Sep 2026

Tourette syndrome - GPT illustrated. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-31.

Credits and references: retained within the illustration.

III - 32

Define school refusal. What are the various causes of school refusal? Discuss the psychiatric aspects of management of a child presenting with the problem of school refusal. [2+4+4]

2 + 4 + 4 | CHILDHOOD EMOTIONAL, TIC, ATTACHMENT AND ELIMINATION DISORDERS

DNB - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2 Definition	Four elements, and the line that excludes truancy
4 Causes	Child, school and family, each with an example
3 Management	The flowchart: treat, plan, return, hold
1 The urgency rule	One line on why time matters here

THE DEFINITION

Severe difficulty attending school, with marked emotional distress at the prospect of going, the child remaining at home with the parents' knowledge, and no significant antisocial behaviour. That last element separates it from truancy, where the absence is concealed and the child is elsewhere.

- **Causes, in three groups.** Child: separation anxiety in the younger, social anxiety and panic in the older, depression, specific phobia, and undiagnosed learning disorder or autism producing daily failure. School: bullying, punishment, examination pressure, an unfamiliar language of instruction. Family: parental anxiety or depression, overprotection, marital conflict, illness at home.

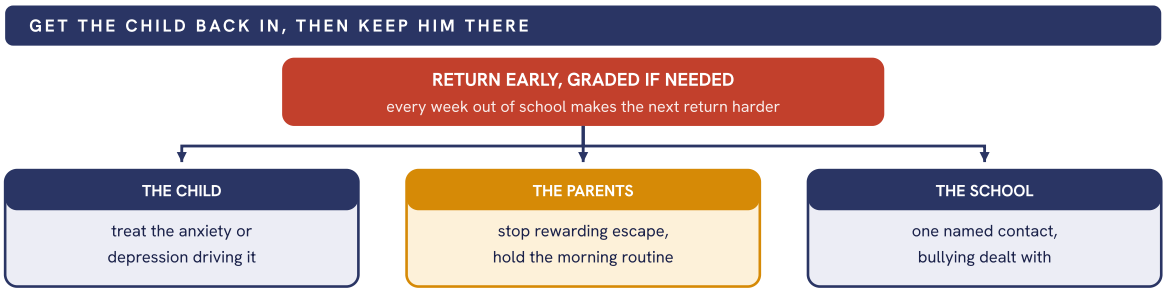


Fig 032.1 Early return drawn as the red first step, then the three parties who each own one part of the plan.

- **The psychiatric part.** Cognitive behavioural therapy with parent sessions alongside, graded exposure built into the return timetable, and a serotonin reuptake inhibitor where anxiety or depression is severe. Home schooling without a dated re-entry plan entrenches the problem.

WHAT EARNS THE MARKS

- **All four elements of the definition,** with truancy excluded by name.
- **Causes grouped as child, school and family,** not listed as one sequence.
- **Early return stated as the principle** before any therapy is described.
- **The parent behavioural work.** Treating only the child is the commonest incomplete answer.

SEE ALSO Slot III - 33 evaluation of school refusal Slot III - 35 childhood anxiety disorders **SPRINT** Day 23, Child behavioural, emotional & other disorders

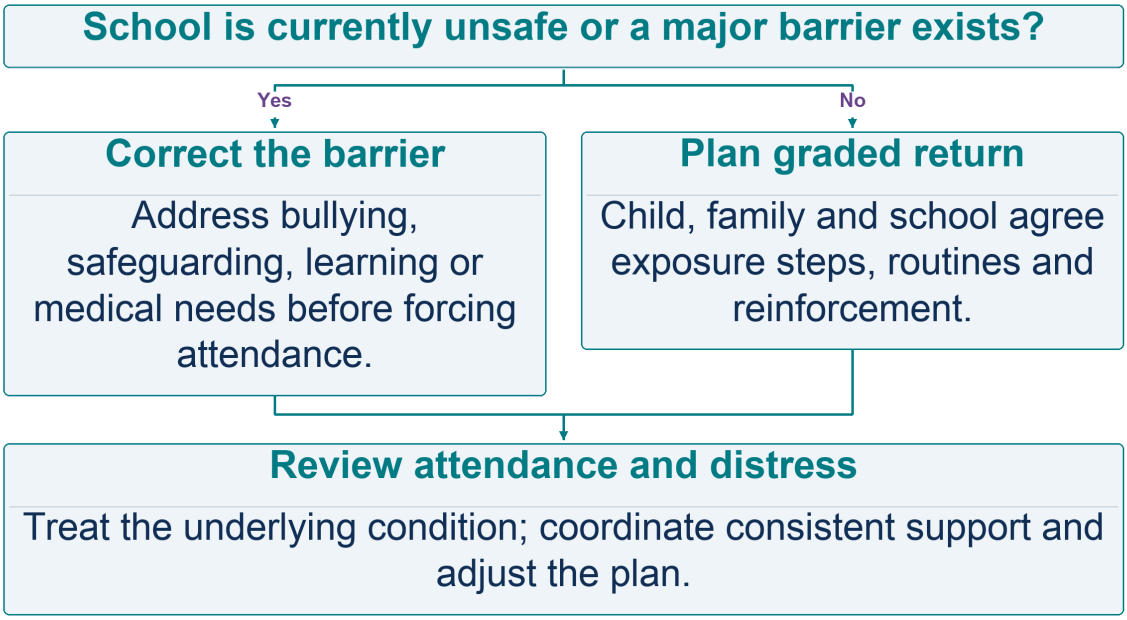
WEAVE 100+ / PAPER III

School refusal versus truancy

School absence is a signal to formulate, not a diagnosis to punish.

Domain	Revision points
School refusal	Distress about attending; caregivers often know and the child may remain at home.
Truancy	Absence may be concealed and associated with rewarding activities or conduct difficulties; overlap is possible.
Assessment	Separation/ social anxiety, bullying, learning problems, depression, family factors and school environment.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 32.1 • Question-linked revision • Source links and qualifications: SOURCES.md

School refusal versus truancy. Read across the labelled contrasts to distinguish the related concepts. Read with III-32.

III - 33

Discuss the evaluation of a child presenting with school refusal. [10]

10 CHILDHOOD EMOTIONAL, TIC, ATTACHMENT AND ELIMINATION DISORDERS

KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 **Frame the problem**	Separate refusal from truancy and from withholding
5 **The five sources**	Child, parent, school, examination, instruments
2 **Formulate the function**	What the absence achieves for this child
1 **Risk**	The two enquiries that are never delegated

FRAME IT BEFORE YOU ASSESS IT

Three things look alike at the door. School refusal: the child stays home, the parents know, and there is distress. Truancy: the absence is concealed and the child is elsewhere. School withholding: the parents keep the child at home for their own reasons. The assessment differs completely, so the frame comes first.

SOURCE	WHAT TO COVER	WHAT IT SETTLES
The child, alone	Morning symptoms, fears, mood, sleep, self harm, bullying, abuse	**The private history the parent will not hear**
The parents	Timeline, what happens each morning, what the child does at home	Reinforcement, and secondary gain
The school	Attendance record, marks, peer group, a named teacher's account	**Whether the trigger is inside the school**
Examination	Physical review of the headache and abdominal pain	Rules out illness without endless tests
Instruments	Anxiety and depression rating scales; learning assessment where marks have fallen	Severity, and a baseline to measure

- **Formulate the function.** Four functions are described: avoiding what provokes distress at school, escaping social or evaluative situations, gaining attention at home, and pursuing something more rewarding outside. The first two are anxiety driven and the last is closer to truancy, and the function chosen decides the plan.
- **Risk, never delegated.** Ask the child directly and privately about self harm and about abuse. A sudden refusal in a previously well child is a safeguarding question until it is answered, and a child protection referral runs under the Juvenile Justice Act 2015 where neglect or abuse is found.

WHAT EARNS THE MARKS

- **The three-way frame at the start.** Refusal, truancy, withholding.
- **The child interviewed alone,** written as a step rather than assumed.
- **A named school contact treated as a data source,** not as an afterthought.
- **The function formulated,** because it is what turns an assessment into a plan.

SEE ALSO Slot III - 32 causes and management Slot III - 35 childhood anxiety disorders SPRINT

Day 23, Child behavioural, emotional & other disorders

III - 34

What is enuresis? Classify enuresis. Describe the management of enuresis in a 15-year-old child and in a 70-year-old adult? [1+2+3+4]

1 + 2 + 3 + 4 | CHILDHOOD EMOTIONAL, TIC, ATTACHMENT AND ELIMINATION DISORDERS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

1	**Definition**	Frequency, duration, age, and the exclusion
2	**Classification**	Three axes: timing, primary or secondary, symptoms
3	**The adolescent**	Reassess first, then alarm, then a drug
4	**The older adult**	A different problem with a different framework

DEFINITION AND CLASSIFICATION

Repeated voiding into the bed or clothes, at least twice a week for three months or causing distress, at a chronological or developmental age of at least five, and not due to a substance or medical condition. Three axes: nocturnal, diurnal or both; primary if never dry for six months, secondary if dryness was lost; monosymptomatic, or with daytime symptoms.



Fig 034.1 The two ages split at the top because they are different problems. Only the left lane is enuresis as the definition above uses the word.

- **The adolescent.** After reassessment: fluid timing, void before bed, treat constipation. An alarm is first line and has the best sustained response. Desmopressin gives quick control for a camp or an examination, with fluid restricted around the dose. An anticholinergic if the bladder is overactive; imipramine last, with cardiac caution.
- **The older adult.** Work the reversible causes: delirium, infection, atrophic change, diuretics and sedatives, excess output from heart failure or diabetes, poor mobility, stool impaction. Then prostate, overactive bladder, dementia. Timed voiding, pelvic floor work, environment and aids come before any drug. Anticholinergics carry cognitive risk, and desmopressin is avoided over sixty-five.

WHAT EARNS THE MARKS

- **The definition with all four elements,** and the three classification axes named as axes.
- **The statement that the seventy year old does not have enuresis.** That one line is what the question is testing.
- **Alarm placed first for the adolescent,** desmopressin positioned as short term control.
- **Drug cautions specific to old age:** anticholinergic cognitive risk, and low sodium with desmopressin.

SEE ALSO Slot III - 36 treatment in detail Slot III - 38 aetiology **SPRINT**

Day 23, Child behavioural, emotional & other disorders

WEAVE 100 · PAPER III · selected-34.3

34 • ENURESIS

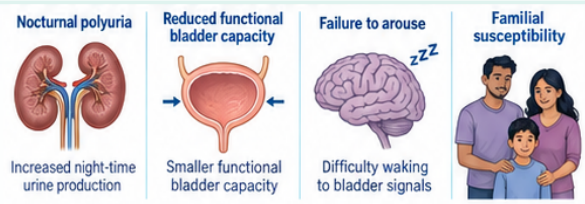
WEAVE 100+ • PAPER III | Links: original Q36 / Q38



DIAGNOSIS & TYPES

- **DSM-5-TR:** repeated urine passage into bed/clothes, involuntary or intentional; age ≥5 years or developmental equivalent; ≥2/week for ≥3 months OR significant distress/impairment; exclude substances and medical causes.
- **Specify** nocturnal only / diurnal only / both.
- **Primary:** never dry ≥6 months. **Secondary:** recurs after ≥6 months dry.
- **Monosymptomatic nocturnal enuresis:** no daytime LUTS. **Nonmonosymptomatic:** associated LUTS, NOT psychiatric comorbidity.

WHY & WHAT TO ASSESS



- **Bladder/bowel diary;** timing, frequency, urgency, weak stream, constipation, previous dryness; snoring/OSA, polydipsia, stress and medicines. Examine abdomen, growth, spine/neurology as indicated.
- **Urinalysis** if recent onset, daytime symptoms, illness, UTI/diabetes suspicion; not routinely required in straightforward primary monosymptomatic cases. Continuous leakage, recurrent UTI or neurologic signs → investigate/refer.

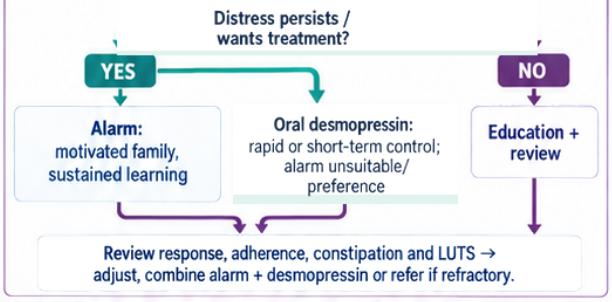
FOUNDATIONS

- Explain without blame; no punishment.
- Normal daytime hydration, regular voiding and bedtime void; avoid caffeine.
- Treat constipation and daytime LUTS.
- Reward behaviours, not dry nights.



- ☑ Hydrate (daytime)
- ☑ Regular voiding
- ☑ Bedtime void
- ☑ Treat constipation
- ☑ Positive support

ACTIVE CHOICE — Distress persists / wants treatment?



ALARM: SHOW HOW



- **Review at 4 weeks:** smaller patches/later or fewer alarms = early response.
- No early response → stop/reassess.
- Improving → continue until ≥14 consecutive dry nights.
- At 3 months, continue only if improving and family willing.
- Restart for relapse.

Consistency builds success

DESMOPRESSIN — PRESCRIBED ORAL FORMULATION

Example UK product-label regimen, age 15; confirm local product

Swallowed tablet:	**0.2 mg** at bedtime → **0.4 mg** if needed
Sublingual tablet/melt:	**120 micrograms** at bedtime → **240 micrograms** if needed



- Different bioavailability: do **NOT** substitute the same numerical dose.
- No intranasal desmopressin for bedwetting.
- **Restrict fluids from 1 hour BEFORE until 8 hours AFTER** dose.
- Skip during fever, vomiting/diarrhoea or evenings requiring rehydration.
- **Hyponatraemia warning:** headache, nausea, weight gain, confusion/seizure → stop and urgent assessment.
- **Check contraindications:** low sodium/SIADH, polydipsia, significant renal impairment, heart failure/fluid-overload states; review interacting medicines.
- **Review** around 4 weeks; responders: 3-month course then treatment break/reassess. Relapse is common.
- **Continuous use:** CPS advises sodium/electrolytes about every 3 months; monitoring varies by guideline and risk.

REFRACTORY — SPECIALIST ONLY

Oxybutynin for selected detrusor overactivity/LUTS

- After checking emptying: age >5, immediate-release 2.5 mg twice daily; titrate if needed up to 5 mg 2–3 times daily (UK label), last dose at bedtime.
- Monitor constipation, retention and CNS effects; not routine monosymptomatic monotherapy.



Imipramine: exceptional refractory use

- Specialist cardiac/ECG and overdose-risk assessment.
- UK label: 6–7 y 25 mg; 8–11 y 25–50 mg; >11 y 50–75 mg at bedtime; never >2.5 mg/kg/day.
- Max 3 months then gradual withdrawal; cardiac toxicity/overdose risk, secure storage.





AGE 70 • EXAM CUE

- **Adult enuresis exists.** Look for UTI, constipation, diabetes/polyuria, OSA, medicines, retention/obstruction and impaired mobility/cognition. Diary, urine tests, renal function and post-void residual as indicated. Support safe toileting; treat cause.
- Anticholinergics may worsen cognition/retention. Desmopressin needs indication/product-specific assessment and sodium monitoring: hyponatraemia risk rises with age; do not copy the child regimen.

Different causes
Different assessment
Different plan

DSM-5-TR 2022 • NICE CG111 • CPS 2023 • UK SmPC dose examples (checked 19 Sep 2026). Dedicated IPS enuresis CPG not verified. Educational revision; individual prescribing requires clinical review.

Enuresis - Illustrated doses alarm and age70. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-34.

Credits and references: retained within the illustration.

III - 35

Classify childhood anxiety disorders. Discuss principles of management of each of them. [4+6]

4 + 6 | CHILDHOOD EMOTIONAL, TIC, ATTACHMENT AND ELIMINATION DISORDERS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	The classification	Named, and what sits just outside the group
2	The common core	What every one of them is treated with first
4	Disorder by disorder	The specific twist each one needs
2	Medication	When it is added, which drug, and for how long

DISORDER	THE CORE FEAR	THE SPECIFIC TWIST IN MANAGEMENT
Separation anxiety	Loss of the attachment figure	**Graded separations, parent coached**
Selective mutism	Speaking where it is evaluated	**Shaping; never pressure to speak**
Specific phobia	One object or situation	Graded exposure, often one long session
Social anxiety	Scrutiny and humiliation	Exposure plus social skills
Panic and agoraphobia	The bodily sensations	Interoceptive, then situational
Generalised anxiety	Uncertainty across domains	Worry exposure, problem solving

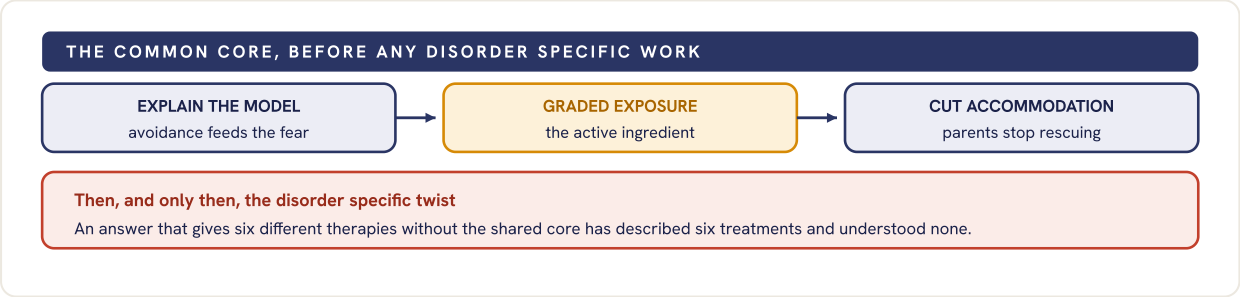


Fig 035.1 Three shared steps run before any disorder specific work, which is why the table's last column is a twist rather than a separate treatment.

- **Medication.** A serotonin reuptake inhibitor, usually fluoxetine or sertraline, when the disorder is moderate to severe or therapy alone has failed. Start low, review within a fortnight for activation and suicidal thinking, continue six to twelve months after response. Benzodiazepines are avoided in children.

WHAT EARNS THE MARKS

- **The classification named,** with obsessive compulsive and post-traumatic disorders placed outside the group but managed on the same exposure principle.
- **The shared core stated once** before the disorder by disorder section.
- **Selective mutism handled correctly.** Shaping, never pressure to speak, is the discriminating detail.
- **Drug placed second line with a duration attached.**

SEE ALSO Slot III - 32 school refusal Slot III - 33 evaluation of school refusal **SPRINT**

Day 23, Child behavioural, emotional & other disorders

WEAVE 100 · PAPER III · 35.2

35 • CHILDHOOD ANXIETY DISORDERS

WEAVE 100+ • PAPER III • DSM-5-TR (2022)

Developmentally excessive + persistent + distress/impairment; exclude medical/substance causes and better explanations.
Assess child, caregivers and school; school refusal is a presentation, not a diagnosis.

1. SEPARATION ANXIETY DISORDER



Developmentally excessive separation fear; ≥3 of 8 symptoms; ≥4 weeks in children/adolescents. Worries: separation, harm/loss, events causing separation; refuses school/going out, being alone or sleeping apart; separation nightmares; physical symptoms.

TREAT: graded separations, brief predictable goodbyes, parent coaching and supported school return; CBT ± SSRI when indicated.

ADULT CONTRAST

Also an adult diagnosis; duration typically ≥6 months. Focus may be partner/children; work or travel avoidance. Same core symptom threshold. Child care adds parent/school work.

2. SELECTIVE MUTISM



Consistently silent where speech expected despite speaking elsewhere; ≥1 month, not just first school month; impairs education/communication. Not unfamiliarity/discomfort with required language; not better explained by communication disorder or exclusively during ASD/psychosis.

TREAT: school + family + speech-language team; graded speaking exposure, shaping and stimulus fading: do not pressure speech.

ADULT CONTRAST

May persist into adulthood; no separate adult duration cutoff. Impacts work/relationships. New adult mutism warrants broader differential; not automatically selective mutism.

3. SPECIFIC PHOBIA



Immediate fear/avoidance of a specific object or situation, dispoportionate to danger; typically ≥6 months. Children may cry, cling, freeze or tantrum.

TREAT: developmentally adapted graded exposure, modelling, parent-supported practice; applied tension for blood/injection fainting. Medicines not routine.

ADULT CONTRAST

Same duration and core criteria. Adults may describe fear more clearly; children need behavioural observation and developmental context. Exposure remains central at both ages.

4. SOCIAL ANXIETY DISORDER



Fear of negative evaluation; social situations avoided or endured with intense fear; typically ≥6 months. Must occur with PEERS, not only adults. May cry, cling, freeze, shrink away or fail to speak.

TREAT: social-anxiety CBT/exposure with peer practice and parent/school support. NICE: do not routinely medicate under-18s.

ADULT CONTRAST

Same core fear/duration; work, dating and performance contexts. Adult CBT or SSRI are established options. NICE permits suitable cognitively mature 15+ youth to use adult-style therapy.

5. PANIC DISORDER



Recurrent UNEXPECTED panic attacks; ≥1 attack followed by ≥1 month of worry about more attacks/consequences OR maladaptive behaviour change. Panic surge peaks within minutes, ≥4 symptoms. More typical in adolescence; assess medical mimics.

TREAT: panic-focused CBT, interoceptive exposure and re-engagement; SSRI may be considered.

ADULT CONTRAST

Same criteria; no special childhood duration. A panic attack alone ≠ panic disorder. Agoraphobia is diagnosed separately, either can occur without the other.

6. AGORAPHOBIA



Fear in ≥2 of 5: public transport, open spaces, enclosed places, queues/crowds, outside home alone. Escape/help feared unavailable if panic-like or incapacitating symptoms occur. Avoids, needs companion or endures; typically ≥6 months.

TREAT: graded real-world exposure/CBT; help parents reduce accommodation and build independent travel.

ADULT CONTRAST

Same criteria. Child avoidance may resemble school/separation anxiety—ask WHAT is feared. Separate from panic disorder; diagnose both if both sets of criteria met.

7. GENERALISED ANXIETY DISORDER (GAD)



Hard-to-control, multi-domain excessive worry more days than not ≥6 months. Child needs ≥1 associated symptom: restless, fatigued, poor concentration, irritable, tense muscles or disturbed sleep. School/performance worries, perfectionism, reassurance seeking, somatic complaints.

TREAT: CBT for worry/uncertainty, exposure and problem-solving; parent coaching; SSRI ± CBT by severity/access/preference.

ADULT CONTRAST

Adults need ≥3 of the 6 associated symptoms; children need ≥1. Duration same. Adult themes often work/finances/family; child themes often school/competence.

COMMON CARE: collaboratively assess impairment, bullying/trauma, development, comorbidity and safety. Use child-adapted CBT and parent/school collaboration. AACAP 2020 supports CBT and SSRIs; combined treatment may help. Choice depends on diagnosis, severity, access and preference—not a rigid CBT-failure rule. If prescribing: confirm age/indication, start low/titrate, monitor activation, suicidality, sleep/GI effects and manic symptoms. Benzodiazepines are not routine maintenance.

IPS 2019 assessment: integrate child, caregiver and other informants with developmental context.

Sources: DSM-5-TR • AACAP 2020 (older guideline; not a 2026 update) • NICE CG159 • ASHA selective mutism • IPS assessment CPG 2019. Checked 19 Sep 2026.

Childhood anxiety - Child adult contrasts. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-35.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · selected-35.3

35 • CHILDHOOD ANXIETY DISORDERS

WEAVE 100+ • PAPER III • DSM-5-TR (2022)

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TREAT: graded separations, brief predictable goodbyes, parent coaching and supported school return; CBT ± SSRI when indicated.

ADULT CONTRAST

Also an adult diagnosis; duration typically ≥6 months. Focus may be partner/children; work or travel avoidance. Same core symptom threshold. Child care adds parent/school work.

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Consistently silent where speech expected despite speaking elsewhere; ≥1 month, not just first school month; impairs education/communication. Not unfamiliarity/discomfort with required language; not better explained by communication disorder or exclusively during ASD/psychosis.

TREAT: school + family + speech-language team; graded speaking exposure, shaping and stimulus fading: do not pressure speech.

ADULT CONTRAST

May persist into adulthood; no separate adult duration cutoff. Impacts work/ relationships. New adult mutism warrants broader differential; not automatically selective mutism.

3. SPECIFIC PHOBIA



Immediate fear/avoidance of a specific object or situation, disproportionate to danger; typically ≥6 months. Children may cry, cling, freeze or tantrum.

TREAT: developmentally adapted graded exposure, modelling, parent-supported practice; applied tension for blood/injection fainting. Medicines not routine.

ADULT CONTRAST

Same duration and core criteria. Adults may describe fear more clearly; children need behavioural observation and developmental context. Exposure remains central at both ages.

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TREAT: graded real-world exposure/CBT; help parents reduce accommodation and build independent travel.

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Sources: DSM-5-TR • AACAP 2020 (older guideline; not a 2026 update) • NICE CG159 • ASHA selective mutism • IPS assessment CPG 2019. Checked 19 Sep 2026.

Childhood anxiety - Wider adult contrasts. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-35.

Credits and references: retained within the illustration.

III - 36

What is nocturnal enuresis? Describe its pharmacological and non-pharmacological management in detail. [2+4+4]

2 + 4 + 4 | CHILDHOOD EMOTIONAL, TIC, ATTACHMENT AND ELIMINATION DISORDERS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	What it is	Definition, natural course, and the three mechanisms
4	Non-pharmacological	General measures, then the alarm protocol in full
3	Pharmacological	Each drug with its rule and its risk
1	Relapse	What is done when it comes back

WHAT IT IS, AND WHY IT HAPPENS

Bedwetting at or beyond five years, at least twice a week for three months or causing distress. A substantial proportion remit each year without treatment. Three mechanisms combine: more urine at night than the bladder holds, a small functional capacity with an overactive detrusor, and a high arousal threshold.

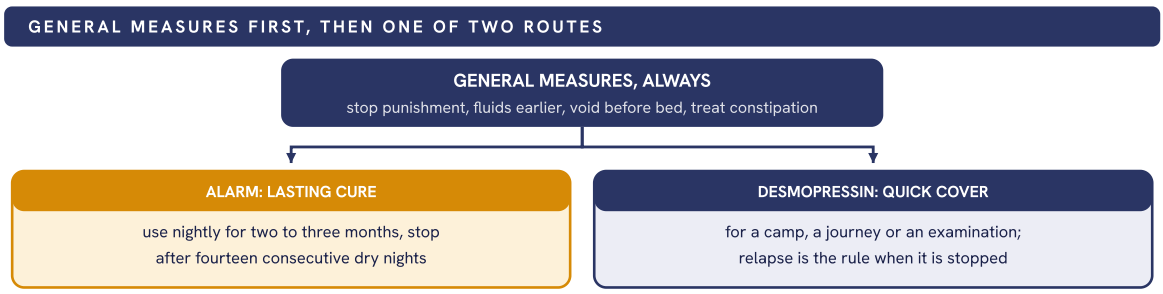


Fig 036.1 The two routes answer different questions. The alarm is chosen for a lasting result, desmopressin for cover on a known date, and the pair can be combined when either alone fails.

- **The alarm, in detail.** It conditions waking to bladder fullness. Reward the behaviours the child controls, getting up and resetting it, never a dry night. Overlearning, extra fluid at bedtime once dry, reduces relapse. A family too tired to wake with it is the commonest reason it fails.
- **The drugs, with their rules.** Desmopressin in the evening, with fluid restricted from an hour before to eight hours after, and withheld during vomiting or diarrhoea, because water intoxication is the serious harm. An anticholinergic where daytime urgency suggests an overactive bladder. Imipramine last, with cardiac review and a real overdose risk in the home.

WHAT EARNS THE MARKS

- **The three mechanisms named,** because each treatment maps onto one of them.
- **The alarm protocol with its stopping rule,** not just the word alarm.
- **Rewarding behaviour rather than dry nights.** It is the detail that shows the method is understood.
- **The fluid restriction with desmopressin,** and the reason for it.

SEE ALSO Slot III - 38 aetiology and management Slot III - 40 choosing the first treatment **SPRINT**

Day 23, Child behavioural, emotional & other disorders

III - 37

Describe the clinical features and management of mother infant relationship disorders. [10]

10 CHILDHOOD EMOTIONAL, TIC, ATTACHMENT AND ELIMINATION DISORDERS

KUHS, RGUHS - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2 What the disorder is	The dyad is the patient, not the mother alone
4 Clinical features	On the mother's side and on the infant's side
3 Management	The flowchart: safety, mother, dyad, support
1 Safeguarding	The threshold at which the law is involved

PATTERN	IN THE MOTHER	IN THE INFANT
Emotional rejection	Delayed or absent warmth, no pleasure in the baby, avoidance	Gaze avoidance, reduced social smile, frozen watchfulness
Hostility	Anger at the infant, thoughts or threats of harm	Distress on approach; injuries requiring explanation
Anxious overinvolvement	Hypervigilance, constant checking, cannot let others hold	Feeding and sleep disturbance, irritability
Neglect	Care given mechanically or not at all	Poor weight gain, developmental delay



Fig 037.1 The safety question comes first because it decides whether the infant may be left unsupervised, and only then do the three arms of treatment begin.

- **Assessment.** Watch a feed and a period of play rather than relying on report. Rate maternal mood and bonding on the standard questionnaires. Ask about the pregnancy being wanted, pressure over the infant's sex, violence at home, and who else can help.
- **Safeguarding.** Where there are thoughts of harm, the infant is not left alone with the mother until the risk is managed, and admission with the infant is arranged where a facility exists. Significant neglect makes this a child in need of care and protection under the Juvenile Justice Act 2015.

WHAT EARNS THE MARKS

- **The dyad named as the patient.** An answer that only treats maternal depression has answered a different question.
- **Infant signs described,** not merely implied from the mother's behaviour.
- **Observation of a feed as the method,** and the safeguarding threshold with its statute.

SEE ALSO Slot III - 100 adverse childhood experiences Slot III - 98 temperament

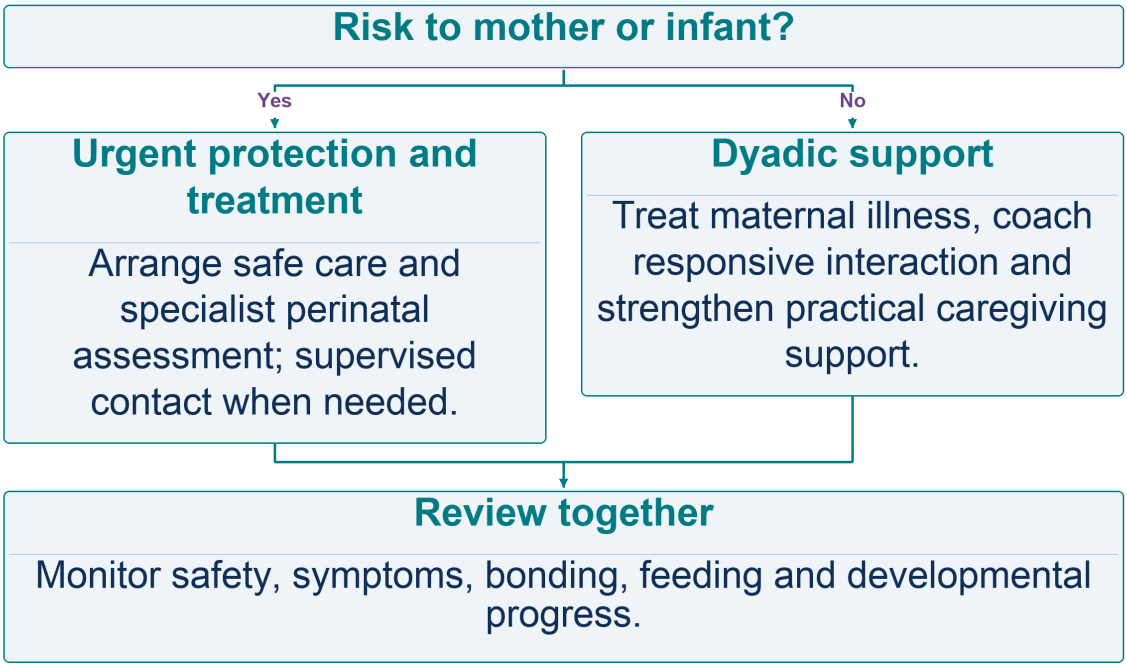
WEAVE 100+ / PAPER III

Mother– infant relationship

Assess the dyad, the caregiver's mental state and the infant's needs.

Domain	Revision points
Possible problems	Emotional rejection, anxiety about care, anger, withdrawal or impaired interaction.
Assess the mother	Depression, psychosis, trauma, sleep, support, violence and thoughts of harm.
Assess the infant	Feeding, growth, development, medical issues and observed interaction.
Context	Pregnancy/ birth experience, caregiving expectations, partner/ family support and practical strain.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 37.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Motherinfant relationship. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-37.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

37 • Mother– infant relationship

Assess the mother, infant and their interaction together; support without blame.

Describe, do not label	Clinical meaning
Relationship concerns	Emotional distance/ rejection, hostility, anxious overinvolvement or neglect are descriptive patterns— not four DSM diagnoses. Delayed warmth alone does not establish a disorder.
Observe the dyad	Watch feeding and play: infant cues, warmth, sensitive and timely responses, turn-taking, soothing and physical care. Interpret infant behaviour developmentally; one observation is not a diagnosis.
Assess mother + context	Mood, anxiety/ OCD, psychosis, trauma, sleep, substance use, physical illness; pregnancy/ birth experience, family expectations, violence, practical strain and available support.
Assess the infant	Feeding, growth, sleep, health and development; distress/ withdrawal and interaction across settings. Check strengths as well as difficulties.

SAFETY: ASSESS THE MEANING OF HARM THOUGHTS

Unwanted intrusive thoughts

Ego-dystonic, distressing thoughts with avoidance/ compulsions may indicate perinatal OCD. They are not equivalent to intent or psychosis. Assess carefully; no automatic separation.

Intent, psychosis or unsafe care

Assess intent/ plan, beliefs, reality testing, capacity to care, severe depression and other risks. Credible immediate danger or serious neglect needs urgent specialist help and a proportionate safeguarding plan.

COORDINATED CARE — PARALLEL, NOT A RIGID SEQUENCE

Care strand	What to do
Maternal treatment	Treat identified illness; individualise psychological and medication care, including breastfeeding considerations. Urgent perinatal assessment for severe illness.
Dyadic work	Coach cue recognition and responsive interaction during feeding/ play; consider parent–infant therapy or video feedback where appropriate. Build confidence without blame.
Family + practical help	Agree safe caregiving support, rest/ sleep, feeding help and follow-up. Involve trusted supports with consent; assess domestic safety.
Review together	Reassess symptoms, safety, interaction, infant feeding/ growth and development. Supervision/ separation only when individually needed; supported joint care where safe.

NICE CG192: relationship assessment • RCPsych: perinatal OCD and specialist services

Original Q37 • Native A4 2480 × 3508 at 300 DPI • Candidate: user review pending

Mother-infant relationship. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-37.

Credits and references: retained within the illustration.

III - 38

Etiology and management of enuresis. [4+6]

4 + 6 | CHILDHOOD EMOTIONAL, TIC, ATTACHMENT AND ELIMINATION DISORDERS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	Primary aetiology	Genetic and physiological, the three mechanisms
2	Secondary causes	Medical and psychological, each with its clue
4	Management by cause	Treat the cause found, then the symptom
2	The general programme	What every child gets whatever the cause

CAUSE	THE CLUE THAT POINTS THERE	WHAT IT CHANGES
Genetic and maturational	A wet parent, primary and monosymptomatic	Reassure, then the general programme
Constipation	Infrequent hard stools, soiling, a palpable mass	**Treat it and a third become dry**
Sleep disordered breathing	Snoring, mouth breathing, large tonsils	**Refer; surgery can resolve the wetting**
Urinary or metabolic	Dysuria, thirst, weight loss, poor stream	**Urine test and glucose before anything else**
Psychological	Secondary onset after a birth, a move, a loss or abuse	Address the event, not only the bed
Neurological	Sacral dimple, gait change, continuous dribbling	Imaging and specialist referral



Fig 038.1 Cause before symptom, with the general programme running underneath the whole sequence rather than at the end of it.

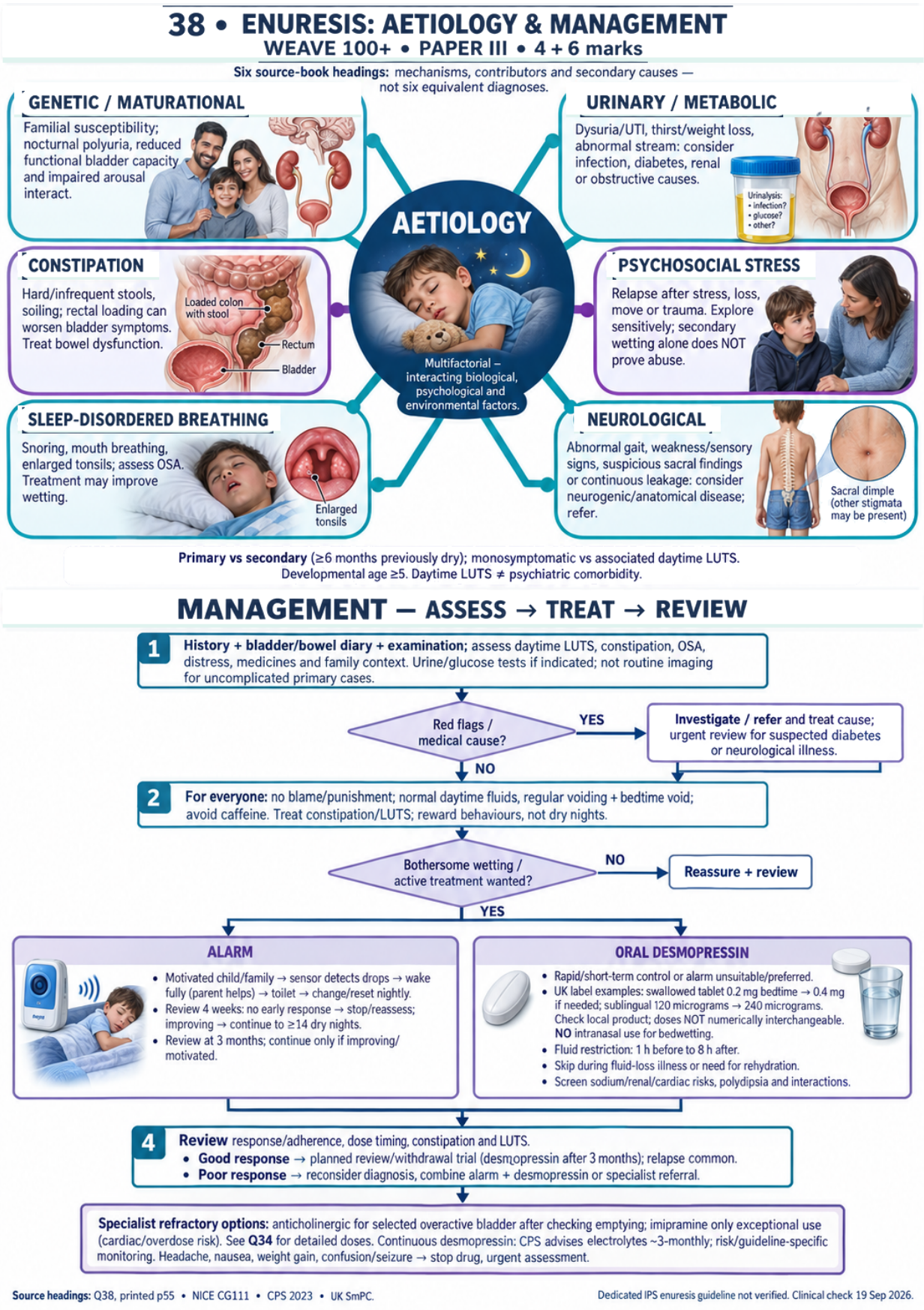
- **Primary aetiology.** Strongly familial, with concordance far higher in identical twins. Three mechanisms combine: a blunted night-time rise in vasopressin so more urine is made, a small functional bladder capacity with an overactive detrusor, and a raised arousal threshold so a full bladder does not wake the child. Attention deficit disorder and developmental delay are associated.

WHAT EARNS THE MARKS

- **The three mechanisms named,** because the treatments map onto them one for one.
- **Constipation identified as the highest-yield reversible cause.**
- **Secondary onset treated as a signal,** with abuse included in what is asked about.
- **Cause before symptom, stated as the order of work.**

SEE ALSO Slot III - 36 treatment in detail Slot III - 40 choosing the first treatment SPRINT
Day 23, Child behavioural, emotional & other disorders

WEAVE 100 · PAPER III · selected-38.1



Enuresis - Six aetiology branches and management. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-38.

Credits and references: retained within the illustration.

III - 39

PICA. [10]

10 CHILDHOOD EMOTIONAL, TIC, ATTACHMENT AND ELIMINATION DISORDERS

RGUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 Definition	Four criteria, and the cultural exclusion
2 Who gets it, and why	The populations, then the causes behind them
3 Complications	What the substance does once swallowed
3 Assessment and management	Investigate, correct, then change the behaviour

THE DEFINITION

Persistent eating of non-nutritive, non-food substances for at least a month, inappropriate to developmental level, and not part of a culturally supported or socially normative practice. Where it occurs alongside another disorder such as intellectual disability, autism or pregnancy, it is diagnosed separately only when severe enough to warrant clinical attention in its own right.

SUBSTANCE	WHERE IT POINTS	WHAT IT DOES
Soil and clay	Iron deficiency, poverty, cultural practice	Worm infestation, lead, obstruction
Ice	Iron deficiency anaemia	Dental damage; resolves with iron
Paint and plaster	Old housing, unsupervised toddler	Lead poisoning, itself causing disability
Hair	Trichotillomania, intellectual disability	Trichobezoar, obstruction, surgery
Paper, cloth, chalk	Understimulation, neglect, autism	Obstruction, malnutrition

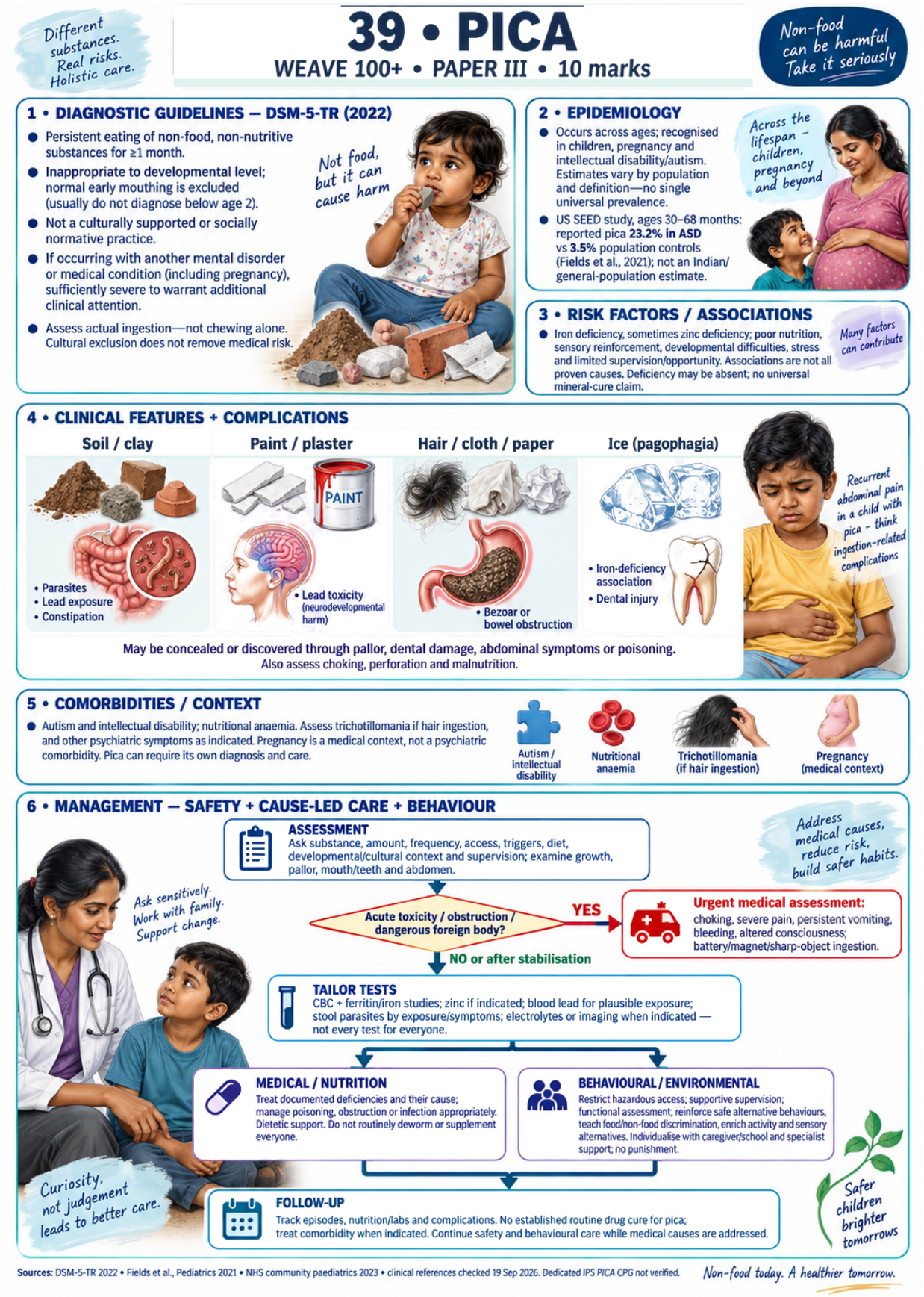
- **Assessment.** Developmental and dietary history, who supervises the child, and what is available to eat. Examine for pallor and an abdominal mass. Check haemoglobin, ferritin and zinc, a lead level where exposure is plausible, and stool for ova and parasites. Image the abdomen if obstruction is suspected.
- **Management.** Correct iron and zinc, deworm, and remove the source: lead abatement, supervision, and enough food. Then behavioural work: reinforcing an alternative, discrimination training, blocking the response, and enriching the environment. No drug treats pica. Under national programmes, iron and folic acid supplementation and periodic deworming already reach many of these children.

WHAT EARNS THE MARKS

- **The cultural exclusion in the definition.** Geophagia that is normative in a community is not a disorder.
- **The one month duration and the developmental age rule.**
- **Complications tied to the specific substance,** not listed as one general set.
- **Deficiency corrected before behaviour work,** because in many children that alone ends it.

SEE ALSO Slot III - 19 stereotypic movement disorder Slot III - 12 aetiology of intellectual disability SPRINT Day 23, Child behavioural, emotional & other disorders

WEAVE 100 · PAPER III · selected-39.3



Pica. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-39.

Credits and references: retained within the illustration.

III - 40

Causes and treatment of Nocturnal Enuresis. [10]

10 CHILDHOOD EMOTIONAL, TIC, ATTACHMENT AND ELIMINATION DISORDERS

RGUHS, TN-MGRMU - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2	The first split	Monosymptomatic or not, and why it decides everything
3	Causes	The three mechanisms, then the red flags
4	Choosing the treatment	Which child gets the alarm, which gets the drug
1	Review	When to stop, and when to refer onward

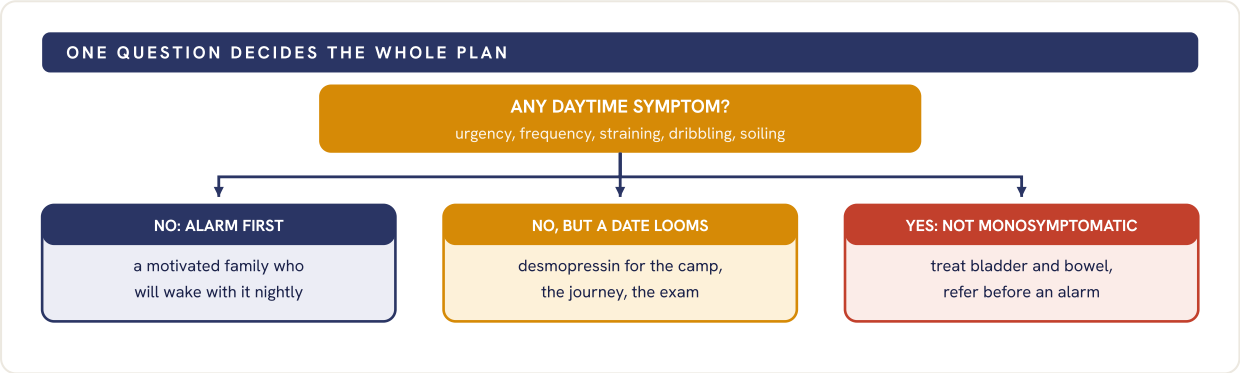


Fig 040.1 The daytime question is asked first because an alarm started in a child with an overactive bladder or constipation fails, and the failure is then blamed on the child.

- **Causes, in one line each.** More urine at night than the bladder holds, from a blunted night-time vasopressin rise. A small functional capacity with an overactive detrusor. A high arousal threshold. Layered on those: constipation, urinary infection, sleep disordered breathing, diabetes, and a psychological trigger where the wetting is secondary.
- **Red flags that redirect.** Continuous dribbling, a poor stream, a sacral dimple or hair tuft, gait change, new daytime wetting after years of dryness, weight loss with thirst, or any concern about abuse. These go to paediatrics, urology or safeguarding before any enuresis treatment begins.

WHAT EARNS THE MARKS

- **The monosymptomatic question asked first,** with the reason it comes first.
- **Alarm and desmopressin matched to different children,** rather than ranked against each other.
- **The red flag list, with where each one goes.**
- **Family capacity treated as part of the choice.** An alarm nobody wakes for is not a treatment.

SEE ALSO Slot III - 36 treatment in detail Slot III - 38 aetiology and management **SPRINT**
Day 23, Child behavioural, emotional & other disorders

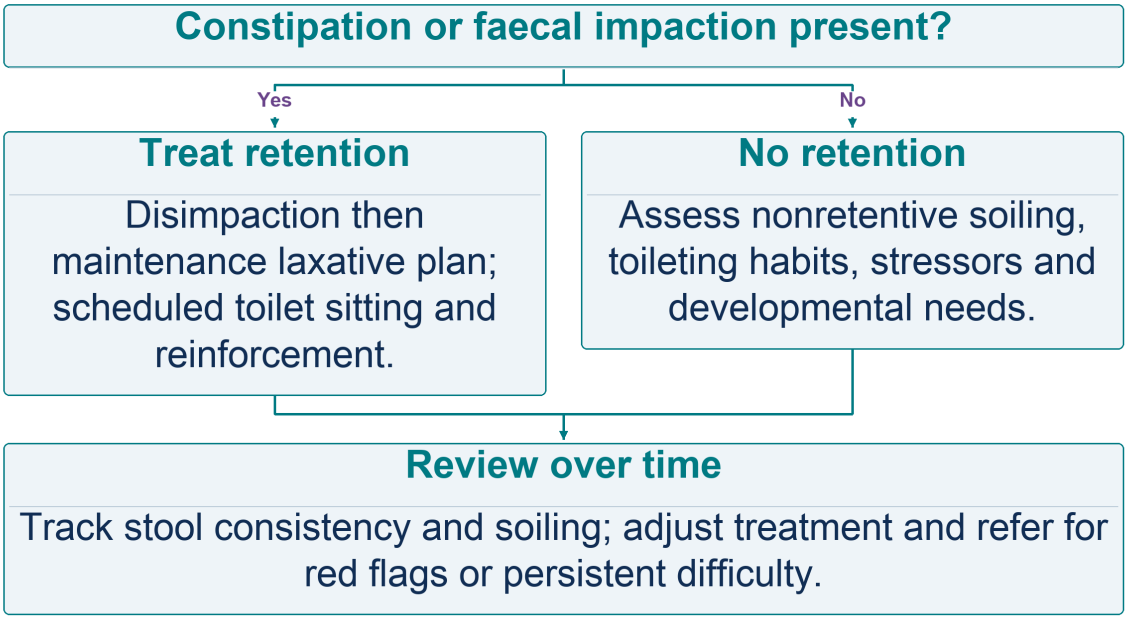
WEAVE 100+ / PAPER III

Encopresis and faecal soiling

Look for constipation and overflow before calling soiling behavioural.

Domain	Revision points
Definition frame	Repeated stool passage in inappropriate places at developmental age at least 4 years; assess frequency and duration.
Retentive pattern	Painful stools, withholding, rectal loading and overflow soiling.
Assessment	Bowel history, growth, examination and red flags; use a non-blaming approach.

DECISION PATHWAY



DO NOT

Punish accidents or rely on dietary advice alone for established impaction.

Weave Sprint elimination disorders; NICE CG99.

III 39.2 • Supplement • Source links and qualifications: SOURCES.md

Encopresis and faecal soiling. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Childhood emotional, tic, attachment and elimination disorders.

Credits and references: retained within the illustration.

AREA 05 OF 13 · P3-A07

Mental health legislation and disability law

9	9.6%	III-41	III-49
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SINGLE 9

REVISION ORDER

The Act is five of the nine slots, so read the Act itself once rather than five summaries of it. Then RPWD 2016. Then the two disability assessment slots, which reuse the certification material from the intellectual disability area.

WHAT IS IN THIS AREA

The Mental Healthcare Act 2017 across five slots (advance directive, nominated representative, capacity and admission, the definition clauses, admission of a minor), the Rights of Persons with Disabilities Act 2016, disability assessment and IDEAS.

III - 41

Critically analyze the various aspects of Mental Health Care Act 2017. [10]

10 MENTAL HEALTH LEGISLATION AND DISABILITY LAW

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

4	What it replaced	The 1987 Act, the treaty behind it, the rights charter
3	The decision machinery	Capacity, advance directive, nominated representative
2	Admission and oversight	Four routes, Boards in place of Magistrates
1	The critique	What is enacted but not yet delivered

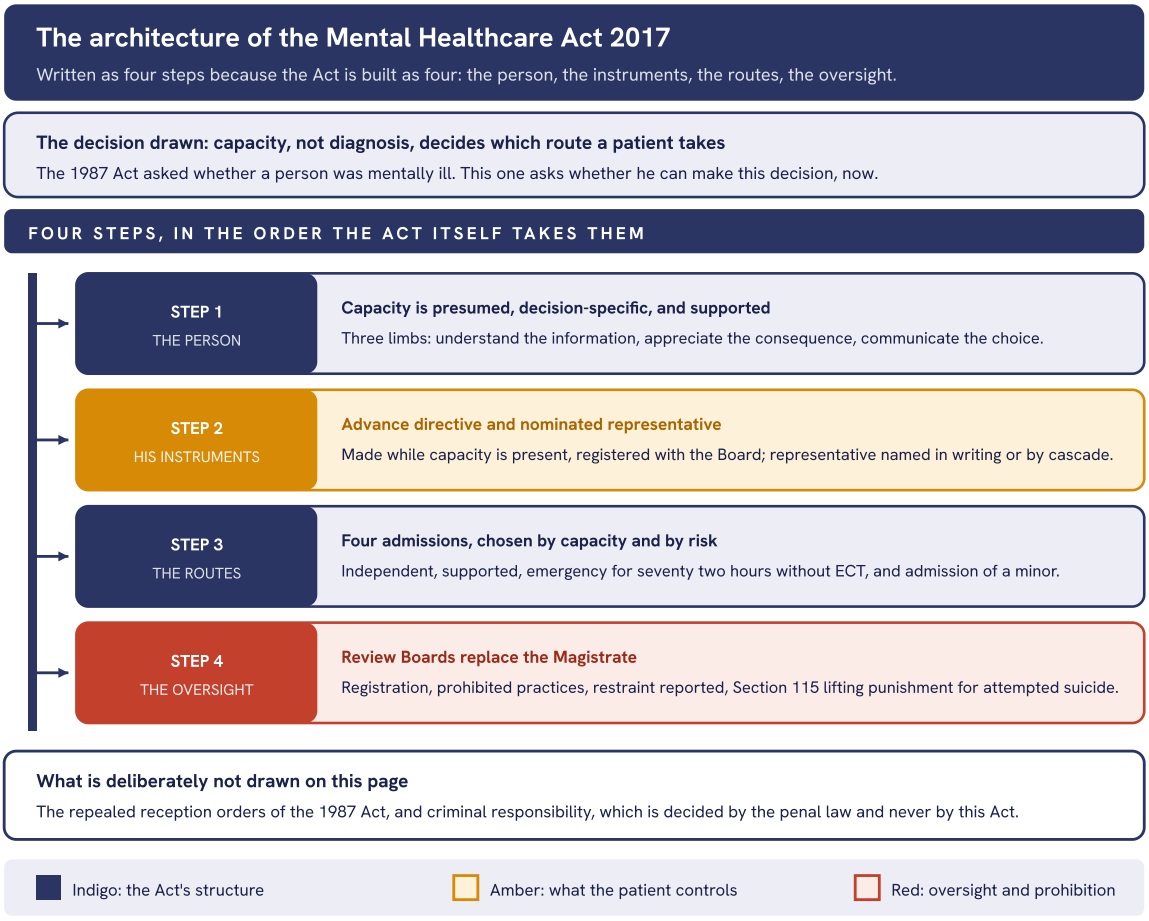


Fig 041.1 The Act drawn as the four steps it takes in its own order, with the two instruments the patient controls kept in amber.

- **What it gets right.** It converts a custodial statute into a rights statute: care as an entitlement, community living, confidentiality, free care for the poor, and insurance cover for mental illness on the same terms as physical illness.
- **Where it falls short.** Boards are unconstituted or under-resourced in many States, the advance directive register is largely unbuilt, capacity assessment is demanded of services without the staff for it, and insurance parity has needed repeated prodding.

WHAT THE ACT DOES NOT COVER

Intellectual disability by itself, excluded from the definition of mental illness and left to the Rights of Persons with Disabilities Act 2016. Criminal responsibility, which the penal law decides. And no right to any particular treatment.

WHAT EARNS THE MARKS

- **Capacity named as the organising idea,** not a list of chapters.
- **Both instruments the patient controls,** the directive and the representative.
- **A real critique, not a summary.** The stem says critically, and the implementation gap answers it.

SEE ALSO Slot III - 43 capacity at admission and discharge Slot III - 46 the advance directive **SPRINT** Day 25, Mental health legislation and forensic psychiatry

III - 42

Define nominated representative and his/her role in mental health care as defined in the MHCA, 2017. Discuss challenges in managing a wandering mentally ill patient, where nominated representative is not known or available. [2+2+6]

2 + 2 + 6 | MENTAL HEALTH LEGISLATION AND DISABILITY LAW

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	**Who the representative is**	Appointed in writing, or the statutory cascade
2	**What the role carries**	Support the decision, do not replace the person
4	**The wandering patient**	The steps, in order, with the actor at each
2	**The challenges**	Identity, collateral, consent, and afterwards

- **Nominated representative.** A person appointed in writing by an adult to support his mental healthcare decisions. Where none is appointed, the Act supplies a cascade: the person named in an advance directive, then a relative, then a caregiver, then a person appointed by the Board.
- **The role.** To support, not to substitute: consider the person's expressed wishes, consent where he cannot, receive information, apply for supported admission, seek Board review, and prefer community care.

STEP	WHAT HAPPENS	WHO ACTS	TIME LIMIT OR CONDITION
1	Person found wandering at large and unable to care for himself is taken under protection	Officer in charge of the police station	**Section 100 duty, not a discretion**
2	Conveyed to the nearest public mental health establishment for assessment	Police officer	**Within twenty four hours**
3	Assessment of mental illness, capacity and immediate risk	Psychiatrist at the establishment	On arrival
4	No representative traceable, so one is appointed for the patient	Mental Health Review Board	On the establishment's application
5	Treatment on the supported route, or emergency treatment meanwhile	Psychiatrist with the appointed representative	Thirty days, then Board review

The amber cells are the two an examiner looks for: the police duty is mandatory, and it is time-bound.

WHAT THE ACT DOES NOT COVER

Tracing identity: there is no statutory mechanism, so the work falls to photographs, missing-person records and voluntary bodies. Nor does the Act fund long stay for the unclaimed, or settle repatriation across States.

WHAT EARNS THE MARKS

- **The cascade written out in order,** not merely the phrase appointed in writing.
- **Support rather than substitution,** stated as the character of the role.
- **Police duty and its twenty four hour limit,** with the word Section used for the provision.
- **The Board naming a representative** as the answer to the missing one.

SEE ALSO Slot III - 41 the Act as a whole **SPRINT** Day 25, Mental health legislation and forensic psychiatry

WEAVE 100+ / PAPER III • 42.1

MHCA: NR and wandering patient

LEGAL ACTS APPENDIX • III Q 42 • definition 2 + role 2 + management 6

1 NOMINATED REPRESENTATIVE • §§14–17

Definition	Adult, competent and consenting person appointed to **support mental-healthcare decisions** and perform statutory duties. Appointment alone does not imply incapacity.
Appointment	Adult nominates in writing with signature/thumb impression; NR consents in writing. Minor: legal guardian unless Board orders otherwise.
Default order	AD nominee → willing relative → willing caregiver → Board-appointed suitable person → **Social Welfare Director/designee**. Eligible NGO representative can act temporarily pending Board appointment.

2 NR'S ROLE

Support choice	Respect current/past wishes, values and life history; assist treatment decisions and access to information.
Statutory functions	Applications for admission/review, discharge planning, complaints and rehabilitation; consent only within statutory conditions—not unlimited substitution.

3 WANDERING PERSON: FIRST CONTACT

Assess immediate danger and **medical causes**: injury, delirium, intoxication, hypoglycaemia, dehydration

↓

Police §100 protection → nearest public health establishment **as soon as possible, ≤24 h**; explain grounds

↓

Never police lock-up/prison for §100 protection → clinical assessment and correct care route

4 NO KNOWN NR: MANAGE THE WHOLE PROBLEM

Identify / reconnect	Document identity clues respectfully; missing-person FIR and police family tracing. Verify safety before reunification; protect confidentiality.
Treat / support	Assess mental state, cognition, capacity and needs; communication aids; treat urgent problems; arrange temporary NR and Board appointment where needed.
Choose route	Independent if appropriate; supported only when criteria met. Magistrate §102 may authorise **up to 10 days assessment**, followed by report and lawful next route.
If no admission need	Police return to residence or government homeless establishment; coordinate shelter, food, welfare and follow-up. **Do not detain solely for homelessness**.

5 CONTINUITY

Discharge plan	Housing, benefits, documents, medicines, outreach and rehabilitation; clarify responsibilities and crisis access.
Challenges	Identity, language, absent supports, fluctuating capacity, exploitation, stigma and lack of community resources.

Mental Healthcare Act 2017, India Code. Standard national time limits shown; §114 modifies specified regions.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

MHCA: NR and wandering patient. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-42.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · legacy-42.2

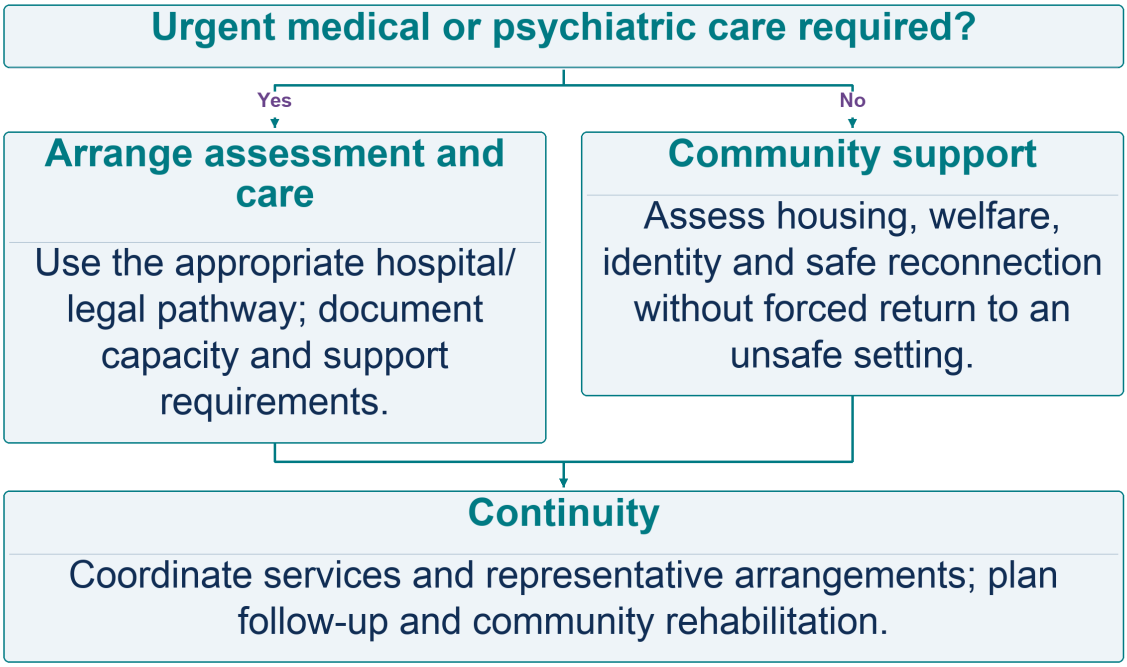
WEAVE 100+ / PAPER III

Wandering person with mental illness

Care, identity and rights must be addressed together.

Domain	Revision points
Immediate assessment	Medical instability, delirium, injury, intoxication, hunger/ dehydration and risk.
Support needs	Communication, capacity, identification, family contact and nominated representative.
Police role	Use the statutory protection and assessment pathway; mental illness alone does not justify penal custody.

DECISION PATHWAY



Weave 100 III-42; MHCA s100 and relevant admission provisions.

III 42.2 • Question-linked revision • Source links and qualifications: SOURCES.md

Wandering person with mental illness. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-42.

Credits and references: retained within the illustration.

III - 43

Discuss capacity assessment and its implications during admission and discharge of psychiatric patients as per MHCA, 2017. [5+5]

5 + 5 | MENTAL HEALTH LEGISLATION AND DISABILITY LAW

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	What capacity is	Three limbs, presumed until assessed
3	How it is assessed	Decision-specific, time-specific, supported first
3	At admission	Which route the finding opens, and for how long
2	At discharge	Who may leave, and what may briefly hold them

- **Capacity, in three limbs.** The ability to understand the information relevant to the decision, to appreciate any reasonably foreseeable consequence of taking it or not taking it, and to communicate the decision by any means. All three are needed, and each is judged for this decision at this time.

STEP	WHAT HAPPENS	WHO ACTS	TIME LIMIT OR CONDITION
1	Capacity is presumed and support is offered before any conclusion	The treating team	Until assessed otherwise
2	The three limbs are tested against this specific decision	Psychiatrist	**Recorded with the reasons**
3	Capacity present: independent admission on the person's own request	The person himself	Discharge on request
4	Capacity absent plus a stated risk ground: supported admission	Nominated representative, two assessments	**Up to thirty days**
5	Continuation beyond that period, or any dispute	Mental Health Review Board	Board review before extension

The risk grounds are stated, not assumed: recent harm or threat of harm to self, violence to others, or an inability to care for oneself that places one at risk.

- **At discharge.** An independent patient may leave on request, subject only to a brief statutory hold while the establishment assesses whether the supported criteria are met. A supported patient is discharged when capacity returns or the risk ground lapses, with a discharge plan.

WHAT THE ACT DOES NOT COVER

Capacity is not global, not permanent, and not a diagnosis. The Act does not permit incapacity to be inferred from the illness, from an unwise choice, or from refusal of the recommended treatment; and it gives no power to detain an independent patient who retains capacity.

WHAT EARNS THE MARKS

- **All three limbs named,** with the decision-specific and time-specific qualifiers.
- **The finding tied to a route,** so capacity is shown to have a consequence.
- **Risk grounds stated separately from incapacity.** Supported admission needs both.
- **Refusal distinguished from incapacity,** as the exclusions strip does.

SEE ALSO Slot III - 45 admission routes compared **SPRINT** Day 25, Mental health legislation and forensic psychiatry

WEAVE 100+ / PAPER III • 43.1

MHCA: capacity, admission and discharge

LEGAL ACTS APPENDIX • III Q 43 • 5 + 5 marks

1 CAPACITY FIRST • §4

Presume capacity	§4 uses **understand OR appreciate consequences OR communicate**. Assess and document these abilities with support; do not silently rewrite the statutory test as AND.
Support	Simple language, interpreter or visual aids; treat reversible barriers. Record the particular decision and time. **An unwise choice is not incapacity**.

2 INDEPENDENT • §§85–86,88

Who / consent	Adult requests admission; severity warrants it, likely benefit, free choice and capacity with **no/minimal support**. Treatment requires informed consent; NR presence is not required.
Discharge	Discharge on request. §88 allows **up to 24 h** to assess §89 eligibility where statutory grounds exist; then supported admission or discharge, whichever decision occurs earlier.

3 SUPPORTED: INITIAL vs CONTINUING

Authority	**§89: up to 30 days**	**§90: beyond 30 days**
Application	**NR applies** to medical officer / MHP in charge	**NR applies** for continuing supported admission
Assessors	Psychiatrist + MHP/doctor; independent examinations on admission day or preceding 7 days	**Two psychiatrists**; preceding 7 days
Common criteria	Severe illness with recent self-harm/violence/risk from inability to self-care; **very high decision support**; least restrictive option	Same framework with risk **consistently over time**; continued high support and least restrictive setting
Board	Report women within 3 days; others 7. Review on application within 7 days	Report within 7 days; Board decision within 21 days of admission
Duration	Stop earlier when criteria cease; no automatic renewal	**90 days →120 days →180 days each** with statutory reassessment
Consent review	If NR temporarily consents for nearly 100% support needs: **every 7 days**	Same condition: **every fortnight**

4 REVIEW → DISCHARGE → CONTINUITY

Criteria no longer met → end supported status; independent care only when appropriate

↓

Plan with person + NR/carer + next treating team: **medicines, appointments, relapse/crisis plan and community support**

5 EXAM TRAPS

Do not conflate	**§94 is emergency treatment, not an admission category.** Under 18 uses §87.
Readmission	Within 7 days of §89 discharge, consider **§90**, not another fresh §89 cycle.
Rights	Explain status and review rights; document reasons and capacity; discharge planning **§98 applies to all discharges**.

Mental Healthcare Act 2017, India Code. Standard national time limits shown; §114 modifies specified regions.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

MHCA: capacity, admission and discharge. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-43.

Credits and references: retained within the illustration.

III - 44

Disability assessment in mental illness. [10]

10 MENTAL HEALTH LEGISLATION AND DISABILITY LAW

KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	The frame	Impairment, activity limitation, participation restriction
2	The statute	RPWD 2016, the schedule, and the benchmark
4	The instrument	IDEAS: four domains, duration, conversion
2	What follows	The certificate, the card, the entitlements

THE DEFINITION

Disability assessment quantifies the loss of function that a mental illness causes, not the illness itself. The frame is the international classification of functioning: impairment of the mind, limitation of activity, and restriction of participation. Forty per cent or more is a benchmark disability under the Rights of Persons with Disabilities Act 2016.

DOMAIN SCORED	WHAT IS RATED	SCALE
Self care	Hygiene, dressing, feeding, health upkeep	Nought, none, to four, profound
Interpersonal activities	Relations within the family and outside it	Nought to four
Communication and understanding	Comprehension, expression, everyday reasoning	Nought to four
Work	Employment, housework or schooling, as applies	Nought to four
Duration of illness	Added to the four domain scores	**A separate score, then converted**

The amber row is the step most candidates omit: the four domain scores are summed, the duration score is added, and only then is the total converted to a percentage by the notified table.

- **Who certifies.** A medical authority notified by the State, in practice a board with a psychiatrist, issuing a certificate with a stated validity and a review date where improvement is expected.
- **What it unlocks.** The unique disability identity card, reservation in higher education and government employment, income tax relief, travel concession, and access to limited guardianship rather than the plenary guardianship the Act abolished.

WHAT EARNS THE MARKS

- **Function separated from diagnosis** in the opening line.
- **All four IDEAS domains, plus duration as a fifth added score.**
- **Forty per cent named as the benchmark,** with the statute it comes from.
- **The entitlements,** which are the reason the assessment is requested at all.

SEE ALSO Slot III - 48 IDEAS and the RPWD categories Slot III - 47 the RPWD Act in psychiatry SPRINT Day 25, Mental health legislation and forensic psychiatry

WEAVE 100+ / PAPER III • 44.3

Mental-illness disability certification

LEGAL ACTS APPENDIX • III Q 44 • assessment/regulations; Q 48 with 44.1 +47.1

1 WHAT IS BEING CERTIFIED?

Function	Residual impairment and participation limitations associated with mental illness. **Diagnosis ≠ disability percentage ≠ legal incapacity**.
Assessment	Clinical history, longitudinal records, MSE, function, treatment, supports and collateral. IDEAS and/or IQ only as indicated under 2024 §24.
Differentials	Separate mental illness, ID, neurological and substance-related effects; combined ID+MI may require **multiple-disability** certification.

2 2024 DURATION & VALIDITY

Permanent	Normally **≥2 years from onset**; residual disability despite appropriate evidence-based treatment documented in records.
Duration <2 years	Time-valid certificate ordinarily; Board may consider permanent certification if **severe/profound** disability.
Untreated	Without standard care: only **time validity up to 2 years**; advise appropriate treatment and subsequent assessment.
Treated, no records	Time-valid certificate may be issued; advise treatment, preserve records and **repeat assessment after 2 years**.
Do not promise	No blanket rule that every mental-illness certificate is permanent or that every case must be recertified exactly every 2 years.

3 NOTIFIED MEDICAL AUTHORITY

Chair	Medical Superintendent / CMO / Civil Surgeon / State-notified equivalent.
Members	**Psychiatrist**, plus psychiatrist/physician or RCI clinical/rehabilitation psychologist/psychiatric social worker as specified.
Where needed	Psychological assessment report from RCI-registered psychologist **within preceding 3 months**. Notification permits qualified private members where required; chair remains government doctor.

4 PROCESS & ENTITLEMENTS

Apply through notified system → verify identity/records → clinical + functional assessment

↓

Record diagnosis, percentage, validity, reasons and review needs → certificate/UDID through authority

↓

Explain **appeal, benefits, accommodations, rehabilitation and follow-up**

5 EXAM APPRAISAL

Strength	Standardisation links disability to rights and support rather than diagnosis alone.
Limitations	Variable function, inaccessible records, inter-rater/context effects, service gaps and ambiguous legacy appendix. **Document version and reasoning**.
Cross-reference	44.1: IDEAS scoring; 47.1: RPwD categories/benefits; 13.1: SLD; 14.1: ID certification.

DEPwD S.O.1338(E), 2024, §24.1–24.4 (printed pp 496–497); RPwD 2016 §§56–59.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Mental-illness disability certification. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-44.

Credits and references: retained within the illustration.

III - 45

a) What is mental illness and who are mental health professionals as per the MHCA, 2017? b) How the admission and discharge procedures as per the MHCA, 2017 are different from Mental Health Act,1987? c) What are the guidelines for ECT in the MHCA, 2017? [2+2+4+2]

2 + 2 + 4 + 2 | MENTAL HEALTH LEGISLATION AND DISABILITY LAW

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	**Two definitions**	What is in, what is expressly out, who qualifies
4	**The routes, then and now**	Route by route, with the 1987 equivalent named
2	**What actually changed**	Capacity, the Board, and discharge on request
2	**ECT**	Three rules, one of them absolute

- **Two definitions.** Mental illness is a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or the ability to meet the ordinary demands of life. It includes conditions associated with alcohol and drug abuse, and excludes intellectual disability. A mental health professional is a psychiatrist, psychologist, psychiatric social worker or nurse registered with the State Authority.

ROUTE UNDER THE 2017 ACT	WHO APPLIES	DURATION	ITS 1987 PREDECESSOR
Independent admission	The person himself, having capacity	Until he asks to leave	Voluntary admission
Supported admission	Representative, two assessments	**Thirty, then ninety, then a hundred and twenty days**	Special circumstances; reception order
Emergency treatment	Any registered medical practitioner	Seventy two hours, and no ECT	No true equivalent
Admission of a minor	Nominated representative only	Reported to and reviewed by the Board	Admission by the guardian

What changed: capacity replaced diagnosis, the Board replaced the Magistrate, and the independent patient gained a right to leave.

- **ECT, three rules.** Unmodified ECT, without muscle relaxant and anaesthesia, is prohibited absolutely. ECT for a minor requires both the guardian's informed consent and the Board's prior permission. ECT can never be given as emergency treatment.

WHAT THE ACT DOES NOT COVER

It sets no upper limit on the number of treatments, prescribes no technique or electrode placement, and regulates private practice only through registration of the establishment. Those are matters of clinical guideline, not of statute.

WHAT EARNS THE MARKS

- **The express exclusion of intellectual disability** from the definition.
- **Routes matched to their 1987 predecessors,** which is what the question asks.
- **The three ECT rules, with the absolute one named as absolute.**

SEE ALSO Slot III - 49 admission of a minor **SPRINT** Day 25, Mental health legislation and forensic psychiatry

WEAVE 100+ / PAPER III • 45.1

MHCA: definitions, change and ECT

LEGAL ACTS APPENDIX • III Q 45 • 2 + 2 + 4 + 2 marks

1 MENTAL ILLNESS • §2

Definition	Substantial disorder of **thinking, mood, perception, orientation or memory** grossly impairing judgment, behaviour, reality recognition or ordinary life demands.
Includes / excludes	Includes mental conditions associated with **alcohol/drug abuse**. Statutory definition excludes intellectual disability (older wording: mental retardation).

2 MENTAL HEALTH PROFESSIONALS • §2

Who	Psychiatrist; professional registered with State Authority under §55; specified postgraduate Ayurveda/Homoeopathy/Unani/Siddha mental-health qualifications.
Registered groups	Clinical psychologists, mental health nurses and psychiatric social workers under §55, with prescribed qualifications. **Work only within professional scope** (§106).

3 MHA 1987 → MHCA 2017

Orientation	1987: institutional regulation/admission framework	2017: **rights, supported decisions, community care**
Admission	Voluntary admission, special circumstances and reception-order routes	Independent §86; minor §87; supported **§§89–90** with criteria/time limits
Decision-making	No equivalent statutory AD/NR framework	**Capacity §4, AD, NR**, informed treatment consent
Review / discharge	Older authority/court and discharge provisions	**Boards**, specified reviews, independent discharge rights, §98 continuity planning
Safeguards	Different older statutory framework	Explicit prohibitions and safeguards for ECT, psychosurgery, seclusion/restraint

4 ECT • §95

Adults	**Anaesthesia + muscle relaxant mandatory**; follow informed-consent / lawful treatment-decision route.
Minors	Generally prohibited. If treating psychiatrist considers required: **guardian informed consent AND prior Board permission**.
Emergency	**No ECT under §94**, even when emergency treatment is otherwise justified.

5 SHORT CRITIQUE

Gain	Moves toward enforceable rights, least restriction and supported decisions.
Challenge	Benefits depend on functioning Boards, staffing, services and community alternatives. **A statute does not itself supply care capacity**.

Mental Healthcare Act 2017, India Code. Standard national time limits shown; §114 modifies specified regions.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

MHCA: definitions, change and ECT. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-45.

Credits and references: retained within the illustration.

III - 46

What is advance directive? Discuss the concept with critically examining its utility and limitations. What is the legal status of advance directive in Psychiatry in India. [2+4+4]

2 + 4 + 4 | MENTAL HEALTH LEGISLATION AND DISABILITY LAW

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 What it is	A choice recorded while capacity is present
3 The steps	Make, register, invoke, review, revoke
3 Utility and limits	Both sides, because the stem says critically
2 Legal status in India	Statutory since 2018, and distinct from a living will

- **Advance directive.** A written statement by an adult, made while he has the capacity to make mental healthcare decisions, saying how he wishes to be cared for and treated if he later loses that capacity, and who shall be his nominated representative.

STEP	WHAT HAPPENS	WHO ACTS	CONDITION
1	The directive is written and signed	The person, having capacity	**Capacity at the time of making**
2	It is registered and made available	Mental Health Review Board	Held on the Board's register
3	It governs treatment once capacity is lost	Treating psychiatrist	A duty to follow it
4	It may be reviewed, altered or cancelled on application	The Board, on any party's application	**The Board may override it**
5	It may be revoked or amended by the maker	The person himself	Only while capacity is present

It does not apply to emergency treatment, so a directive refusing admission cannot block seventy two hours of emergency care.

- **Utility.** It extends autonomy across an episode, reduces family conflict at the worst moment, records a preference between agents already tried, and suits relapsing illness.
- **Limits.** Registers are largely unbuilt, awareness is low, capacity at the time of making is rarely documented, the Board can set it aside, and it cannot demand a treatment that is not indicated.

WHAT THE ACT DOES NOT COVER

It is not a living will. End-of-life refusal of life-sustaining treatment rests on Common Cause, 2018, and the procedure the Supreme Court simplified in 2023; the psychiatric advance directive is statutory, and the two should never be run together in an answer.

WHAT EARNS THE MARKS

- **Capacity at the time of making,** named as the condition that validates it.
- **Both sides argued,** because the stem says critically.
- **The emergency exception,** which is the commonest omission.
- **Separated from the living will,** with the Indian authority for each.

SEE ALSO Slot III - 42 the nominated representative SPRINT Day 25, Mental health legislation and forensic psychiatry

WEAVE 100+ / PAPER III • 46.1

MHCA: advance directive

LEGAL ACTS APPENDIX • III Q 46 • definition, utility, limitations and legal status

1 WHAT IT RECORDS • §§5–8

Who	An **adult** may write one regardless of prior illness or treatment. Legal guardian may make one for a minor under §11(4), until majority.
Content	How the person **wants / does not want** mental healthcare and treatment; preferred NR(s) in order.
Form / access	Follow prescribed procedure; Board register. The person/NR should ensure treating professionals have access. May be **revoked, amended or cancelled**.

2 WHEN IT OPERATES

Person has capacity → **current decision prevails** over an earlier directive

↓

Capacity lost → valid AD invoked → regains capacity → current decision governs

3 LEGAL STATUS & REVIEW

Duty	§10: medical officer/psychiatrist must follow a **valid directive**, subject to Board review. Provisions contrary to law are void.
Disagreement	Apply to **Mental Health Review Board** under §11; do not silently disregard it. Board hears concerned parties and may uphold/modify/cancel.
Review tests	Free will; relevance to present circumstances; adequate information; capacity when made; consistency with law/Constitution.
Emergency	AD does **not apply to statutory emergency treatment**. This does not authorise ECT under §94.
Liability	§13 protection for unforeseen consequences of following a valid AD, and noncompliance where no copy was provided.

4 UTILITY vs LIMITATIONS

Utility	Extends autonomy into relapse; records values/preferences; supports shared planning; may reduce conflict and unwanted care.
Limitations	Low awareness, literacy/access barriers, unavailable copies, vague or outdated preferences, unforeseen clinical situations and review delays.
Improve usefulness	Make collaboratively when well; clear treatments/reasons; trusted NR; accessible copy; **periodic review** and crisis planning.

5 KEEP THE CONCEPTS DISTINCT

Not the same	Psychiatric AD under MHCA ≠ general consent ≠ end-of-life advance medical directive.
Critical conclusion	Strong autonomy tool; usefulness depends on **valid preparation, availability, implementation and review capacity**.

WISHES NOW → CARE DURING INCAPACITY → CURRENT CHOICE WHEN CAPACITY RETURNS

Mental Healthcare Act 2017, India Code. Standard national time limits shown; §114 modifies specified regions.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

MHCA: advance directive. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-46.

Credits and references: retained within the illustration.

III - 47

Discuss the Rights of Persons with Disabilities Act 2016 in relation to Psychiatry. [10]

10 | ASKED AT 15 MARKS | MENTAL HEALTH LEGISLATION AND DISABILITY LAW

TN-MGRMU - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	What it is for	The treaty behind it, and the 1995 Act it replaced
3	Who it covers	Twenty one conditions; five of them psychiatric
3	The rights that bite	Legal capacity, healthcare, education, employment
2	Certification and redress	Benchmark, authority, Commissioner, offences

- **Why it matters to psychiatry.** It gives the treatment of chronic mental illness a legal destination beyond symptom control: certification, entitlement and enforceable non-discrimination. Passed to give effect to the disability rights convention, it replaced the 1995 Act and widened the schedule from seven conditions to twenty one.

PROVISION	WHAT IT GIVES	WHERE IT BITES IN PRACTICE
The schedule	Mental illness, intellectual disability, specific learning disability, autism and chronic neurological conditions	**Five of the twenty one are ours**
Legal capacity	Equal recognition before law, with support	**Limited guardianship replaces plenary**
Healthcare	Free or affordable care, insurance, early detection	Grounds a claim, not merely a policy
Education and employment	Free education to eighteen, reservation in higher education and in government posts	Applies at benchmark disability
Enforcement	Chief and State Commissioners, penalties for atrocity and for false certification	A forum the 1995 Act lacked

Benchmark disability is forty per cent or more of a specified condition, certified by the notified medical authority, and it is the threshold most entitlements are keyed to.

WHAT THE ACT DOES NOT COVER

It is not a treatment statute: admission, capacity to consent to treatment and involuntary care remain with the Mental Healthcare Act 2017. It does not displace the National Trust Act 1999 for guardianship in autism, cerebral palsy and intellectual disability, and it creates no right to a cure.

WHAT EARNS THE MARKS

- **The psychiatric entries counted out of the twenty one.**
- **Limited guardianship named as the change,** not just legal capacity as a phrase.
- **Forty per cent tied to the entitlements it unlocks.**
- **The boundary with the 2017 Act,** as the exclusions strip draws it.

SEE ALSO Slot III - 44 disability assessment in mental illness Slot III - 48 IDEAS and the RPWD categories **SPRINT** Day 25, Mental health legislation and forensic psychiatry

III - 48

What is IDEAS, its domains and scoring? Discuss the various categories of psychiatric disorders included as per the Rights of Persons with Disability Act? [5+5]

5 + 5 | MENTAL HEALTH LEGISLATION AND DISABILITY LAW

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	What IDEAS is	Who made it, what it measures, why it exists
3	Domains and scoring	Four domains, duration added, then converted
3	The RPWD categories	The psychiatric entries in the schedule
2	The certificate	Benchmark, authority, validity, appeal

- **IDEAS.** The Indian Disability Evaluation and Assessment Scale, developed by the Indian Psychiatric Society and gazetted as the instrument for quantifying disability in mental illness. It rates current functioning, not symptoms, and it needs an illness that has been diagnosed and treated, not a single cross-sectional interview.

STEP	WHAT IS DONE	SCALE	CONDITION
1	Rate self care, interpersonal activities, communication and understanding, and work	Each nought to four	Current function, all four rated
2	Sum the four to a global disability score	Nought to sixteen	No domain omitted
3	Add the score for duration of illness	A further nought to four	**The step most often forgotten**
4	Convert the total by the notified conversion table	To a percentage	**Forty per cent is the benchmark**
5	Certificate issued, with validity and a review date	Notified medical authority	Appeal lies against the finding

The psychiatric entries in the schedule: mental illness; intellectual disability, which carries specific learning disability and autism spectrum disorder alongside it; and chronic neurological conditions, named there as multiple sclerosis and Parkinson's disease.

WHAT THE INSTRUMENT DOES NOT COVER

IDEAS is for mental illness only. Intellectual disability is quantified by intelligence and adaptive testing, and autism by the notified Indian scale, each with its own certification route. Using IDEAS for those is a procedural error that invalidates the certificate.

WHAT EARNS THE MARKS

- **All four domains named, in the scale's own words.**
- **Duration added as a separate score before conversion.**
- **The schedule entries listed,** not a general statement that mental illness is covered.
- **Instrument matched to condition,** as the exclusions strip does.

SEE ALSO Slot III - 44 disability assessment in mental illness **SPRINT**

Day 25, Mental health legislation and forensic psychiatry

III - 49

Admission of Minor as per Mental Health Care Act (MHCA) 2017. [10]

10 | ASKED AT 7 MARKS | MENTAL HEALTH LEGISLATION AND DISABILITY LAW

TN-MGRMU - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 **Who is a minor here**	Under eighteen, and who represents him
4 **The steps**	Application, admission, report, review, discharge
2 **The protections**	Separate space, an attendant, and the ECT bar
2 **Why it is separate**	A minor cannot consent, so oversight replaces consent

- **The principle.** A minor cannot give the consent that makes an adult admission independent, so the Act does not ask him to. It substitutes an application by his nominated representative, who is his legal guardian unless the Board orders otherwise, and then supplies external review in place of the consent that is missing.

STEP	WHAT HAPPENS	WHO ACTS	TIME LIMIT OR CONDITION
1	Application for admission of the minor	Nominated representative, ordinarily the guardian	**No other route exists**
2	Two independent assessments support the need for inpatient care	Psychiatrist and a second professional	Care not possible in the community
3	Admission is reported to the Review Board	Medical officer in charge	**Within seventy two hours**
4	Continued stay is reviewed	Mental Health Review Board	Where the stay passes thirty days
5	Discharge on the representative's request, with a plan	Representative and treating team	Unless the Board directs otherwise

The two amber cells carry the marks: the application route is exclusive, and the clock for reporting starts at admission, not at review.

- **The protections.** The minor is accommodated separately from adults; a parent, guardian or suitable attendant stays with him, and a female attendant for a girl; and electroconvulsive therapy needs both the guardian's informed consent and the Board's prior permission.

WHAT THE ACT DOES NOT COVER

It does not create a minor's right to admit himself, and it does not answer the case of a child brought by one parent against the other's objection, which goes to the Board. Protection from abuse and neglect is the business of the Juvenile Justice Act 2015, not of this one.

WHAT EARNS THE MARKS

- **The exclusive application route,** stated before anything else.
- **Both time limits,** the report and the review of a longer stay.
- **The three physical protections,** which are cheap marks most answers skip.
- **The ECT bar for minors,** with both conditions named.

SEE ALSO Slot III - 45 admission routes compared Slot III - 27 the Juvenile Justice Act **SPRINT** Day 25, Mental health legislation and forensic psychiatry

WEAVE 100+ / PAPER III • 49.1

MHCA: admission of a minor

LEGAL ACTS APPENDIX • III Q 49 • section 87

1 WHO APPLIES & WHO EXAMINES	
Minor	**Under 18 years**. Legal guardian is NR unless Board appoints another under §15.
Application	**NR applies** to medical officer in charge. Obtain and consider the minor's wishes when ascertainable.
Two assessments	Two psychiatrists OR psychiatrist + MHP OR psychiatrist + doctor. **Independent examinations: same day or preceding 7 days**.

2 ALL FOUR CONDITIONS	
Illness	Severity requires inpatient admission.
Best interests	Health, wellbeing and safety; consider the minor's wishes and record reasons.
Need	Healthcare needs **cannot be fulfilled without admission**.
Alternatives	Community alternatives **failed or are demonstrably unsuitable**.

3 SAFEGUARDS DURING ADMISSION	
Placement	**Separate from adults**; age- and development-appropriate environment and quality of care.
Attendant	NR or appointed attendant stays **throughout**. Minor girl with male NR: **female attendant** must stay.
Treatment	**Informed consent of NR**; seek developmentally appropriate assent and supported participation.
ECT	Generally prohibited in minors; exception requires **guardian's informed consent + prior Board permission** under §95. Never emergency ECT under §94.

4 BOARD CLOCK	
Initial notice	Inform Board **within 72 hours** of admission.
At 30 days	Immediately inform Board when admission continues 30 days.
Continuing review	Board mandatory review **within 7 days of notification**, and every subsequent 30 days; records at minimum, interview when necessary.

5 DISCHARGE & TRANSITION	
NR withdraws support	If NR no longer supports admission or requests discharge, **discharge under §87(8)**; make a safety and continuity plan.
Turns 18	§88(2): classify as independent under §86; apply adult provisions and reassess decision support/status.
Planning	§98: person, NR/carer and future care team; school/family support, follow-up and crisis access.

NR → TWO ASSESSORS → FOUR CONDITIONS → SAFEGUARDS → BOARD REVIEW

Mental Healthcare Act 2017, India Code. Standard national time limits shown; §114 modifies specified regions.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

MHCA: admission of a minor. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-49.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III • 41.1

MHCA 2017: rights and critical appraisal

LEGAL ACTS APPENDIX • III Q 41 • overview

1 PURPOSE & SCOPE	
Paradigm	**Rights, autonomy, access and community care**, reflecting UNCRPD. Replaces MHA 1987; in force **29 May 2018**.
Mental illness	§2: substantial disturbance with gross impairment; includes conditions associated with alcohol/drugs; statutory definition **excludes intellectual disability**.
Diagnosis / capacity	§3: use accepted medical standards; social nonconformity or past admission alone is insufficient. **Diagnosis ≠ incapacity**.
2 RIGHTS: §§18–28	
Access / community	Affordable, available, good-quality services; **community living** and less restrictive care. Free care provisions for eligible BPL, destitute and homeless persons.
Dignity / equality	Protection from cruel, inhuman or degrading treatment; non-discrimination; **insurance for mental illness on the same basis as physical illness**.
Information / privacy	Understand diagnosis, treatment and rights; **confidentiality**, restricted release of information and access to records, subject to lawful exceptions.
Participation / remedy	Personal contacts and communication, legal aid and complaints about deficient services.
3 HOW THE ACT OPERATES	
Choice	§4 capacity; **advance directives §§5–13**; nominated representatives **§§14–17**.
Admission	Independent **§86**; minors **§87**; supported **§§89–90**. Admission and treatment consent are separate questions.
Safeguards	Emergency treatment §94; ECT §95; psychosurgery §96; restraint/seclusion §97; discharge planning §98.
Oversight	Central/State Mental Health Authorities: registration and standards. **Mental Health Review Boards:** rights, admissions, AD/NR disputes and complaints.
4 SUICIDE & COMMUNITY PROTECTION	
§115	Attempted suicide: **presumption of severe stress**, unless proved otherwise; duty of care, treatment and rehabilitation. Do not describe every suicide-related act as legally immune.
§§100–103	Police protection and public-health assessment; neglected persons and prisoner treatment. **Homelessness is not an admission criterion by itself**.
5 CRITICALLY APPRAISE	
Strengths	Enforceable rights, supported decisions, review mechanisms, access and reduced custodial emphasis.
Implementation	Service and workforce gaps; uneven Board capacity; scarce community alternatives; administrative load and funding.
Clinical tensions	Autonomy versus protection; fluctuating capacity; practical access to directives; family support without overriding the person.

RIGHTS → CHOICE → SAFEGUARDS → OVERSIGHT → IMPLEMENTATION

Mental Healthcare Act 2017, India Code. Standard national time limits shown; §114 modifies specified regions.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

MHCA 2017: rights and critical appraisal. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Mental health legislation and disability law.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III • 41.2

COTPA 2003: tobacco-control law

LEGAL ACTS APPENDIX • Supplement • PaperII Q 18 • companion to NDPS 41.3

1 WHAT THE ACT DOES

Scope	Cigarettes and other scheduled tobacco products, including **smoked and smokeless** forms. Public-health regulation, not a general ban on every adult's tobacco use.
Four anchors	**Public smoking • advertising • sales to minors/near schools • package warnings**.

2 CORE SECTIONS

§4	**No smoking in public places**. Limited designated smoking-area provisions for qualifying hotels, restaurants and airports; not an unrestricted exception.
§5	Prohibits direct/indirect tobacco advertising and promotion subject to narrow statutory exceptions and detailed rules.
§6(a)	**No sale to persons below 18**. Age verification and display requirements apply under rules.
§6(b)	**No sale within 100 yards of an educational institution**. Do not write 100 metres.
§§7–10	Specified packaging/labelling and health warnings; prescribed rules determine presentation, language and current warning images.

3 IMPLEMENTATION IN A PSYCHIATRIC SERVICE

Environment	Smoke-free campus/wards, visible signage, consistent enforcement; protect patients, visitors and staff from second-hand smoke.
Treat dependence	Screen tobacco use; brief advice, behavioural support and appropriate cessation treatment. **Do not use cigarettes as rewards**.
Withdrawal	Plan management when admitted to a smoke-free setting; explain options and monitor distress.
Medicine review	Changes in smoking can alter exposure to **clozapine/olanzapine** through smoke-related enzyme induction. Review clinically; nicotine itself is not the main inducer.

4 ENFORCEMENT & LIMITS

Penalties	Violations attract section-specific penalties; smoking/public-place and minor/school sales offences include fines under §§21, 24.
Different laws	COTPA regulates tobacco; **PECA 2019** prohibits specified e-cigarette activities; NDPS covers specified narcotic/psychotropic substances.
Public-health context	Combine legislation with cessation access, education, taxation and surveillance; avoid substituting punishment for treatment.

5 EXAM CLOSE

Critical appraisal	Clear population protections; challenges include surrogate advertising, retail enforcement, youth access, smokeless tobacco and treatment gaps.
Cross-reference	**PaperII 18.1**: nicotine pharmacology, intoxication/withdrawal and management. This sheet supplies the statutory framework.

COTPA 2003 §§4–10, 21, 24; MoHFW NTCP Acts/Rules register; MHRA clozapine smoking-interaction guidance.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

COTPA 2003: tobacco-control law. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Mental health legislation and disability law.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III • 41.3

NDPS Act 1985: control and treatment

LEGAL ACTS APPENDIX • Supplement • PaperII Q 15 • opioid-management law

1 SCOPE & PURPOSE

Two objectives	Control illicit narcotic drugs/psychotropic substances while permitting **regulated medical and scientific use**.
§8	Prohibits specified cultivation, production, possession, sale, purchase, transport and use except as legally authorised. **Prescription treatment is subject to rules**, not outside the Act.
Offences / quantity	Drug-specific **small / intermediate / commercial quantities** influence punishment; possession, consumption, trafficking and financing are distinct offences.

2 §64A: TREATMENT IMMUNITY

Person with addiction charged under **§27 OR an offence involving small quantity**

↓

Voluntarily seeks AND undergoes de-addiction treatment at hospital/institution maintained or recognised by Government/local authority

↓

Eligible statutory immunity from prosecution for those offences; **may be withdrawn if treatment not completed**

3 RELATED PROVISIONS

§27	Punishes consumption; offence and substance determine penalty. It is not the same as possession or trafficking.
§39	After guilt for specified eligible offences: court may, **with consent**, release on probation for de-addiction treatment, with bond and reporting conditions. Distinct from §64A.
§71	Government may establish centres for identification, treatment, education, aftercare, rehabilitation and social reintegration; regulates treatment-related supply.
§37	Specified serious offences have stringent bail conditions. Do not promise that a treatment referral automatically produces bail or immunity.

4 PSYCHIATRIST'S ROLE

Assess / document	Dependence, intoxication/withdrawal, comorbidity, risk, capacity, history and treatment needs; distinguish clinical opinion from legal findings.
Treatment	Evidence-based withdrawal/maintenance care, overdose prevention, psychosocial care and rehabilitation. For full opioid management use **PaperII 15.1**.
Regulated medicines	Use authorised procurement, storage, prescription, dispensing and records for controlled medicines/OST under applicable rules and programme authority.
Medico-legal work	Report factual attendance/progress accurately; explain scope of confidentiality and court requests. Do not certify completion without evidence.

5 CRITICAL APPRAISAL

Balance	Treatment provisions recognise dependence as a health problem; stigma, access, documentation and criminalisation can obstruct engagement.
Exam trap	**Not blanket immunity for every drug offence or every person entering rehabilitation.** State the eligible offence, voluntary treatment and recognised setting.

§64A = ELIGIBLE OFFENCE + VOLUNTARY TREATMENT + RECOGNISED SETTING + COMPLETION

NDPS Act 1985 §§8, 27, 37, 39, 64A, 71, Department of Revenue consolidated Act; applicable NDPS Rules.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

NDPS Act 1985: control and treatment. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Mental health legislation and disability law.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III • 41.4

PECA 2019: electronic cigarettes

LEGAL ACTS APPENDIX • Supplement • tobacco-control law • PaperII Q 18

1 NAME & PURPOSE	
Act	**Prohibition of Electronic Cigarettes Act 2019**: prohibition of production, manufacture, import, export, transport, sale, distribution, storage and advertisement.
Why	Prevent youth uptake and population exposure to e-cigarette harms; distinct from COTPA's regulation of conventional tobacco.

2 WHAT COUNTS • §3	
Definition	Electronic device heating a substance **with or without nicotine/flavours** to create an inhalable aerosol.
Included	Electronic nicotine-delivery systems, heat-not-burn products, e-hookah and like devices regardless of name, shape, size or form.
Exclusion	A product licensed under the **Drugs and Cosmetics Act 1940** is excluded by the statutory definition. Do not assume every marketed cessation device qualifies.

3 PROHIBITIONS • §§4–5	
§4	No production/manufacture/import/export/transport/sale/distribution of e-cigarettes as complete products or parts; no direct/indirect advertising or promotion.
§5	No owner/occupier/person controlling a place may knowingly permit **storage of stock** of e-cigarettes.
Exam precision	Distinguish the listed commercial/supply/storage acts from claiming the statute expressly criminalises **every act of personal use**.

4 PENALTIES	
First §4 offence	Up to **1 year imprisonment OR Rs 1 lakh fine OR both**.
Subsequent §4	Up to **3 years imprisonment AND up to Rs 5 lakh fine**.
§5 storage	Up to **6 months imprisonment OR Rs 50, 000 fine OR both**.
Enforcement	Authorised search/seizure and disposal provisions; statutory powers and procedures apply.

5 RELEVANCE TO PSYCHIATRY	
Assessment	Ask specifically about vaping, liquids/devices, nicotine content, dual use and youth exposure. "Not smoking cigarettes" does not mean no nicotine use.
Counselling	Explain dependence and health risks in clear terms; support evidence-based cessation with authorised treatments.
Clinical boundary	Do not present prohibited retail vaping products as a routine legal cessation prescription. Assess coexisting substance use and mental-health needs.
Compare	**COTPA: tobacco regulation. PECA: listed e-cigarette prohibitions. NDPS: controlled narcotic/psychotropic drugs.**

WITH OR WITHOUT NICOTINE • SUPPLY/ADVERTISING BAN • STOCK-STORAGE BAN

Prohibition of Electronic Cigarettes Act 2019 §§3–8; MoHFW NTCP official Act PDF.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

PECA 2019: electronic cigarettes. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Mental health legislation and disability law.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III • 44.1

IDEAS: domains and scoring

LEGAL ACTS APPENDIX • III Q 44, Q 48 • use with 44.3 and 47.1

1 WHAT IT MEASURES	
IDEAS	**Indian Disability Evaluation and Assessment Scale**: functional disability associated with mental illness; not IQ or symptom severity alone.
Method	Interview, observation, collateral and records; consider functioning across settings and environmental supports. Use anchored domain ratings.

2 FOUR DOMAINS • EACH 0–4	
Self-care	Personal hygiene, dressing, eating and physical health.
Interpersonal	Initiating and maintaining appropriate social relationships.
Communication	Understanding and exchanging information verbally/nonverbally.
Work	Relevant **employment, housework or education** role; unemployment alone is not a disability rating.
Anchor scale	0 none • 1 mild • 2 moderate • 3 severe • 4 profound. **Domain subtotal 0–16**.

3 2024 PRINTED APPENDIX XIII: TIME COMPONENT	
MI2Y	Months symptomatic within the **previous 2 years**, assessed with records/informant. Add to domain subtotal.
Printed bands	**<6 months:+1 • 7–12:+2 • 13–18:+3 • >18:+4**. Exactly 6 months is not clearly allocated in the printed form.
Worked example	Domains 2+1+2+2=7; 15 symptomatic months adds 3 → **global score 10**.

4 2024 PRINTED GLOBAL BANDS	
0 /1–7	0: no disability; 1–7: mild, printed as <40%.
8–13 /14–19 /20	Moderate / severe / profound. Form prints 8 and above as >40%; **RPwD benchmark definition is ≥40%**. Do not improvise exact percentages.

5 VERSION CAUTION • DO NOT MIX TABLES	
Older convention	Common 2002/2018 teaching adds **years since onset** (<2, 2–5, 6–10, >10) and uses different cut-offs. Label it as an older version if discussed.
Conflicts	Appended legacy form names four diagnoses and two-year recertification; **main 2024 §24 uses broader mental illness and differentiated validity**. Read together; seek authority clarification for disputed boundaries.
Certification	Do not infer a legal percentage or permanent certificate from a memorised global score alone. Apply **main notification, assessment and authorised interpretation**.

DOMAIN SUBTOTAL + NOTIFIED TIME COMPONENT → INTERPRET WITH THE CORRECT VERSION

DEPwD S.O.1338(E), 2024: §24 and Appendix XIII, printed pp 849–851, visually checked. See source record.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

IDEAS: domains and scoring. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Mental health legislation and disability law.

Credits and references: retained within the illustration.

Assessment of Disability in Persons Suffering from Mental Retardation

ADPMR • Original five-domain version, Nizamie et al., 2005

Historical publication wording; current clinical term is intellectual disability.

1. PURPOSE AND ADMINISTRATION

Purpose

- Trained-observer rating of disability and age-appropriate everyday performance in people already diagnosed with intellectual disability, including associated multiple disabilities.
- Not an intelligence test or a stand-alone diagnosis.
- Original field sample: 51 children; mean age 14 years; not universal adult norms.

Administration

- By trained rehabilitation/mental-health personnel, special educators, social workers or nurses.
- Based on direct observation and caregiver interview, with teacher reports and records.
- No standard test kit required.

Timeframe

- Rates current, age-appropriate functioning.
- No fixed retrospective window specified.
- A four-week retest in the validation was a study interval, not a rating timeframe.

2. THE FIVE DOMAINS (ONE ANCHORED RATING EACH)

1. **Perceptual–motor**
   Gross and fine coordination (e.g. movement, manipulation).
2. **Self-care**
   Daily personal care and safety (e.g. feeding, dressing, hygiene, safety).
3. **Communication and socialization**
   Expressive and receptive communication, interpersonal interaction and social behaviour.
4. **Academic**
   Formal and non-formal learning (e.g. reading, writing, numeracy, functional academics).
5. **Occupational**
   Domestic, pre-vocational and vocational functioning (e.g. simple work skills, productive activities).

3. SCORING AND WORKED EXAMPLE

Domain scoring (per domain)

0 – 4, where:

- 0 = none
- 1 = mild
- 2 = moderate
- 3 = severe
- 4 = profound

Total score: 0 – 20.
The manual permits selected intermediate scores such as 1.5, 2,5, 3,5; apply its instructions rather than invent anchors.

Worked hypothetical example (illustrative only)

Domain	Score
Perceptual–motor	1
Self-care	2
Communication and socialization	2
Academic	3
Occupational	3
Total (1 + 2 + 2 + 3 + 3)	**11**

Original integer-score bands (Nizamie et al., 2005)

Total score	Level of disability (original scale scheme)
0	None
1 – 7	Mild
8 – 13	**Moderate**
14 – 19	Severe
20	Profound

- **Example: 11 = Moderate (in the original scale scheme).**
- Original publication places ≥ 8 in its ≥ 40% category.
- This is not a current statutory entitlement rule.

4. LIMITATIONS (KEEP IN MIND)

- Small initial validation sample.
- Age, culture and opportunity affect performance.
- Coexisting sensory or motor problems can significantly influence ratings.
- A total score hides support needs in individual domains.

5. CLINICAL INSTRUMENT VERSUS LEGAL CERTIFICATION

- Indian guidance dated 14 March 2024 (notification 12 March) uses a separate intellectual-disability assessment pathway with Vineland Social Maturity Scale-based disability calculation.
- ADPMR is not a substitute for that notified pathway.
- Diagnosis, disability assessment and certification are distinct; only the notified authority certifies.
- ADPMR has 5 domains; IDEAS has 4 functional domains plus duration weighting.
- Never calculate disability as 100 – intelligence quotient.

This is a clinical instrument for assessment. It does not by itself determine legal entitlement.

Source: Nizamie et al. (2005), Part I: The ADPMR Scale. Indian Journal of Social Psychiatry, 21(3–4), 41–49. | Gazette of India, 2024, Section 21 (notification dated 12 March 2024; guidance dated 14 March 2024).

ADPMR. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Mental health legislation and disability law.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III • 47.1

RPwD Act 2016 and psychiatry

LEGAL ACTS APPENDIX • III Q 47, Q 48 • benefits bridge Q 13–15, Q 17

1 PURPOSE & DEFINITIONS	
Framework	Rights, equality, dignity, participation and **reasonable accommodation**; 21 specified disabilities, replacing 1995 Act's narrower list.
Disability	Long-term physical, mental, intellectual or sensory impairment interacting with barriers to equal participation.
Benchmark	**At least 40% of specified disability**, certified under the statutory framework. Disability rights are not all restricted to benchmark status.

2 PSYCHIATRICALLY RELEVANT CATEGORIES	
Mental illness	Separate scheduled category; assess functional disability—not diagnosis alone. Use notified mental-illness certification guidance.
Developmental	**Intellectual disability, specific learning disability and autism spectrum disorder** under the Schedule's intellectual-disability heading.
Other overlap	Multiple disabilities, chronic neurological conditions and other listed disabilities when their own criteria apply. **ADHD is not a standalone listed category**.

3 RIGHTS & DECISION-MAKING	
§3	Equality, non-discrimination and reasonable accommodation; participation and autonomy.
§§6–7	Protection from cruelty, abuse, violence and exploitation; accessible reporting and protective response.
§§13–14	Equal legal capacity and property/financial rights. When adequate support is insufficient: **limited guardianship**, joint decisions for specified period/purpose, guided by will/preferences.
§§16–17, 20	Inclusive education and accommodations; government employment non-discrimination, reasonable adjustment and statutory protection after acquired disability.

4 BENCHMARK ENTITLEMENTS	
Education	**Free education 6–18 years** in neighbourhood/special school of choice; government/government-aided higher education **≥5% seats**, 5-year upper-age relaxation.
Government jobs	**≥4% reservation**; 1% combined for autism/ID/SLD/mental illness and multiple-disability group, subject to identification/exemptions and rules.
Other support	Social security, healthcare, rehabilitation, accessible environments and high-support assessment. Schemes have separate eligibility; **no universal pension amount**.

5 CERTIFY → ENABLE → REVIEW	
Process	Notified medical authority, standard assessment, certificate/UDID, validity and appeal. **Certificate percentage ≠ global incapacity**.
Psychiatrist	Document residual functional limitations, support needs and accommodations; connect benefits; reassess when required.
Critical appraisal	Wider rights and inclusion; gaps in implementation, accessible assessment, scheme awareness, workplace acceptance and community services.

RPwD Act 2016 §§2–7, 13–17, 20, 24–27, 31–38, 56–59 and Schedule; DEPwD assessment guidelines 2024.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

RPwD Act 2016 and psychiatry. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Mental health legislation and disability law.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III • 47.2

National Trust Act 1999: guardianship

LEGAL ACTS APPENDIX • Supplement • III Q 13–15, Q 17, Q 47

1 PURPOSE & COVERAGE	
Population	**Autism, cerebral palsy, intellectual disability** (statute's older term: mental retardation), and specified multiple disabilities. Not a general mental-illness guardianship Act.
Purpose	Community living, family support, protection when caregivers cannot provide care, and **equal opportunities and independent living**.

2 LOCAL LEVEL COMMITTEE • §§13–14	
Who	District-level **District Magistrate/Collector**, registered organisation representative, and person with disability.
Application	Parent/relative may seek appointment of guardian; registered organisation may apply with statutory consent conditions.
Decision	LLC considers whether guardianship is needed and **for which purposes**. Appointment may concern person, property or both; not diagnosis-based automatic removal of autonomy.

3 GUARDIAN'S DUTIES • §§15–17	
Care	Provide for the person and property within the appointment; maintenance, health and support. Respect wishes and promote participation.
Inventory	Property/assets, claims, debts and liabilities to appointing authority **within 6 months**.
Annual account	Income, expenditure and balance **within 3 months of financial-year end**.
Removal	LLC can investigate abuse, neglect or misappropriation and remove/replace guardian; protective oversight is essential.

4 DISTINGUISH FOUR ROUTES	
MHCA NR	Supports **mental-healthcare decisions**; not a general property guardian.
RPwD §14	Limited, supported and joint decisions for **specified period/purpose**, reflecting the person's will.
National Trust	LLC guardianship for its specified developmental-disability population.
Minor guardianship	Guardians and Wards Act / applicable personal law: **child's welfare**; not this adult decision-support framework.

5 PSYCHIATRIST'S CONTRIBUTION	
Assess function	Communication, adaptive skills, decision-specific understanding, vulnerability, supports and least restrictive option.
Avoid shortcuts	**IQ, diagnosis or 40% disability alone does not establish blanket incapacity**. Explain scope and limits of the clinical opinion.
Schemes	National Trust support includes **Niramaya** health-insurance scheme: up toRs 1 lakh with reimbursement/sub-limits and eligibility conditions. Check current scheme terms.

PERSON'S WILL + NECESSARY SUPPORT + DEFINED SCOPE + ACCOUNTABILITY

National Trust Act 1999 §§10, 13–17; National Trust guardianship/LLC and Niramaya pages; RPwD 2016 §14.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

National Trust Act 1999: guardianship. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Mental health legislation and disability law.

Credits and references: retained within the illustration.

AREA 06 OF 13 · P3-A04

ADHD and disruptive behaviour disorders

9	9.5%	III-50	III-58
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

ANCHOR 1 · HIGH 3 · RECURRENT 1 · SINGLE 4

REVISION ORDER

ADHD management first, it is the highest-scoring question in this book. Conduct disorder next, since three slots ask it three ways. Then the single-drug slot and the two newer diagnostic entities.

WHAT IS IN THIS AREA

ADHD management and neurobiology, adult ADHD, atomoxetine, conduct disorder in three slots, oppositional defiant disorder and disruptive mood dysregulation disorder.

III - 50

Discuss pharmacological and nonpharmacological management of Attention Deficit Hyperactivity Disorder. [10]

10 ADHD AND DISRUPTIVE BEHAVIOUR DISORDERS

DNB, KUHS, NTRUHS, RGUHS, TN-MGRMU - 12 APPEARANCES, 12 OF 78 SESSIONS

SKELETON

2	The principle	Age decides which arm goes first, severity decides speed
3	Non-drug management	Parent, classroom, child, in that order of evidence
3	Drug management	First line, second line, and what each is chosen for
2	Monitoring	What is measured at every visit, and what stops the drug

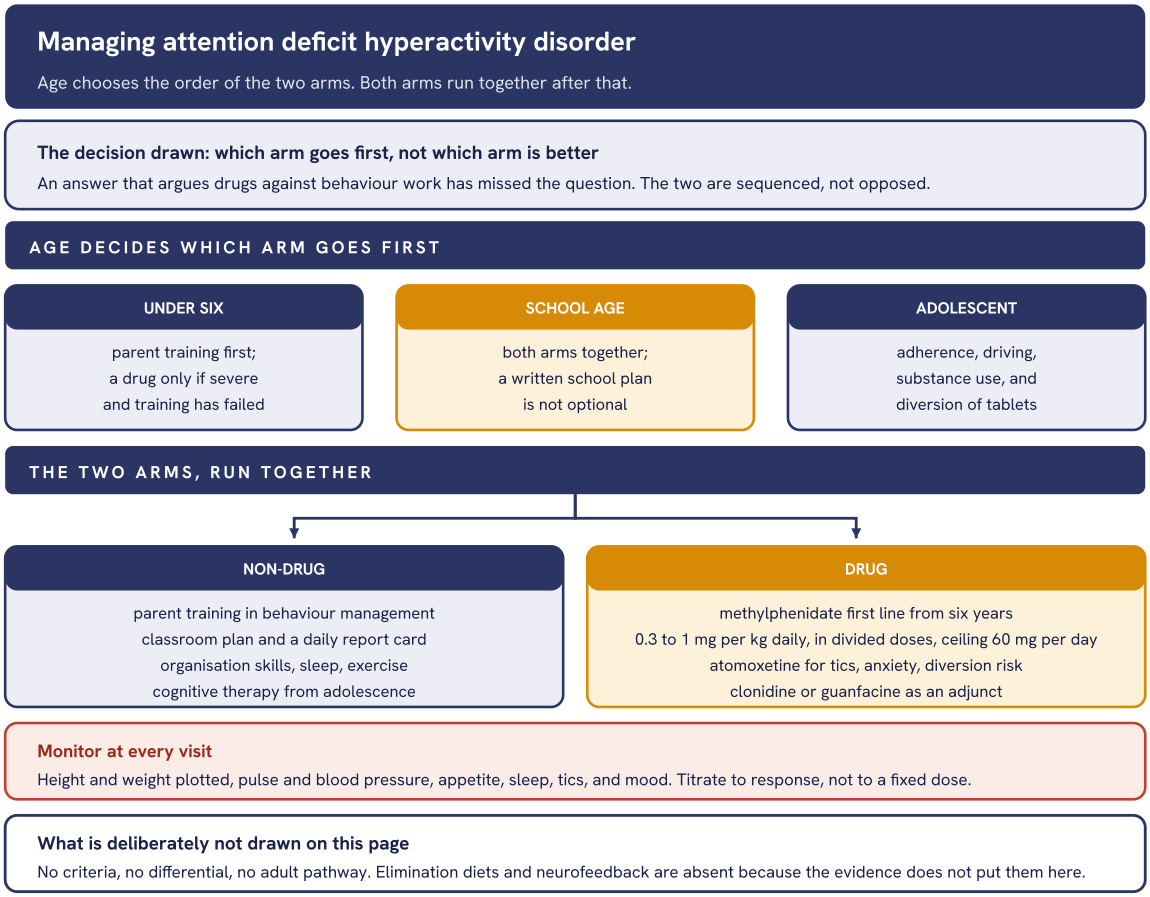


Fig 050.1 Age chooses the order, then both arms run together, with monitoring carried as a red strip because it is the part that is skipped.

- **Choosing between the drugs.** Stimulants act within days and have the larger effect. Atomoxetine takes two to six weeks, is not a controlled drug, and is preferred where there are tics, marked anxiety, or a diversion risk. Alpha-2 agonists help tics and sleep as an adjunct.
- **Indian practice.** Methylphenidate is a controlled substance, so prescribing follows the narcotic rules and long acting preparations are not reliably available. Large classes make a daily report card harder, raising the value of parent training.

PITFALL

A drug holiday is not a routine. It is considered only for growth faltering, and it costs the child the school terms it covers.

WHAT EARNS THE MARKS

- **Age stated as the sequencing rule** before either arm is described.
- **Both arms present.** An answer that is only pharmacology cannot pass a question that names both.
- **One weight-based dose band, with titration to response.**
- **The monitoring list.** Height, weight, pulse, blood pressure, appetite, sleep, tics, mood.

SEE ALSO Slot III - 53 atomoxetine Slot III - 54 adult attention deficit disorder Slot III - 55 neurobiology

III - 51

Discuss briefly the etiology, clinical features, prognosis and treatment of oppositional defiant disorder. [2+4+2+2]

2 + 4 + 2 + 2 | ADHD AND DISRUPTIVE BEHAVIOUR DISORDERS

DNB - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2	Aetiology	Child, parenting and context, named as an interaction
4	Clinical features	Three symptom clusters, the count, and the setting rule
2	Prognosis	Each cluster predicts a different adult outcome
2	Treatment	Parent first, child second, drugs almost never

- **Aetiology, as an interaction.** Difficult temperament and poor effortful control, moderate heritability, low verbal ability and coexisting attention deficit disorder, meeting harsh or inconsistent parenting. The coercive cycle described by Patterson is the mechanism: the child escalates, the parent gives way, and both are rewarded.
- **Clinical features.** Three clusters: angry and irritable mood; argumentative and defiant behaviour; vindictiveness. Four or more symptoms for at least six months, with someone who is not a sibling. Under five they occur on most days, from five at least weekly. Severity is graded by how many settings are affected.

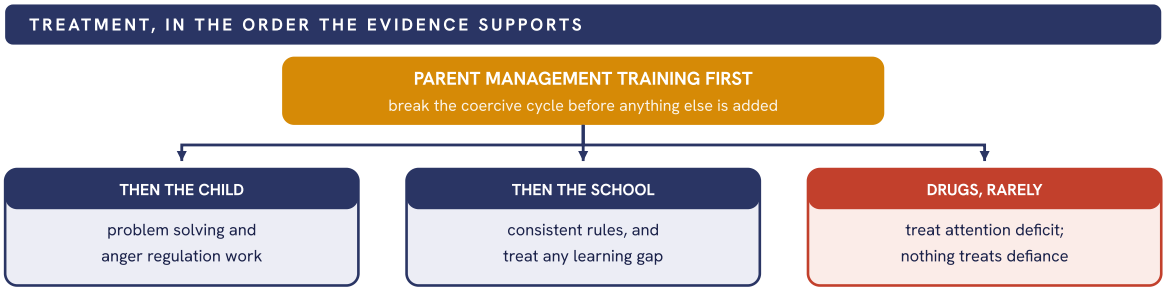


Fig 051.1 Parent work first, then the child and the school, with drugs as a red lane because they treat what coexists rather than the disorder itself.

PROGNOSIS, AND THE PITFALL INSIDE IT

Most children improve. The three clusters predict differently: the irritable cluster predicts later depression and anxiety, the headstrong cluster predicts attention deficit disorder and conduct problems, and the vindictive cluster carries the highest risk of conduct disorder. Treating all defiance as pre-conduct disorder misses the children whose outcome is a mood disorder.

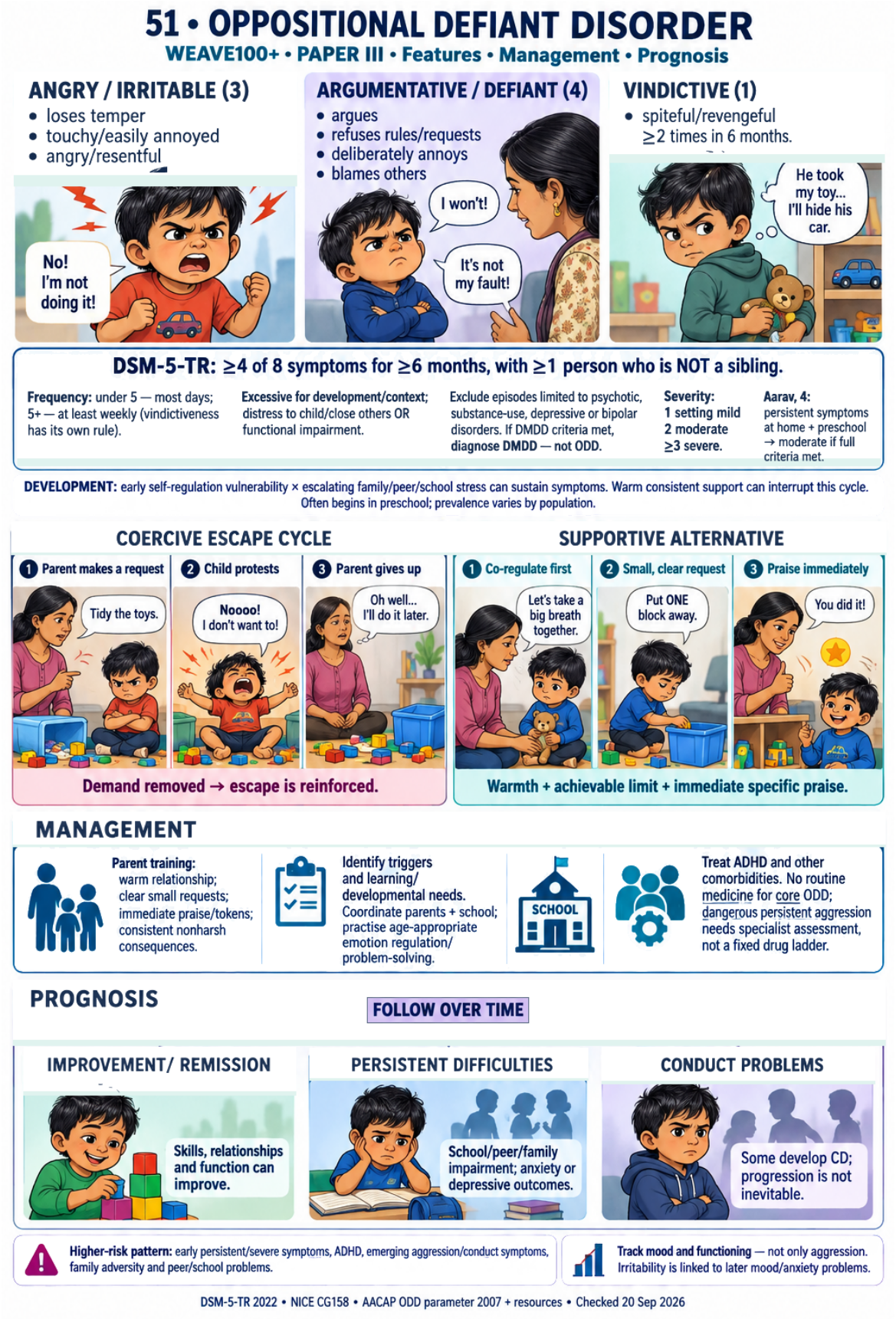
WHAT EARNS THE MARKS

- **Aetiology written as an interaction,** with the coercive cycle named as the mechanism.
- **The count, the non-sibling rule and the age-based frequency.** These turn behaviour into a diagnosis.
- **Prognosis split by cluster,** not given as one figure for the whole disorder.

SEE ALSO Slot III - 57 conduct disorder Slot III - 56 disruptive mood dysregulation disorder **SPRINT**

Day 23, Child behavioural, emotional & other disorders

WEAVE 100 · PAPER III · new-51.6



ODD - Development management and prognosis. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-51.

Credits and references: retained within the illustration.

III - 52

Describe the course and outcome with management of Conduct disorders. [10]

10 ADHD AND DISRUPTIVE BEHAVIOUR DISORDERS

KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 **The two trajectories**	Age at onset is the strongest prognostic fact
3 **Outcome**	Named outcomes, and the honest proportion
3 **Management by age**	Who is the target of treatment at each stage
2 **What makes it worse**	The interventions that harm, and the legal interface

TRAJECTORY	WHAT IT LOOKS LIKE	WHERE IT TENDS TO GO
Childhood onset	Before ten years, aggression, often with attention deficit disorder	**Persistent; a minority reach antisocial personality disorder**
Adolescent onset	After ten, peer group offending, less aggression	**Most desist in early adult life**
Limited prosocial emotions	Callous, unremorseful, shallow affect	Worst outcome at any onset age
Girls	Relational aggression, later onset, more covert	More depression, anxiety and victimisation

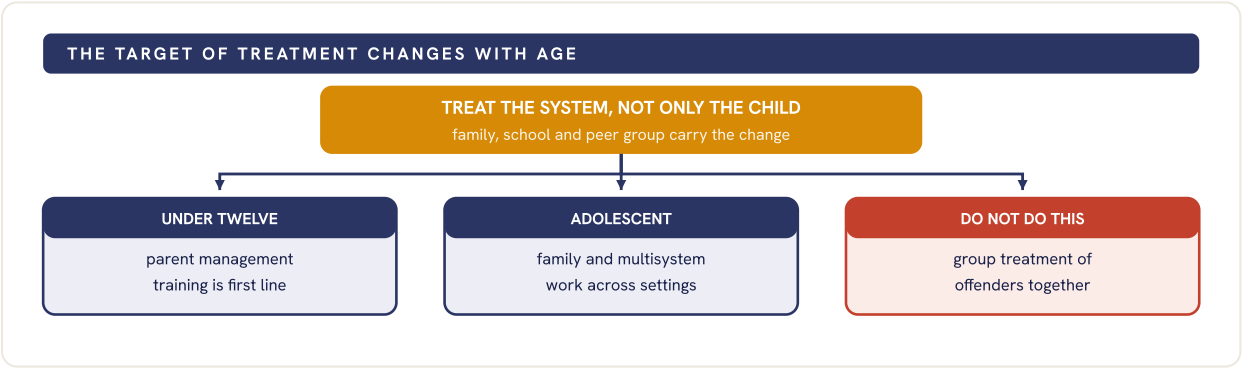


Fig 052.1 The target of treatment moves outward with age, and the red lane names the intervention that reliably makes outcomes worse.

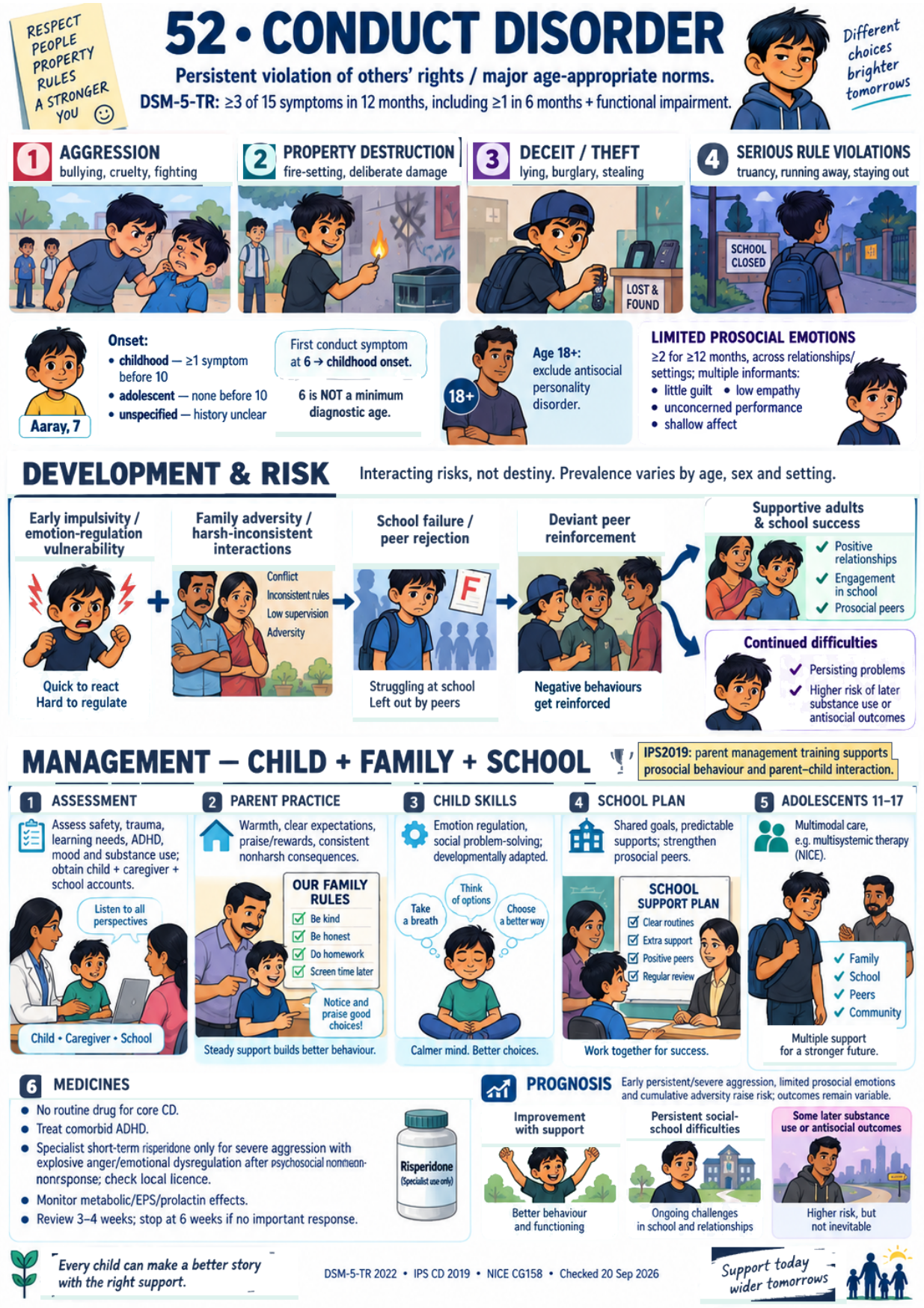
- **Outcome, and the legal interface.** School dropout, substance use, injury, early parenthood, unemployment and offending. Most do not develop antisocial personality disorder, and saying so is a mark. A child in conflict with law is dealt with by the juvenile justice board under the Act of 2015, where the psychiatrist assesses and does not adjudicate.

WHAT EARNS THE MARKS

- **Age at onset named as the strongest prognostic fact,** before any outcome is listed.
- **The honest proportion.** A minority, not most, reach antisocial personality disorder.
- **Group treatment named as harmful,** and the juvenile justice role kept to assessment.

SEE ALSO Slot III - 57 features and aetiology Slot III - 58 definition and comorbidity **SPRINT**
Day 23, Child behavioural, emotional & other disorders

WEAVE 100 · PAPER III · new-52.1



Conduct disorder - Development and management. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-52.

Credits and references: retained within the illustration.

III - 53

Atomoxetine. [10]

10 ADHD AND DISRUPTIVE BEHAVIOUR DISORDERS

KNRUHS, KUHS - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2	What it is	Mechanism, and why the prefrontal effect matters
2	When it is chosen	The four situations that select it over a stimulant
4	Dose and adverse effects	Weight banded dosing, then the warnings
2	Monitoring	What is checked, and what stops the drug

WHAT IT IS

A selective noradrenaline reuptake inhibitor licensed for attention deficit hyperactivity disorder. Blocking the noradrenaline transporter also raises dopamine in the prefrontal cortex, where that transporter does most of the clearing. It is not a stimulant and not a controlled substance.

HEADING	WHAT TO WRITE	THE QUALIFIER
Chosen when	Tics, marked anxiety, substance misuse, or risk of tablets being diverted	Effect is smaller than a stimulant
Dose to 70 kg	Start 0.5 mg per kg daily, then target 1.2 mg per kg daily	Maximum 1.4 mg per kg or 100 mg
Dose over 70 kg	Start 40 mg daily, target 80 mg daily	Maximum 100 mg daily
Onset	Two to six weeks, full benefit later	Never used as needed
Common effects	Appetite loss, nausea, abdominal pain, sedation or insomnia, irritability	Usually settle with time

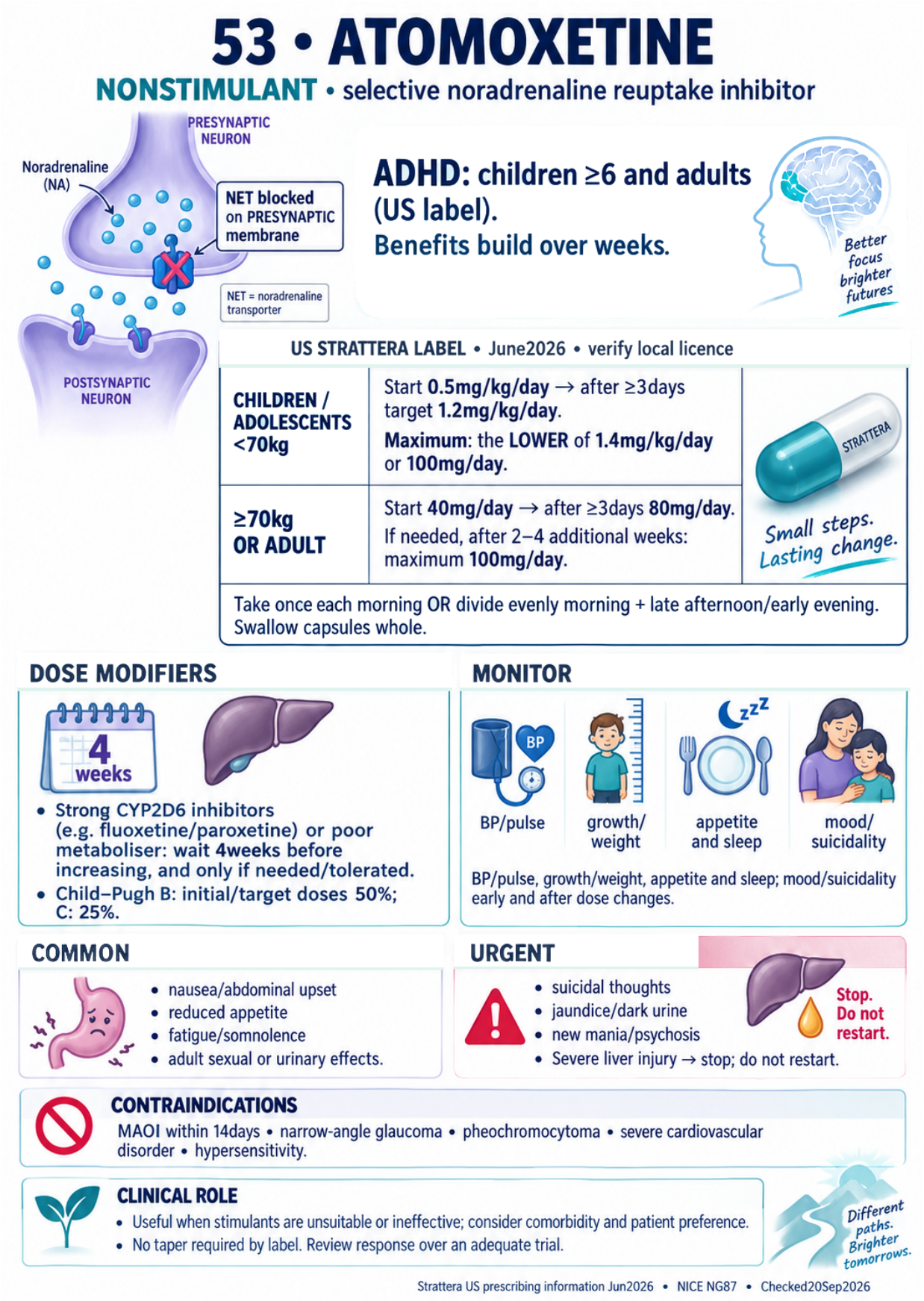
- **Stimulants and tics.** Stimulants are not absolutely contraindicated in tic disorders, so a coexisting attention deficit disorder is still treated, and atomoxetine is the preferred agent where tics are prominent or worsen on a stimulant.
- **The warnings.** Suicidal ideation in children and adolescents, especially in the first months. Rare liver injury, so stop for jaundice or dark urine. Small rises in pulse and blood pressure. Avoid in narrow angle glaucoma, phaeochromocytoma and serious cardiovascular disease, and within a fortnight of a monoamine oxidase inhibitor.
- **Monitoring and interactions.** Height and weight plotted, pulse and blood pressure, mood and suicidal thinking, and any liver symptom. Metabolised by cytochrome P450 2D6, so exposure rises with fluoxetine, paroxetine or bupropion, and in poor metabolisers.

WHAT EARNS THE MARKS

- **The prefrontal dopamine point.** It explains the effect without making it a stimulant.
- **Weight banded dosing with the two ceilings,** not a single adult figure.
- **The slow onset stated,** because it is why families stop the drug early.
- **Suicidality and liver injury named,** with what each one triggers.

SEE ALSO Slot III - 50 management of attention deficit disorder Slot III - 54 adult attention deficit disorder

WEAVE 100 · PAPER III · new-53.2



Atomoxetine. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-53.

Credits and references: retained within the illustration.

III - 54

What are the manifestations of adult ADHD? How does it differ from childhood ADHD? Discuss its management in brief. [3+3+4]

3 + 3 + 4 | ADHD AND DISRUPTIVE BEHAVIOUR DISORDERS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

3	Adult manifestations	By domain, in the form adults actually present
3	The grid	Domain by domain, with the diagnostic rules marked
2	Non-drug management	Psychoeducation, skills, and the environment
2	Drug management	Sequencing around comorbidity, and what to watch

DOMAIN	IN CHILDHOOD	IN ADULT LIFE	WHAT SETTLES IT
Hyperactivity	Runs, climbs, leaves the seat	Inner restlessness, cannot sit through a meal or a film	Form changes, the trait persists
Inattention	Careless work, loses things, distracted	Procrastination, missed deadlines, disorganisation	**The domain that persists most**
Impulsivity	Blurts out, cannot wait a turn	Interrupts, impulsive spending, quits jobs, risky driving	Consequences, not the behaviour
Symptom count	Six or more in a domain	Five or more from seventeen years	**The threshold falls with age**
Onset evidence	Observed directly	Several symptoms before twelve, corroborated by an informant	**Retrospective, so seek records**
Company kept	Oppositional defiant disorder, learning disorder	Substance use, mood and anxiety disorder, personality difficulty	Changes the treatment order

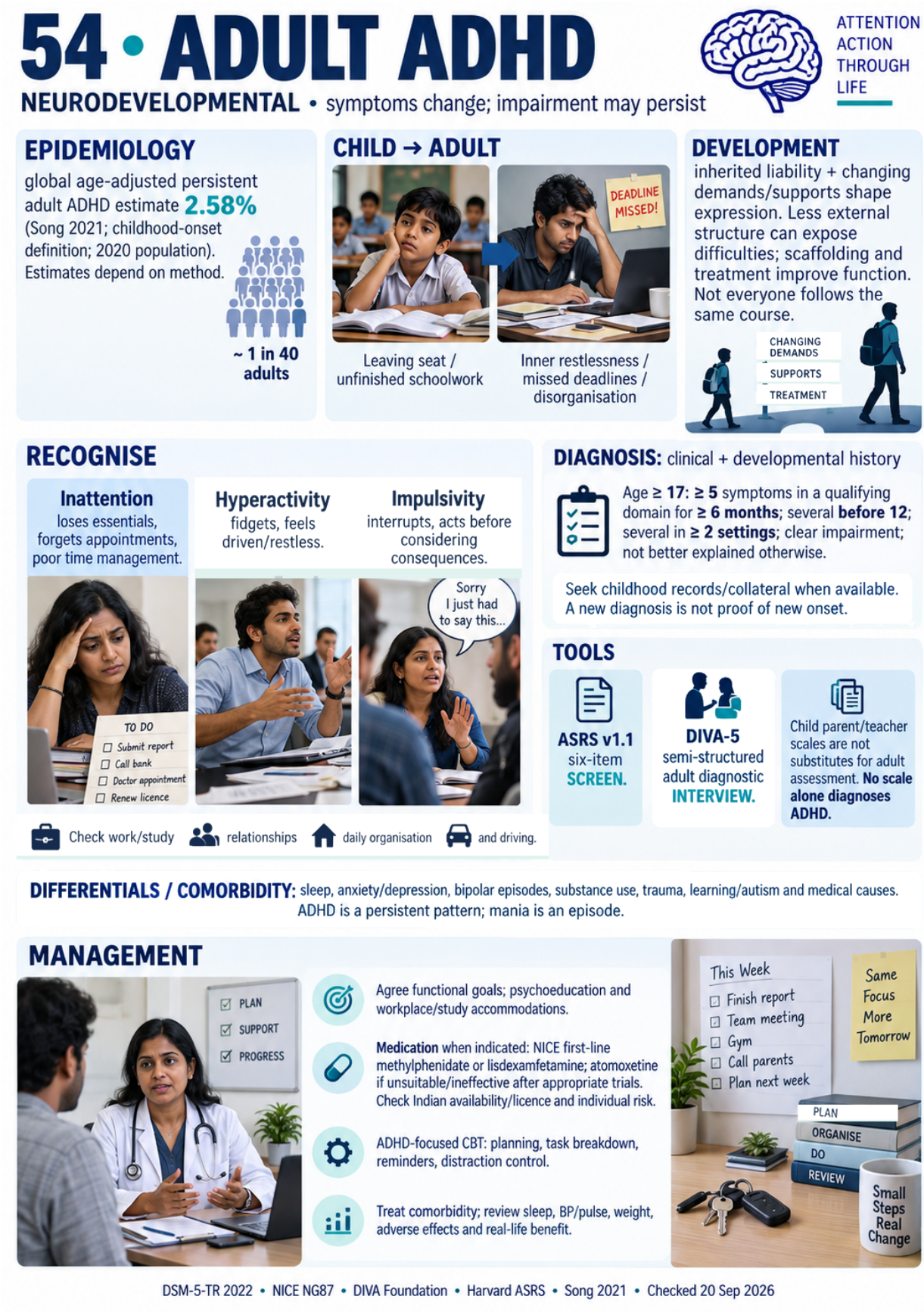
- **Management, non-drug.** Psychoeducation for patient and partner, cognitive therapy adapted for adult attention deficit disorder, structured organisation and time management systems, environmental restructuring at work, sleep regularity, and coaching where available.
- **Management, drugs and order.** Methylphenidate is first line. Atomoxetine where there is substance misuse or a diversion risk. Stabilise an active substance disorder and any bipolar disorder before starting a stimulant, check cardiovascular history and blood pressure, and counsel on driving.

WHAT EARNS THE MARKS

- **A grid, not two paragraphs.** The comparison has to be readable across a row.
- **The two diagnostic rule changes marked:** five symptoms from seventeen, and onset before twelve.
- **Hyperactivity described as changing form,** not as disappearing.
- **Comorbidity sequenced before prescribing.** It is the line that separates a top answer.

SEE ALSO Slot III - 50 management of attention deficit disorder Slot III - 53 atomoxetine

WEAVE 100 · PAPER III · new-54.2



Adult ADHD. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-54.

Credits and references: retained within the illustration.

III - 55

Neurobiology of attention deficit hyperactivity disorder. [10]

10 ADHD AND DISRUPTIVE BEHAVIOUR DISORDERS

KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	Genetics and environment	Heritability, polygenic risk, the exposures that survive
3	Neurochemistry	Which transmitters, where, and how the drugs fit
3	Structure and networks	Maturation, volumes, and the circuits involved
2	Models and limits	Two or three pathways, then the honest caveat

THE ONE-LINE ACCOUNT

A highly heritable, polygenic disorder of catecholamine signalling in fronto-striatal and fronto-parietal circuits, expressed as delayed cortical maturation rather than as a lesion, with group differences that are real, small, and heavily overlapping with typical development.

LEVEL	THE FINDING	THE CAVEAT THAT MUST BE SAID
Genetic	Heritability around seventy to eighty percent, polygenic, many small effects	**No single gene, and no genetic test**
Environmental	Prematurity and low birth weight, lead, severe early deprivation	Prenatal smoking is largely confounded
Chemical	Dopamine and noradrenaline in prefrontal cortex and striatum	**An inverted U, so more is not better**
Structural	Delayed cortical maturation, small reductions in basal ganglia volume	Small effects, wide overlap
Network	Fronto-striatal, fronto-parietal, fronto-cerebellar; default mode intrusion	**Group level, never diagnostic**

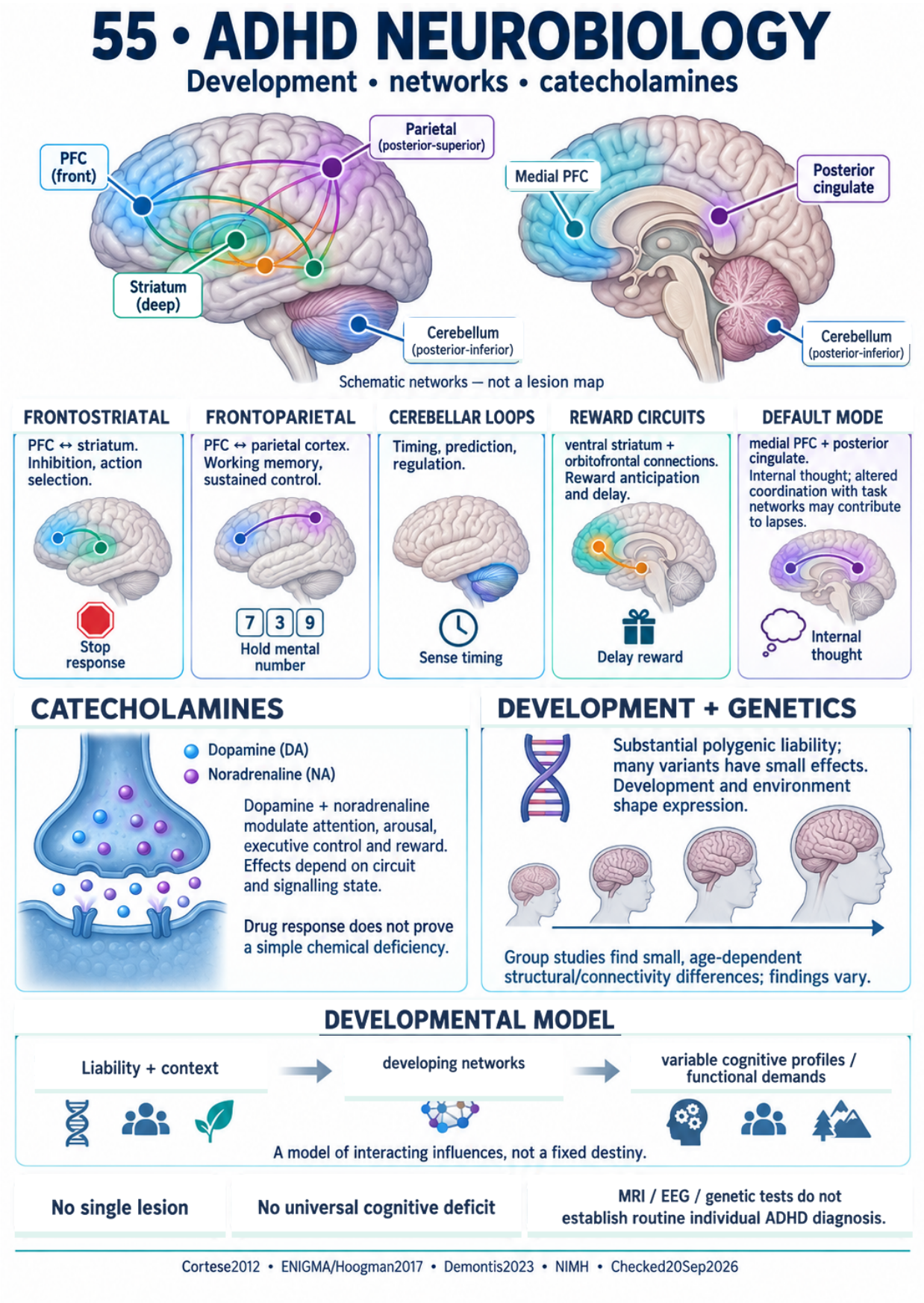
- **How the drugs fit the biology.** Stimulants block the dopamine and noradrenaline transporters, atomoxetine blocks the noradrenaline transporter, and alpha-2A agonists strengthen prefrontal network signalling directly. All three converge on the same catecholamine deficit account.
- **Models, and the limit.** Executive dysfunction from weak behavioural inhibition, delay aversion from a hyposensitive reward system, and a timing pathway make up the dual and triple pathway models. No investigation is diagnostic, and the diagnosis remains clinical.

WHAT EARNS THE MARKS

- **Heritability quoted with the polygenic qualifier.** A number without it invites the wrong follow-up question.
- **Delayed maturation, not a lesion.** That phrase is what the question is testing.
- **Drugs mapped onto the chemistry,** which shows the biology is understood rather than listed.
- **The no-test caveat.** It is the last mark and most answers never reach it.

SEE ALSO Slot III - 50 management of attention deficit disorder Slot III - 16 neurodevelopmental disorders

WEAVE 100 · PAPER III · new-55.2



ADHD neurobiology. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-55.

Credits and references: retained within the illustration.

III - 56

Disruptive Mood Dysregulation Disorder. [10]

10 ADHD AND DISRUPTIVE BEHAVIOUR DISORDERS

NTRUHS, RGUHS - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

3	The criteria	Outbursts, the mood between them, and every threshold
2	Why it exists	The problem it was written to solve
3	Differential	Four confusables, each with the deciding feature
2	Management	What the thin evidence actually supports

THE CRITERIA, WITH THE NUMBERS

Severe recurrent temper outbursts, verbal or behavioural, out of proportion to the provocation and to developmental level, on average three or more times a week. Between outbursts the mood is persistently irritable or angry, most of the day, nearly every day, and others can see it. Twelve months or more, never symptom free for three consecutive months, in at least two of three settings and severe in one. Onset before ten years; the diagnosis is not made before six or after eighteen.

CONFUSABLE	HOW IT DIFFERS	WHAT SETTLES IT
Bipolar disorder	Distinct episodes, with elation, reduced sleep need and grandiosity	**Episodicity; here irritability is chronic**
Oppositional defiant	Defiance directed at authority, outbursts less severe	**Cannot be diagnosed alongside; this takes precedence**
Intermittent explosive	Outbursts only, three months, mood normal in between	**No irritability between episodes**
Depression or attention deficit	Irritability confined to the mood episode, or driven by impulsivity	May coexist; both are allowed

- **Why it exists.** It was written to stop chronic non-episodic irritability being diagnosed as paediatric bipolar disorder. Follow-up studies show that this pattern predicts unipolar depression and anxiety in adult life rather than bipolar disorder, and treating it as bipolar exposed children to lithium and antipsychotics for years.
- **Management, honestly.** The evidence base is thin. Parent management training and anger regulation work first. Where attention deficit disorder coexists, a stimulant has the best evidence for the irritability itself. A serotonin reuptake inhibitor where depressive or anxiety features dominate. An antipsychotic only for severe aggression, briefly, with metabolic monitoring.

WHAT EARNS THE MARKS

- **Every threshold quoted:** three a week, twelve months, two settings, onset before ten, ages six to eighteen.
- **The mood between outbursts.** It is what separates this from every episodic diagnosis.
- **The exclusion with oppositional defiant disorder,** stated as precedence rather than as overlap.
- **The reason the category was created.** It is the two easiest marks on this page.

SEE ALSO Slot III - 51 oppositional defiant disorder Slot III - 57 conduct disorder

III - 57

Describe the clinical features, aetiology and management of Conduct Disorder. [10]

10 ADHD AND DISRUPTIVE BEHAVIOUR DISORDERS

NTRUHS, RGUHS - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

3	Clinical features	Four groupings, the count, and the two specifiers
3	Aetiology	Biological, family and social, as a chain not a list
3	Management	The algorithm: who is treated, at what age
1	Drugs	One line: what they treat, and what they do not

GROUPING	EXAMPLES FROM THE CRITERIA	THE RULE
Aggression to people and animals	Bullying, fights, weapon use, cruelty, robbery, forced sexual activity	Three or more criteria in twelve months
Destruction of property	Fire setting, deliberate damage	At least one in the past six months
Deceitfulness or theft	Breaking in, conning, shoplifting	Fifteen criteria in total
Serious rule violations	Staying out at night, running away, truancy before thirteen	Specify onset, and limited prosocial emotions

- **Aetiology, as a chain.** Heritable temperament with low autonomic arousal and reduced amygdala response to distress, plus weak verbal ability, meeting harsh parenting, maltreatment and poor supervision, and then deviant peers and school failure.

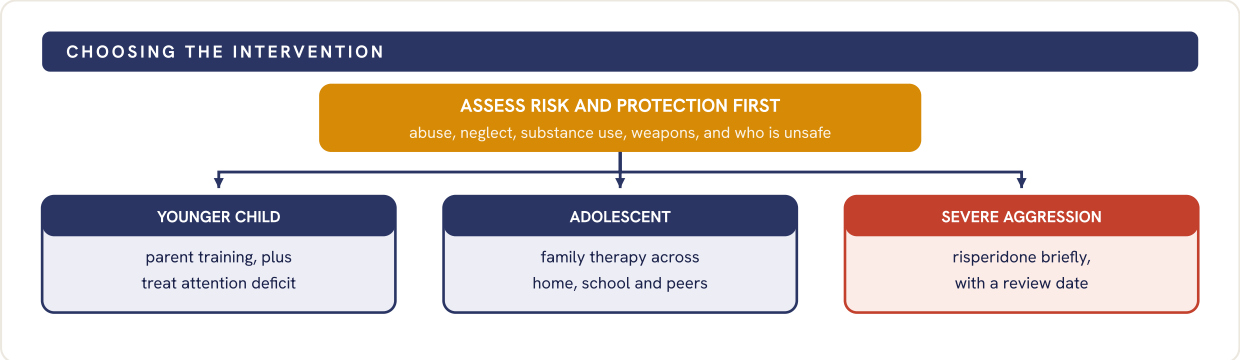


Fig 057.1 Risk assessed before treatment is chosen, then the intervention that matches the age, with medication as a red lane because it is symptomatic and temporary.

- **Drugs, in one line.** No drug treats conduct disorder. Stimulants treat coexisting attention deficit disorder and reduce aggression through it; risperidone reduces severe aggression short term with metabolic monitoring. Neither replaces the family and school work.

WHAT EARNS THE MARKS

- **Four groupings with the counting rule,** not fifteen behaviours in a flat list.
- **The limited prosocial emotions specifier named,** because it changes prognosis and treatment.
- **Aetiology written as a chain** from temperament through parenting to peers.
- **Risk assessment placed before treatment selection.**

SEE ALSO Slot III - 52 course and outcome Slot III - 58 definition and comorbidity SPRINT

Day 23, Child behavioural, emotional & other disorders

III - 58

Conduct disorders. [10]

10 ADHD AND DISRUPTIVE BEHAVIOUR DISORDERS

RGUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	Definition	One sentence, with the duration and the count
3	Subtypes and specifiers	Onset, prosocial emotions, severity
3	Epidemiology and comorbidity	Rates as a range, then what travels with it
2	The Indian interface	Where the law meets the clinic, and our role in it

THE DEFINITION

A repetitive and persistent pattern of behaviour violating the basic rights of others or major age-appropriate norms, shown by three or more of fifteen criteria in the past twelve months, with at least one in the past six months, and causing clinically significant impairment.

AXIS	THE DIVISIONS	WHY IT MATTERS
Age at onset	Childhood onset before ten, adolescent onset, unspecified	The strongest prognostic split
Prosocial emotions	With limited prosocial emotions: remorse, empathy, concern, affect	Two of four, twelve months, more than one setting
Severity	Mild, moderate, severe, by number of criteria and harm caused	Sets intensity of the response
Comorbidity	Attention deficit disorder, learning disorder, substance use, depression, trauma	Each is separately treatable

- **Epidemiology.** Community estimates of a few percent of children and adolescents, with boys diagnosed more often than girls. Indian school and community surveys report a wide range because instruments and thresholds differ, so a range with its reason is the honest answer rather than a single figure.
- **The Indian interface.** A child in conflict with law goes to the juvenile justice board under the Act of 2015, and a neglected or abused child to the child welfare committee as a child in need of care and protection. The psychiatrist assesses capacity, development and mental illness. The board decides, not the clinician.

WHAT EARNS THE MARKS

- **The definition with three of fifteen, twelve months and six months.** Naming behaviours without the rule is a half answer.
- **Both specifiers,** with the two of four rule on prosocial emotions.
- **Prevalence given as a range with its reason.**
- **The legal boundary.** Assessing, not adjudicating, is the line that reads as command of the role.

SEE ALSO Slot III - 52 course and outcome Slot III - 57 features and aetiology SPRINT

Day 23, Child behavioural, emotional & other disorders

WEAVE 100+ / PAPER III

ODD, conduct disorder, DMDD and bipolar

Distinguish persistent irritability, rights violations and episodic mood change.

Domain	Revision points
ODD	Angry/ irritable mood, argumentative/ defiant behaviour or vindictiveness; does not require serious rights violations.
Conduct disorder	Persistent pattern violating others' rights or major age-appropriate norms; aggression, destruction, deceit/ theft or serious rule violations.
DMDD	Severe recurrent outbursts with persistent interepisode irritability; developmental and duration criteria matter.
Bipolar disorder	Distinct mood episodes with change from baseline; look for episodic energy/ activity and other manic features.
Comorbidity/ context	ADHD, trauma, learning needs, family stress, substances and developmental difficulties need assessment.

TRAP

Chronic irritability alone is not mania. Do not use one aggressive incident to diagnose conduct disorder.

DIAGNOSTIC RULES

Apply the relevant exclusion and co-diagnosis rules; DSM DMDD and ODD are not both assigned when DMDD criteria are met.

Weave Sprint Paper III; see source register

III 51.1 • Question-linked revision • Source links and qualifications: SOURCES.md

ODD, conduct disorder, DMDD and bipolar. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ADHD and disruptive behaviour disorders.

Credits and references: retained within the illustration.

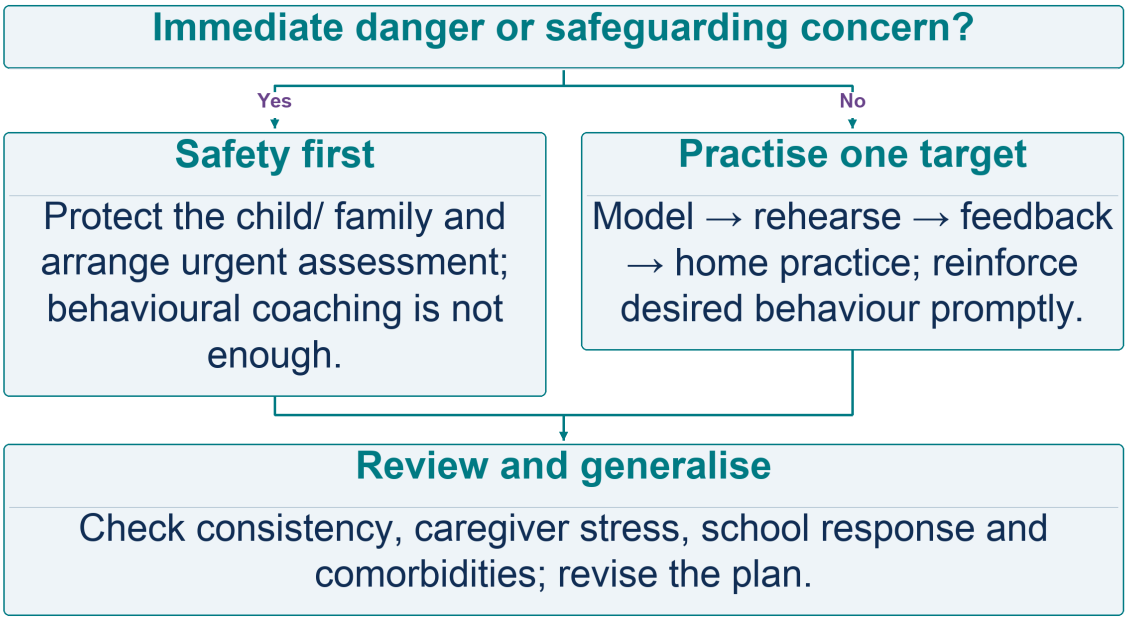
WEAVE 100+ / PAPER III

Parent management training and PCIT

Change the interaction pattern through coached, consistent practice.

Domain	Revision points
Functional analysis	Identify antecedents, the behaviour and consequences that maintain it.
PMT skills	Positive attention, labelled praise, clear instructions and predictable nonviolent consequences.
PCIT	Live coaching of caregiver-child interaction; relationship-building followed by consistent limit-setting.
Measure	Choose a small number of observable targets; use home practice and feedback.

DECISION PATHWAY



Weave Sprint child interventions; NICE CG158 (parent-training recommendations).

III 51.3 • Supplement • Source links and qualifications: SOURCES.md

Parent management training and PCIT. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ADHD and disruptive behaviour disorders.

Credits and references: retained within the illustration.

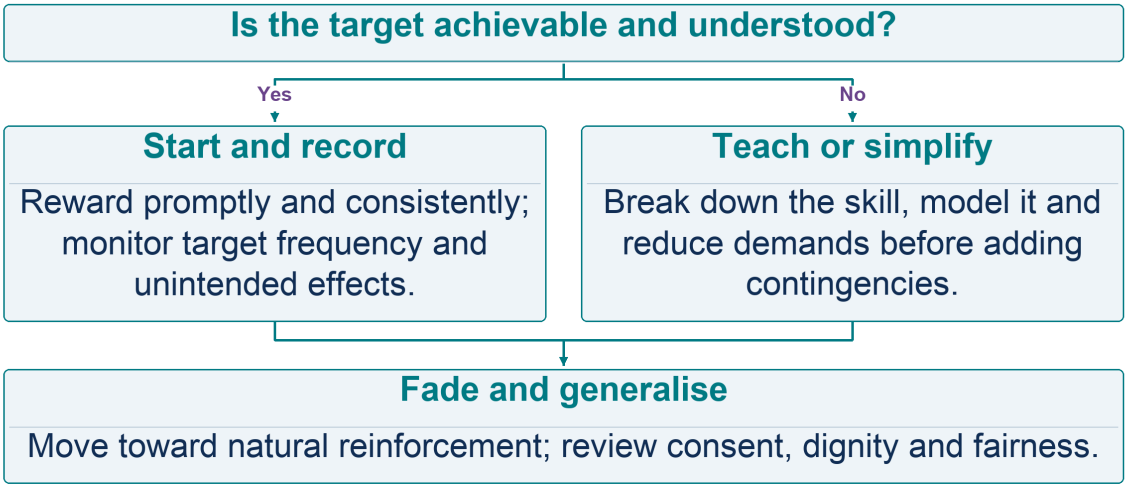
WEAVE 100+ / PAPER III

Behaviour therapy and token economy

Use reinforcement to build a chosen, observable skill.

Domain	Revision points
Antecedent	Identify when and where the behaviour occurs; alter cues and task difficulty.
Reinforcement	Positive: add a valued consequence. Negative: remove an aversive consequence; neither means punishment.
Token programme	Define target, earning rule, exchange menu and timing; choose accessible, meaningful rewards.
Worked example	Completing a short agreed homework block earns one token; exchange for a chosen activity.

DECISION PATHWAY



ETHICAL LIMIT

Do not make food, safety, healthcare or basic rights contingent on tokens.

Weave Sprint Paper III; see source register

III 51.4 • Supplement • Source links and qualifications: SOURCES.md

Behaviour therapy and token economy. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ADHD and disruptive behaviour disorders.

Credits and references: retained within the illustration.

Applied Behaviour Analysis

Functional Behaviour Chain (ABC)

Behaviour occurs in a context and has a consequence.
When the consequence meets a need, the behaviour may be maintained.



If this escape **contingency is repeated, the behaviour may be maintained.**
Observation of the ABC pattern suggests a possible **function, but does not prove it.**

Functions of Behaviour

Common functions that maintain behaviour.

Function	Example
Attention	Gaining social attention (e.g. adult response, peer interaction)
Access to item or activity	Obtaining a preferred item or activity (e.g. toy, tablet, free time)
Escape or avoidance	Avoiding or ending a demand or aversive situation (e.g. difficult task, noisy environment)
Automatic reinforcement	Behaviour is intrinsically reinforcing (e.g. sensory stimulation, pleasure)

From Problem Behaviour to Functional Communication

Replace challenging behaviour with a more appropriate and effective way to meet the same need.

1. **Teach a functional communication response**
   e.g. "Can I have a break please?"
2. **Reinforce the communication**
   Give the requested break when appropriate.
3. **Adjust task difficulty**
   Match demands to current skills and provide supports.
4. **Gradually build tolerance**
   Slowly increase task duration or complexity with ongoing reinforcement and support.



Descriptive Functional Assessment vs Experimental Functional Analysis

Different methods are used to understand the function of behaviour.

	Descriptive functional assessment	Experimental functional analysis
Focus	Observes behaviour in natural environments	Systematically manipulates antecedents and consequences
How it works	Interviews, records, direct observation (e.g. ABC charts)	Tests different conditions (e.g. attention, demand, tangible, play/alone) to identify maintaining consequences
Outcome	Generates a hypothesis about function	Provides stronger evidence for function
Use	Often first step, guides intervention planning	Useful when function is unclear or behaviour is severe

The Seven Dimensions of ABA

Applied Behaviour Analysis is defined by seven key dimensions (credited to Donald Baer, Montrose Wolf and Todd Risley).

1. **Applied (social significance)**
   Focuses on behaviours that are socially important and meaningful to the individual.
2. **Behavioural (observable and measurable)**
   Targets are clearly defined, observable and measurable.
3. **Analytic (demonstrated relation)**
   Demonstrates a functional relation between the intervention and behaviour change.
4. **Technological (replicable procedures)**
   Interventions are described in sufficient detail to be replicated.
5. **Conceptually systematic (learning principles)**
   Based on established principles of learning.
6. **Effective (meaningful change)**
   Produces behaviour change that is meaningful for the individual.
7. **Generality (across time and settings)**
   Skills and behaviour change are maintained over time and generalise to other settings, people and situations.

Key Methods and Principles

Common strategies used in ABA.

- **Operational definition**
  Clearly define the target behaviour (e.g. "pushes worksheet away" as an observable action).
- **Baseline**
  Measure current frequency, duration or other relevant metric before intervention.
- **Antecedent supports**
  Modify the environment (e.g. adjust task difficulty, provide choices, visual supports).
- **Prompting and fading**
  Provide prompts to teach a skill, then gradually reduce support.
- **Shaping and chaining**
  Reinforce successive approximations or link steps to build complex skills.
- **Differential reinforcement**
  Reinforce desired behaviour (e.g. functional communication) and withhold reinforcement for the problem behaviour.
- **Generalisation and maintenance**
  Plan for practice across people, settings and over time to maintain gains.

Reinforcement vs Punishment

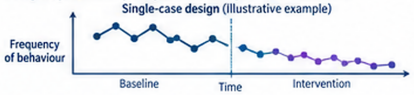
Reinforcement	Punishment
Increases the likelihood of a behaviour occurring in the future.	Decreases the likelihood of a behaviour occurring in the future.
Positive reinforcement Adds a desirable event (e.g. praise, access to an activity).	**Positive punishment** Adds an aversive event (e.g. reprimand).
Negative reinforcement Removes an aversive event (e.g. task is removed), which increases the behaviour. This is not punishment.	**Negative punishment** Removes a desirable event (e.g. loss of a privilege).

Example ABC and Intervention Plan

Situation	Antecedent	Behaviour	Consequence	Function (hypothesised)	Intervention strategies
Math lesson	Difficult worksheet given	Pushes worksheet away and says "No!"	Teacher removes task	Escape from demand	• Teach request for break • Adjust task difficulty • Reinforce appropriate request • Gradually build tolerance

Measuring Outcomes

Evaluate change in behaviour and quality of life using appropriate designs, particularly **single-case designs** where suitable.



Consider multiple outcomes:
- Frequency
- Duration
- Context and function
- Skill acquisition
- Quality of life (e.g. participation, independence)

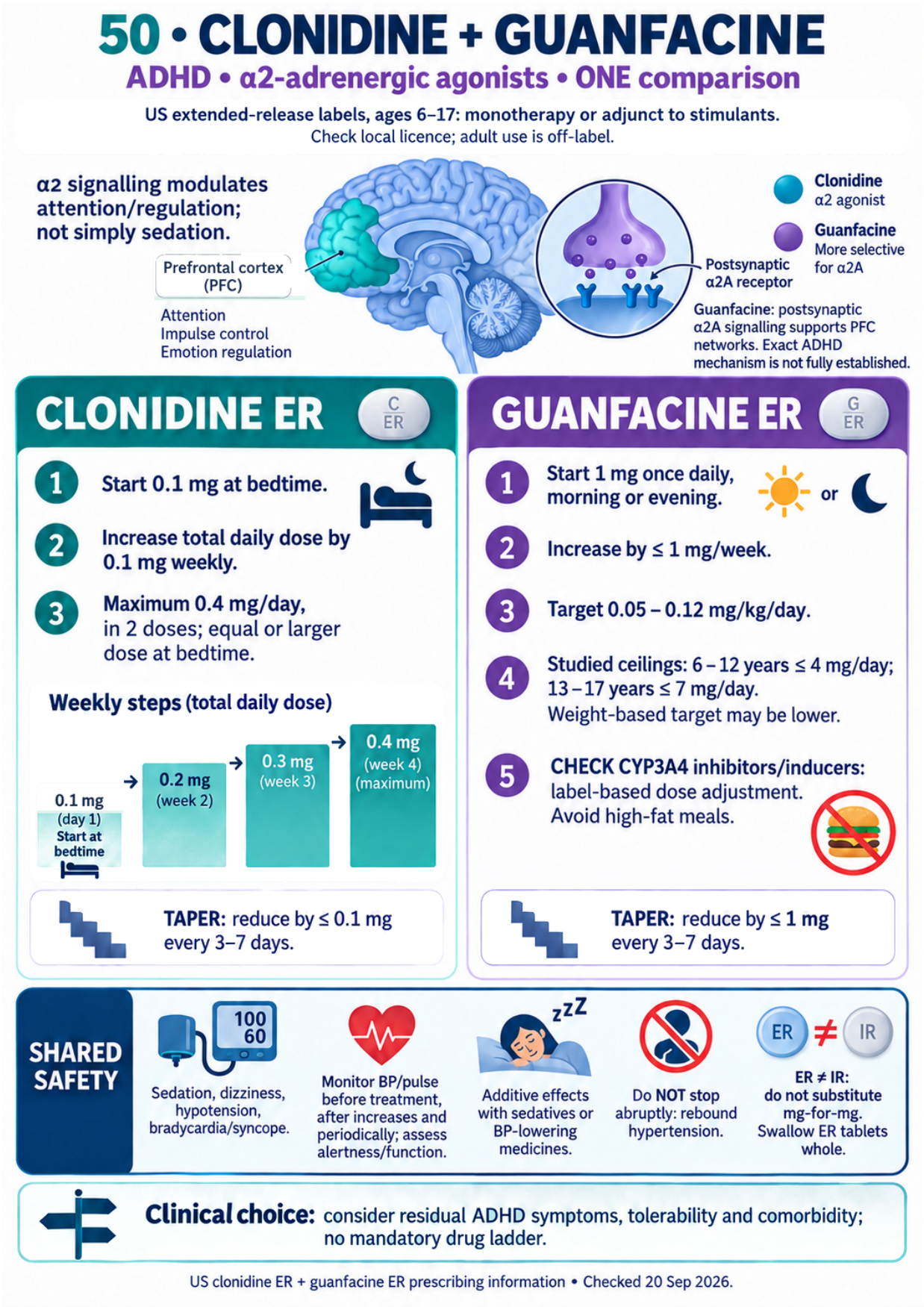
Ethical Considerations and Scope

- Collaborative and meaningful goals developed with the individual and family or carers.
- Obtain assent and consent, and respect communication and autonomy.
- Use the least restrictive supports necessary.
- Do not suppress harmless self-regulation behaviours solely for conformity (e.g. stimming) when they are not harmful.
- Do not use painful or aversive procedures.
- ABA is a scientific approach with applications beyond autism (e.g. education, mental health, acquired brain injury).
- Outcomes vary and evidence is intervention-specific.

Applied behaviour analysis. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ADHD and disruptive behaviour disorders.

Credits and references: retained within the illustration.

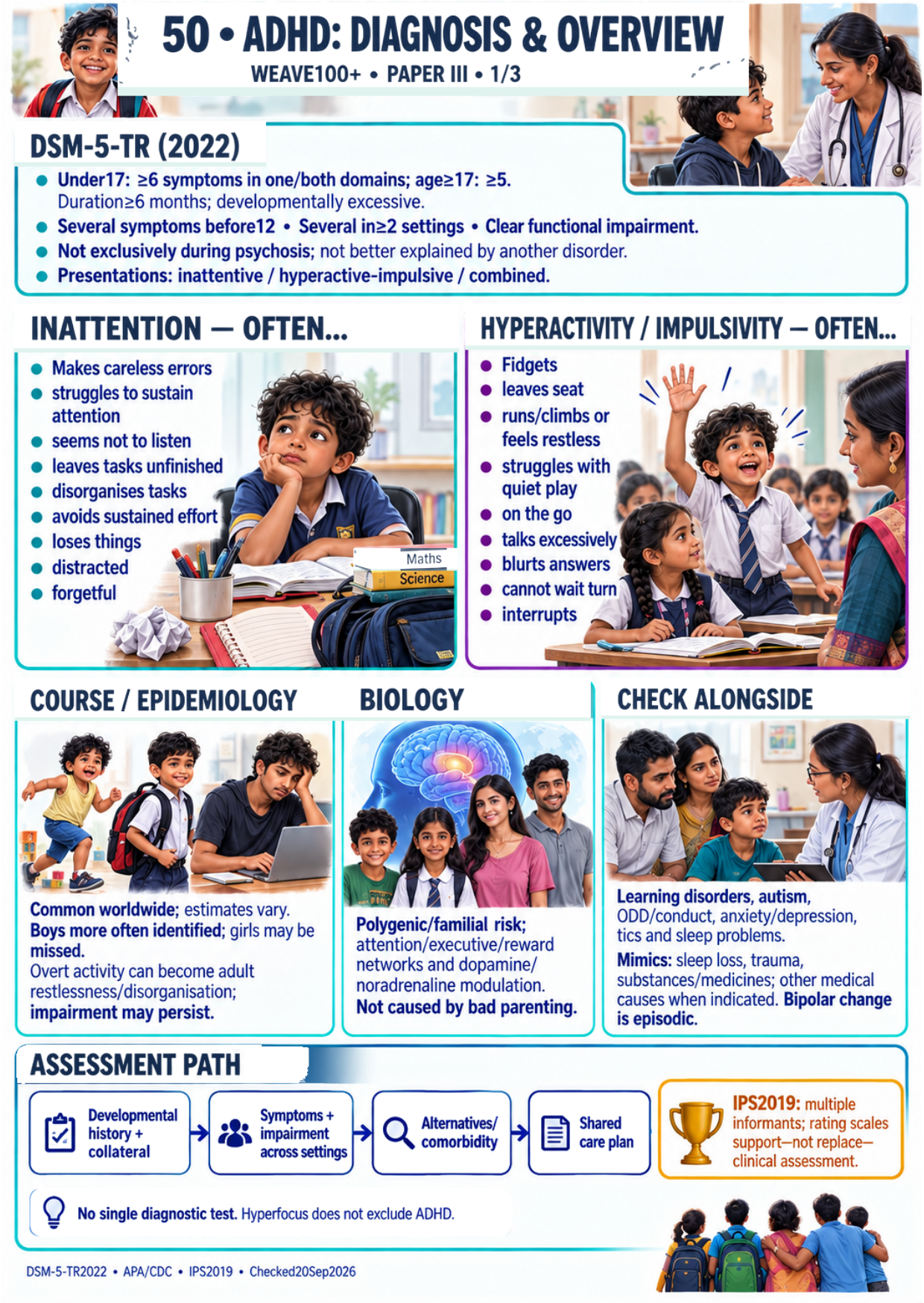
WEAVE 100 · PAPER III · new-50.10



Clonidine and guanfacine. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ADHD and disruptive behaviour disorders.

Credits and references: retained within the illustration.

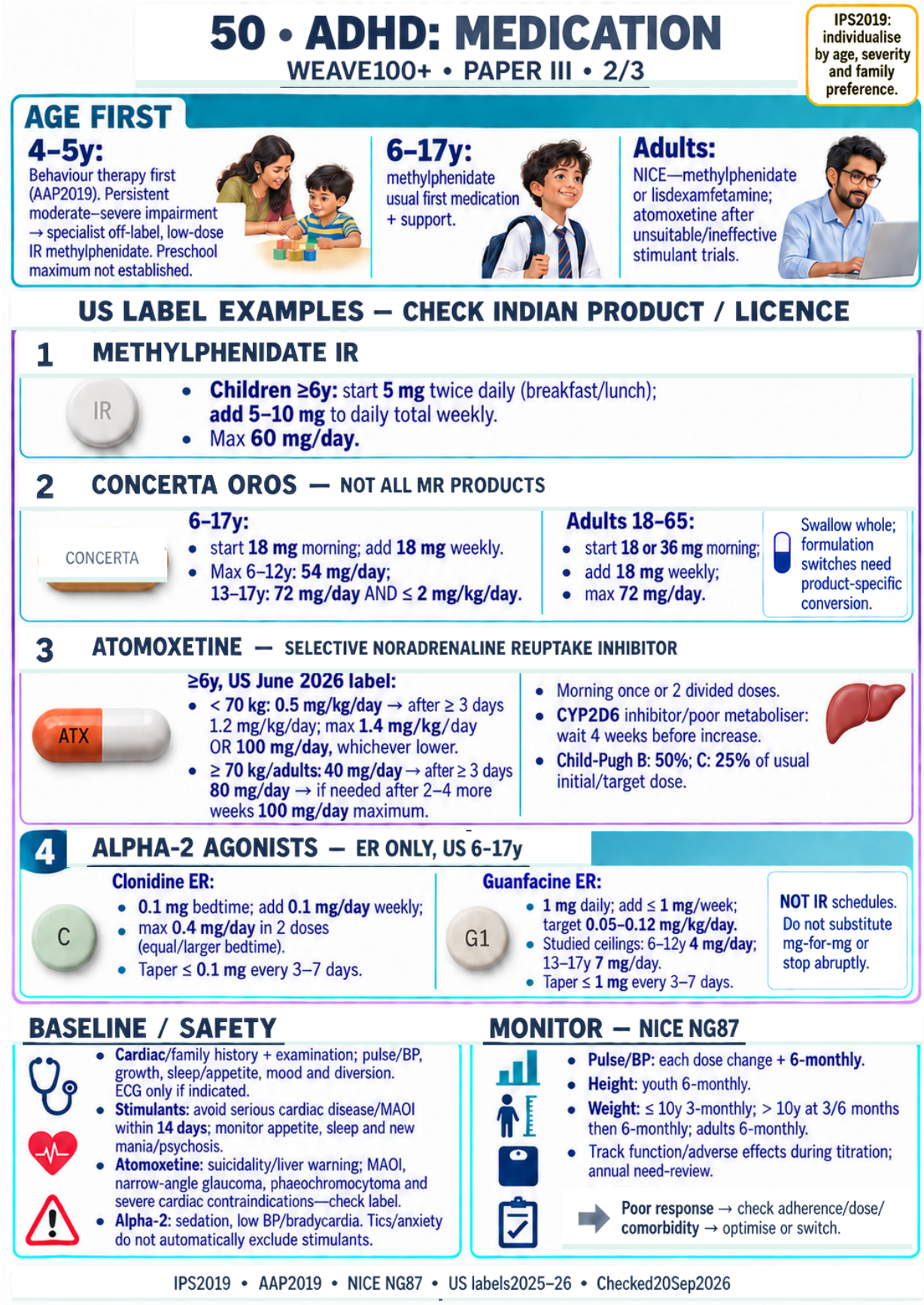
WEAVE 100 · PAPER III · new-50.6



ADHD - Concise diagnosis and overview. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ADHD and disruptive behaviour disorders.

Credits and references: retained within the illustration.

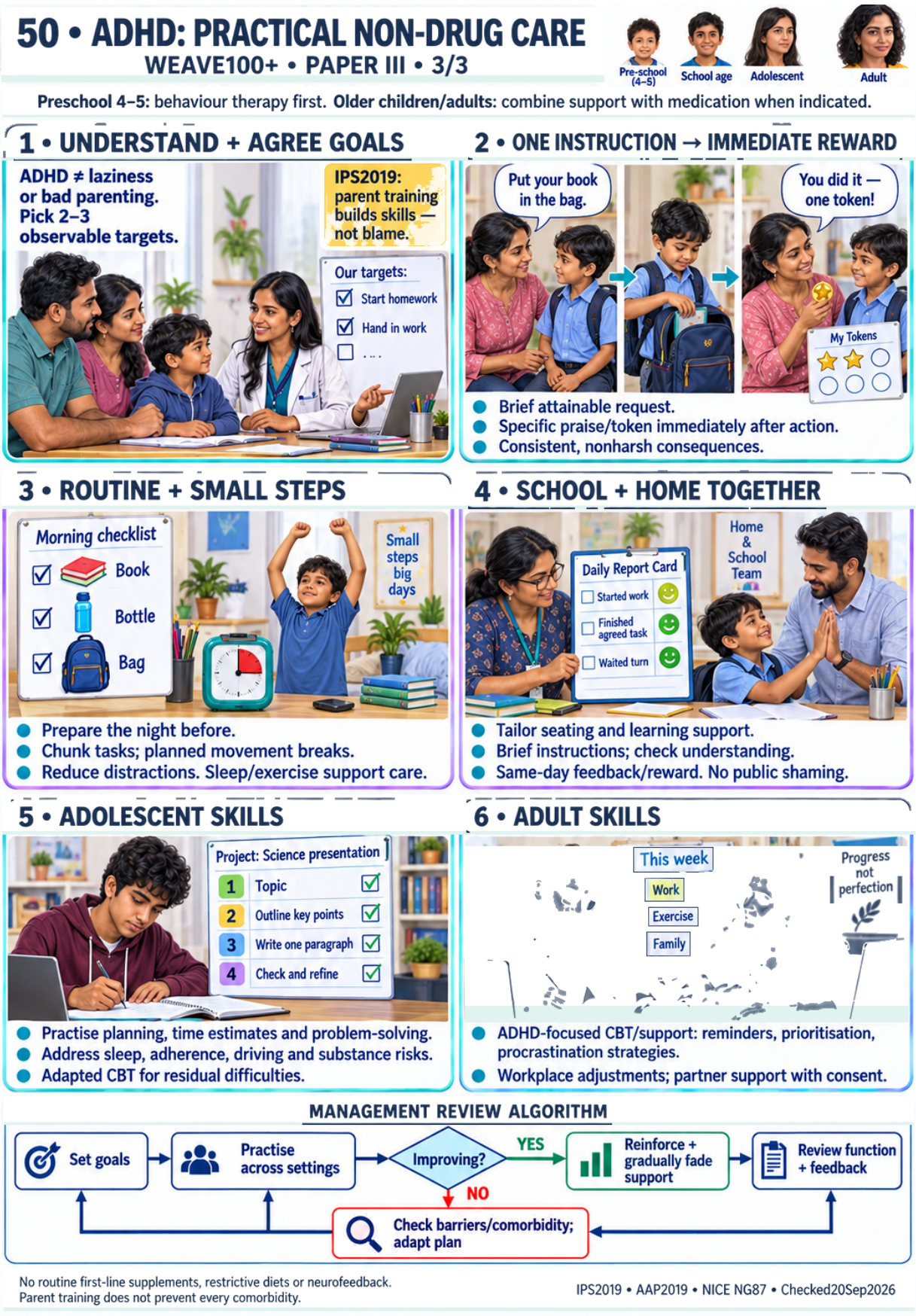
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ADHD - Concise medication. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ADHD and disruptive behaviour disorders.

Credits and references: retained within the illustration.

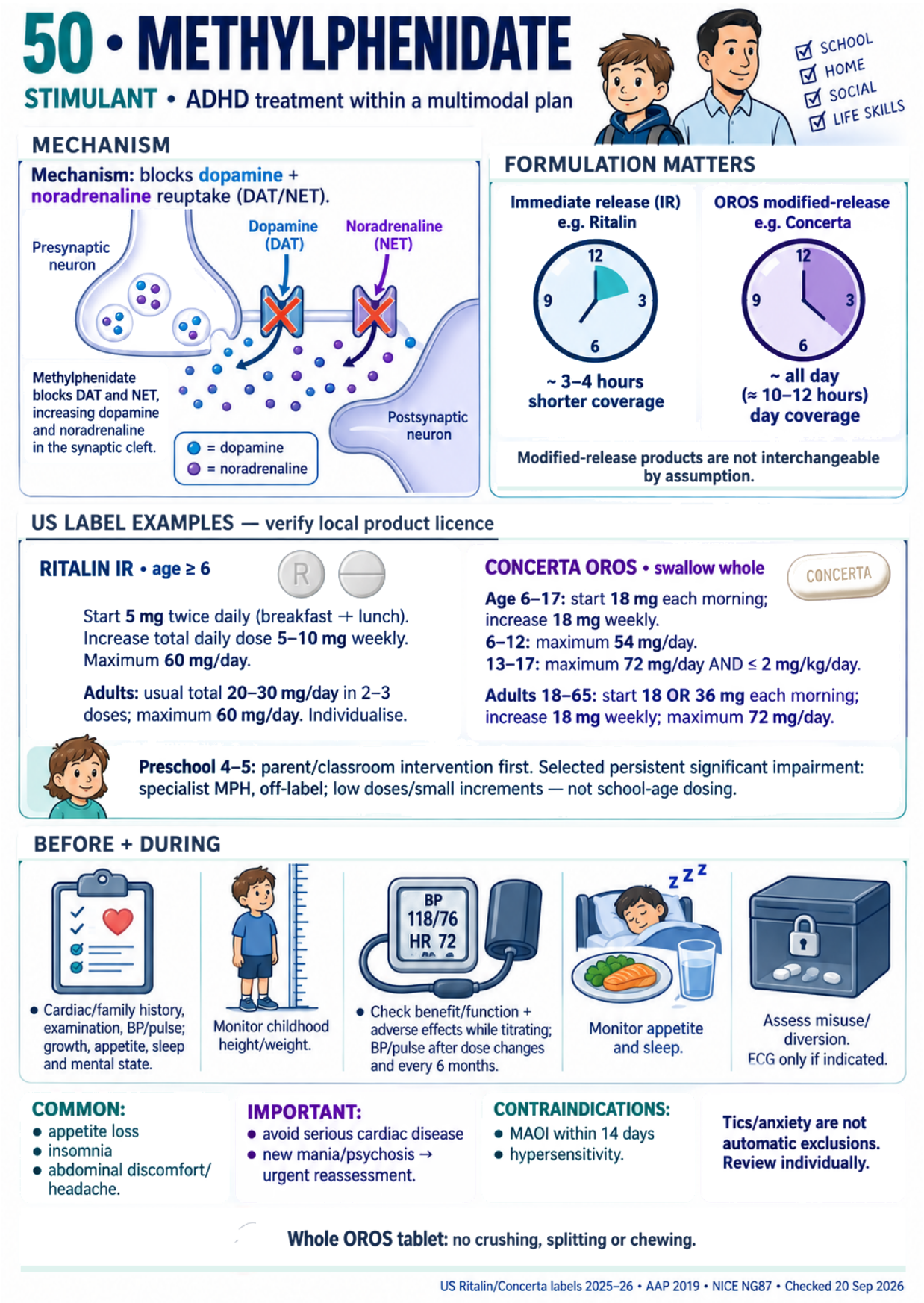
WEAVE 100 · PAPER III · new-50.8



ADHD - Concise non-drug care. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ADHD and disruptive behaviour disorders.

Credits and references: retained within the illustration.

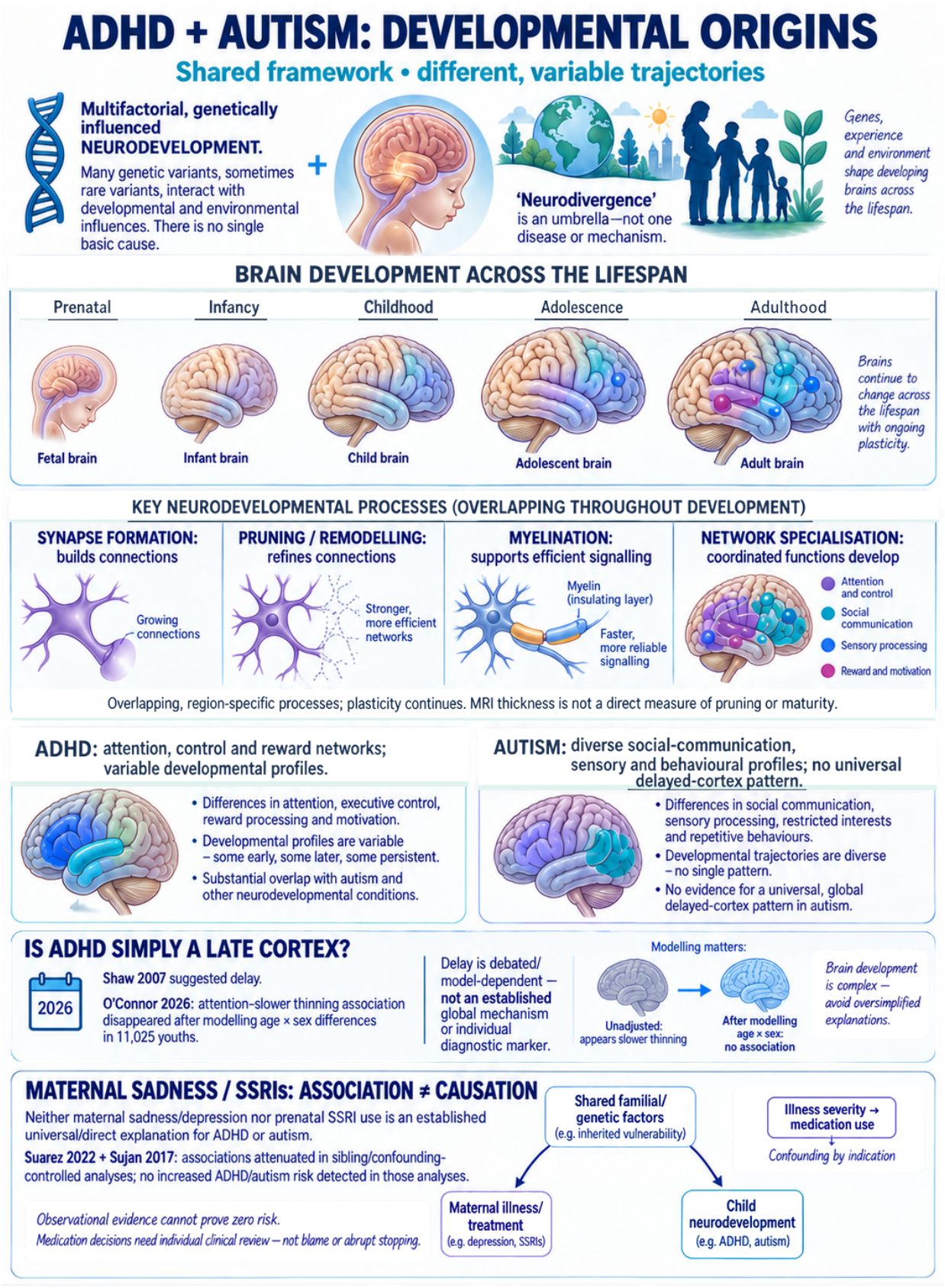
WEAVE 100 · PAPER III · new-50.9



Methylphenidate. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ADHD and disruptive behaviour disorders.

Credits and references: retained within the illustration.

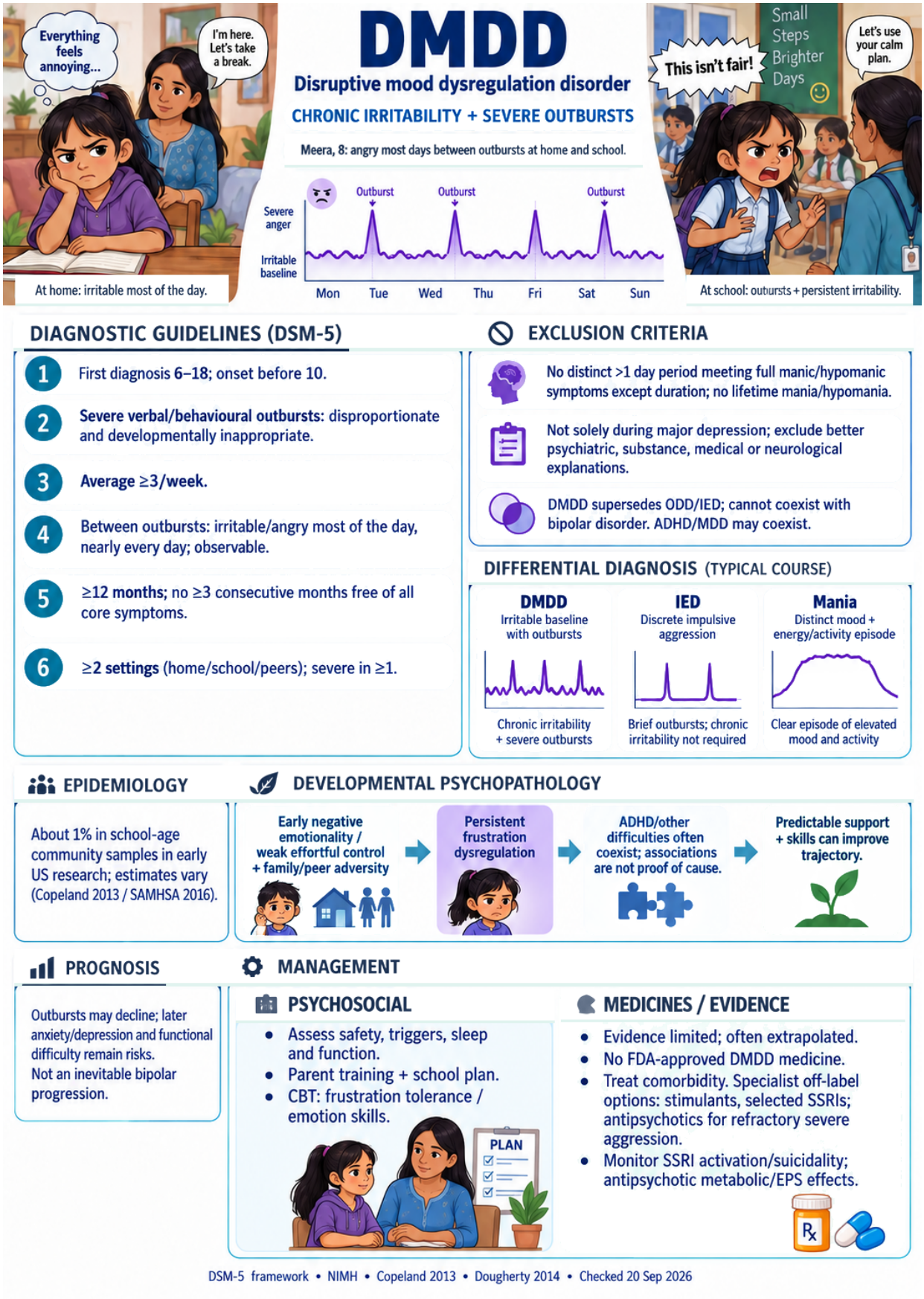
WEAVE 100 · PAPER III · new-55.3



ADHD and autism - Developmental origins. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ADHD and disruptive behaviour disorders.

Credits and references: retained within the illustration.

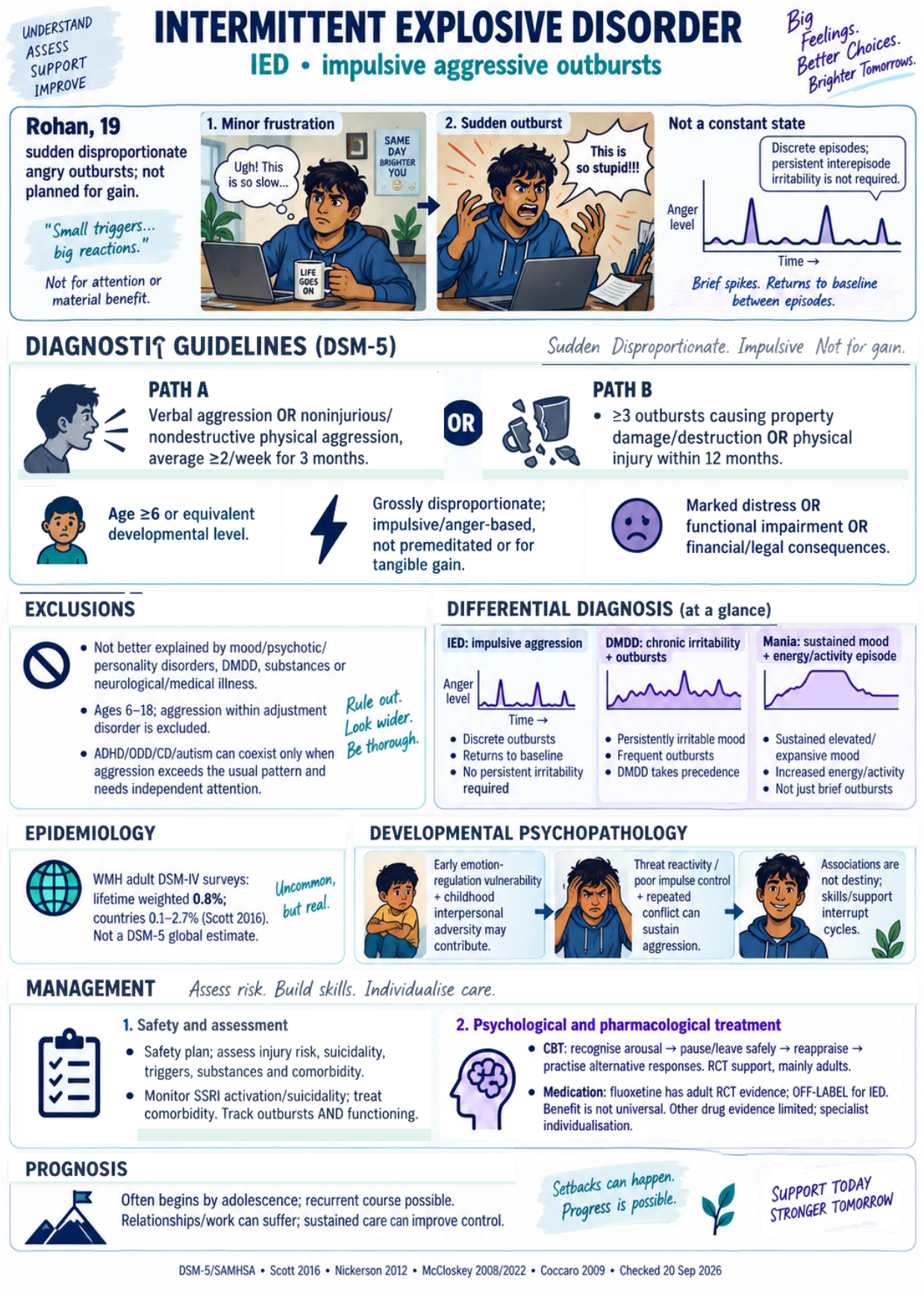
WEAVE 100 · PAPER III · new-56.2



DMDD. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ADHD and disruptive behaviour disorders.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · new-56.3



IED - Differential supplement. Read across the labelled contrasts to distinguish the related concepts. Section companion: ADHD and disruptive behaviour disorders.

Credits and references: retained within the illustration.

AREA 07 OF 13 · P3-A13

Geriatric, consultation-liaison and transcultural psychiatry

8	8.7%	III-59	III-66
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

HIGH 1 · RECURRENT 1 · SINGLE 6

REVISION ORDER

Take the two CL model slots together, they overlap almost completely. Then the two sleep slots, likewise. Elder abuse, geriatric depression and the imbalance slot are independent and can go in any order.

WHAT IS IN THIS AREA

Geriatric psychiatry in five slots (elder abuse, imbalance and its medicolegal aspects, sleep in two slots, geriatric depression) and consultation-liaison psychiatry in three (the Indian model, the models in general, the unconscious patient brought by police). The registered name of this area also carries transcultural psychiatry, and no transcultural question survived selection into it. Nothing on the pages that follow is transcultural, and the area is described here by what it actually holds.

III - 59

What are the different types of elderly abuse and neglect? Discuss the management of elderly abuse. [3+7]

3 + 7 | GERIATRIC, CONSULTATION-LIAISON AND TRANSCULTURAL PSYCHIATRY

DNB - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

3	The types	All five groups, including the two usually missed
2	Recognition	The signs that should raise it unprompted
4	The pathway	Safety, capacity, then the branch that follows
1	The Act	What the 2007 Act actually provides

- **Where it happens.** Most elder abuse in India is domestic and by family, so the relative who brings her is not automatically an ally. Institutional abuse also occurs, and is under-recognised because the complainant depends on the institution.
- **What should raise it unprompted.** Injuries that do not match the account, delayed presentation, dehydration and weight loss, pressure sores, poor hygiene, unexplained loss of money or a sudden transfer of property, repeated attendances, a carer who answers for her, and fear in his presence.

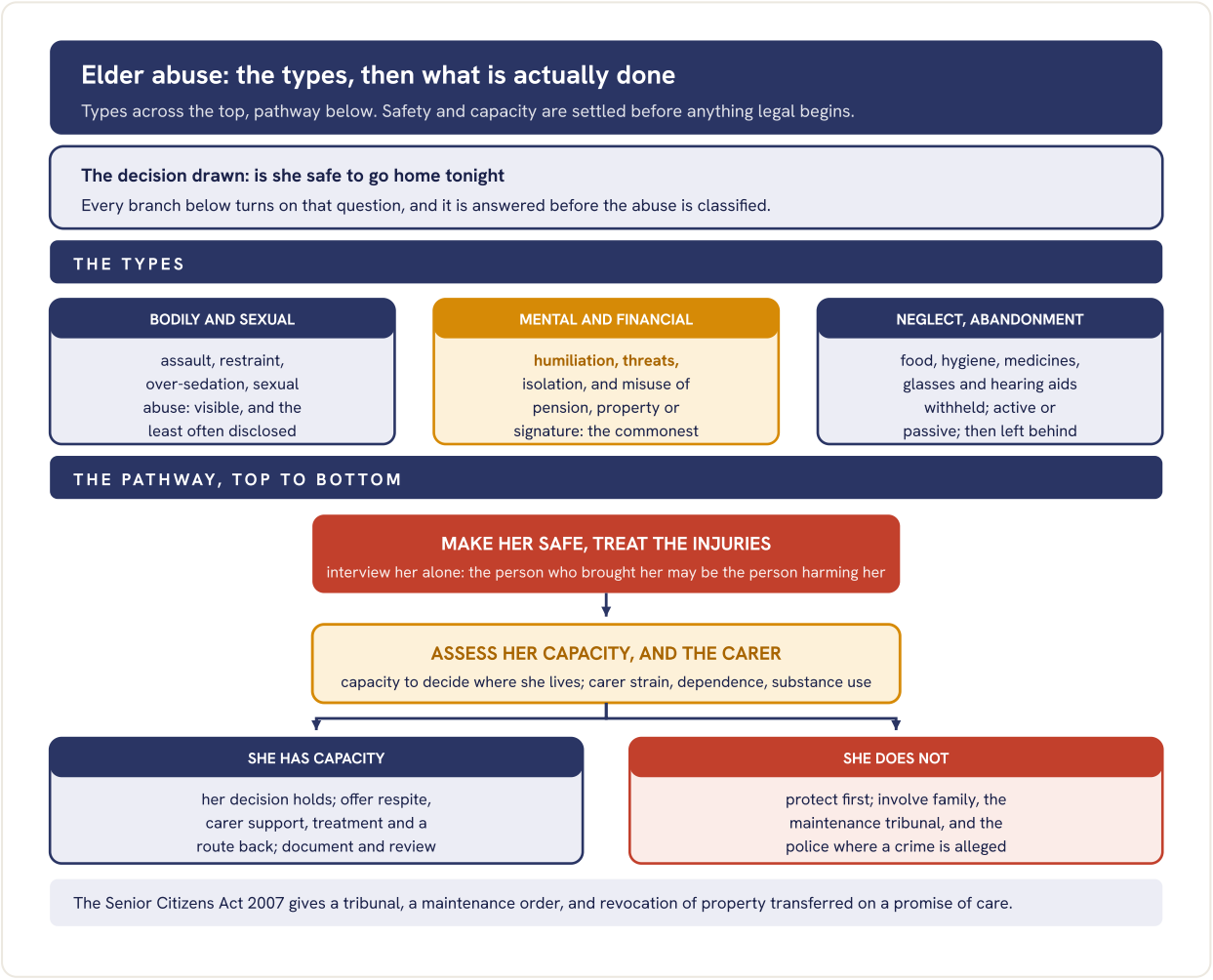


Fig 059.1 Types above, pathway below, with capacity as the single fork that decides everything after it.

PITFALL

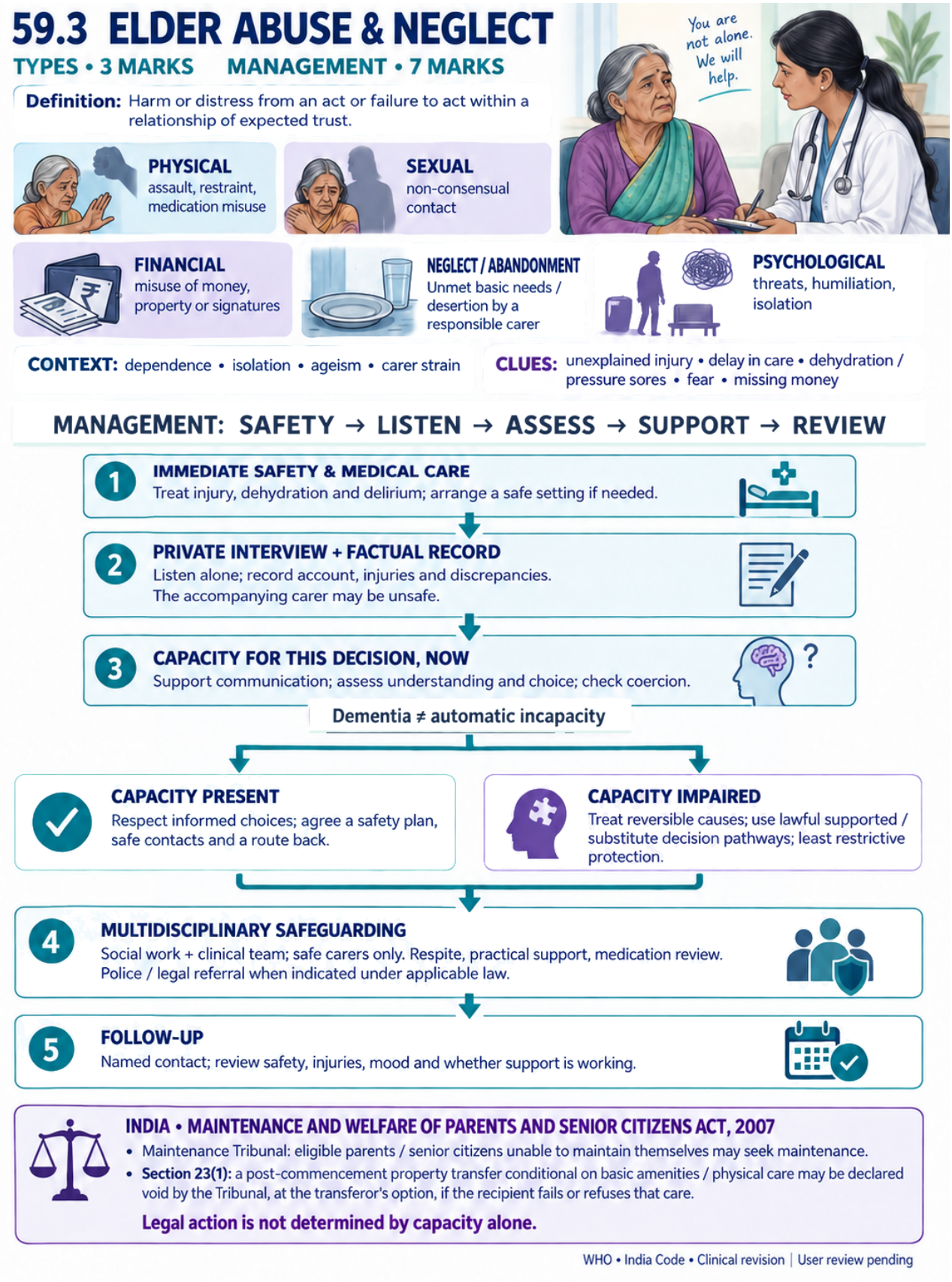
Capacity is decision-specific and is presumed. An older person with capacity may choose to return to a household that is harming her, and the answer then is support, monitoring and an open route back, not removal. Treating a diagnosis of dementia as automatic incapacity is the commonest version of this error.

WHAT EARNS THE MARKS

- **All the types named,** financial abuse and neglect included, since those are the two most answers omit.
- **The alone interview written as a step,** with the reason given in the same line.
- **The Act named with what it actually provides,** not simply cited.

SEE ALSO Slot III - 61 medicolegal aspects of dementia Slot III - 66 geriatric depression **SPRINT** Day 29, consultation-liaison and geriatric psychiatry

WEAVE 100 · PAPER III · G01



Elder abuse and neglect. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-59.

Credits and references: retained within the illustration.

III - 60

Elaborate on the model of consultation liaison psychiatry that is usually used in Indian set up. What are the common causes of referral from ICU to a psychiatrist for epilepsy patients? [6+4]

6 + 4 | GERIATRIC, CONSULTATION-LIAISON AND TRANSCULTURAL PSYCHIATRY

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

3	The Indian model	Named, then described in how it actually runs
3	Why that shape	Workforce, funding and referral culture, not preference
3	Referral causes	Delirium first, then drugs, then the psychiatric ones
1	The real question	What the team is actually asking for

THE MODEL IN INDIAN PRACTICE

The consultation model dominates: the psychiatrist is called after the problem is established, sees the patient once or twice, writes an opinion, and leaves the team to carry it. True liaison, where the psychiatrist joins the unit's rounds and sees patients before a crisis, survives only where a specialty funds it. The reason is workforce and funding, not preference. The taxonomy itself sits on III-65.

REFERRAL TRIGGER	WHAT IS USUALLY HAPPENING	WHAT TO CHECK	WEIGHT
Confusion after seizures	Postictal delirium, a prolonged postictal state, or non-convulsive status	Duration, fluctuation, electroencephalogram	**Non-convulsive status is the one that is missed**
Delirium from the illness	Sepsis, hyponatraemia, hepatic or renal failure, sedative or alcohol withdrawal	Sodium, cultures, drug and alcohol history	Delirium first, psychiatry second
Drug-related disturbance	Levetiracetam irritability and aggression, topiramate slowing, phenobarbitone sedation, steroid mood change	The drug chart against the symptom timeline	**The chart dates the symptom**
Psychiatric complication	Postictal psychosis, interictal depression, suicidality, functional seizures	Timing relative to the fit	Suicide risk is raised in epilepsy
Systems questions	Capacity and consent, breaking bad news, family distress, drug interactions	Enzyme induction, plasma levels	Half of intensive-care liaison work

- **The referral is often a proxy.** Teams ask for sedation when they mean distress, for capacity when they mean disagreement, and for depression when they mean pain. Clarifying the actual question is the first act of a good consultation.

WHAT EARNS THE MARKS

- **The Indian model named as the consultation model,** with the workforce reason attached rather than implied.
- **Delirium placed ahead of every psychiatric label** in the intensive-care setting.
- **The drug chart used as a diagnostic instrument,** with the agents named.

SEE ALSO Slot III - 65 models of consultation-liaison psychiatry Slot III - 62 the unresponsive patient **SPRINT**

Day 29, consultation-liaison and geriatric psychiatry

III - 61

What are the causes of imbalance in an elderly psychiatric patient? Discuss different medicolegal aspects of dementia. [4+6]

4 + 6 | GERIATRIC, CONSULTATION-LIAISON AND TRANSCULTURAL PSYCHIATRY

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	**Imbalance: drugs**	Iatrogenic before neurological, every time
2	**Imbalance: the rest**	By system, ending with delirium itself
4	**The legal questions**	Each one separately: who assesses, who decides
2	**The gap**	What no Indian statute currently provides

- **Imbalance is iatrogenic before it is neurological.** Benzodiazepines, antipsychotics, tricyclics, anticholinergics and antihypertensives, with orthostatic hypotension as the mechanism most often missed. Review the whole chart, not the newest drug.
- **Then the rest, by system.** Neurological: parkinsonism including the drug-induced kind, cerebellar disease, normal pressure hydrocephalus, stroke, neuropathy, cervical myelopathy. Then vestibular, cardiac, metabolic (hyponatraemia on an antidepressant, hypoglycaemia, B12 and thyroid), sensory loss, sarcopenia, and delirium itself.

THE QUESTION	WHAT IS ASSESSED	WHO DECIDES	THE STANDARD
Testamentary capacity	Nature of the act, extent of the property, the claims of those who might benefit	Clinician advises, court decides	**Banks v Goodfellow, still the test**
Consent to treatment	Understand, retain, weigh, communicate, now	Treating clinician, recorded	Decision-specific, presumed
Property and affairs	Handling money, and vulnerability to undue influence	Civil court, on evidence	**Capacity and influence are separate**
Driving	Attention, reaction time, visuospatial ability, insight	Licensing authority, on advice	Advise, document, inform
Criminal responsibility	Unsoundness of mind at the time of the act	The court	The general exception, Penal Code into Sanhita

WHAT NO ACT COVERS

India has no general adult guardianship regime for acquired incapacity. The National Trust Act 1999 does not reach dementia. The advance directive under the Mental Healthcare Act 2017 must be made while capacity is retained, so it arrives too late for most people already diagnosed. The Senior Citizens Act 2007 gives maintenance, not treatment decisions. Families go to the civil court instead.

WHAT EARNS THE MARKS

- **Imbalance answered drugs first,** with orthostatic hypotension named as the mechanism.
- **Each legal question answered separately,** with its own assessor, decider and standard, rather than one paragraph about capacity.
- **The statutory gap named.** Listing provisions is the competent answer; naming what none of them covers is the top one.

SEE ALSO Slot III - 59 elder abuse and neglect Slot III - 62 the unresponsive patient and consent **SPRINT**

Day 29, consultation-liaison and geriatric psychiatry

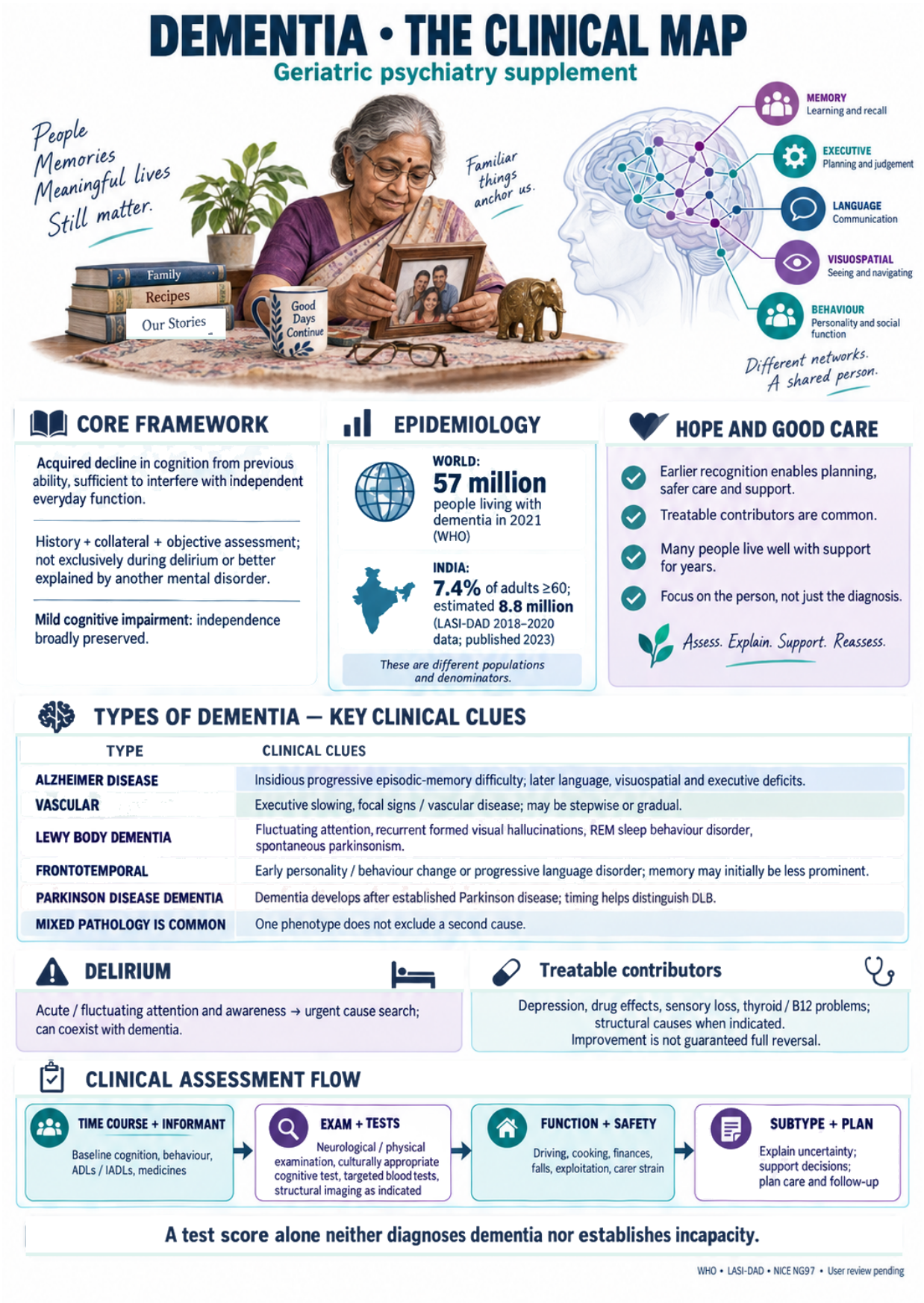
WEAVE 100 · PAPER III · G05



Imbalance in elderly. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-61.

Credits and references: retained within the illustration.

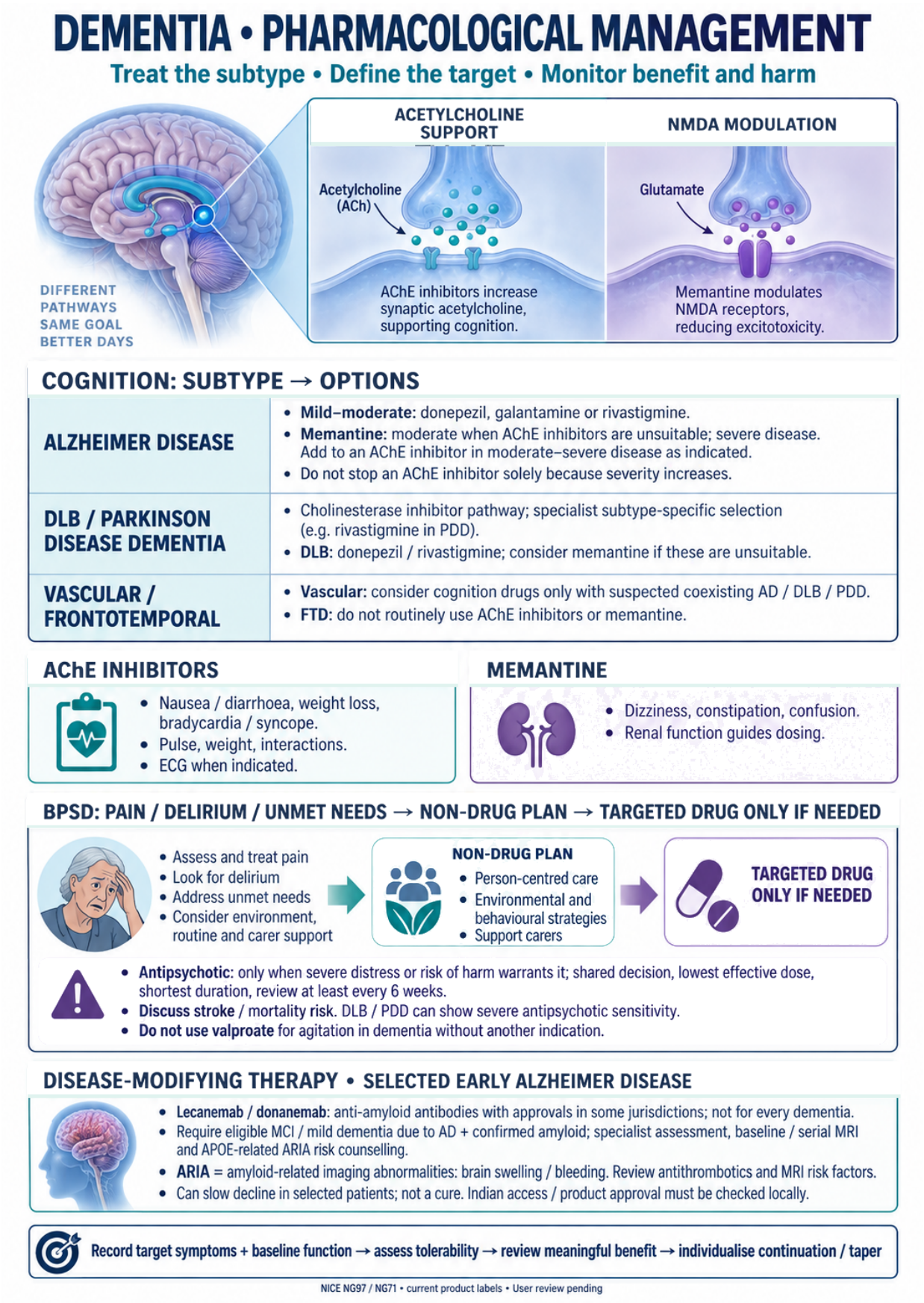
WEAVE 100 · PAPER III · G08



Dementia clinical map. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-61.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · G09



Dementia pharmacological management. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-61.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · G10



Dementia nonpharmacological care. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-61.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Dementia: capacity and legal questions

Diagnosis does not establish incapacity for every decision.

Domain	Revision points
Capacity	Assess the particular decision at the relevant time; support understanding and communication before concluding incapacity.
Consent	Explain options and consequences; document understanding, appreciation and ability to communicate a choice.
Practical issues	Finances, vulnerability to exploitation, driving, independent living and care arrangements need separate assessments.
Legal questions	Testamentary capacity, contracts and guardianship have specific legal tests; seek jurisdiction-specific advice.
Planning	Discuss future preferences early; involve chosen supports with appropriate consent and confidentiality.

TRAP

A low cognitive screening score alone is not a legal finding of incapacity.

INDIA

Use applicable Indian law and current local procedures; do not import a foreign capacity statute as Indian law.

Weave Sprint Paper III; see source register

III 61.2 • Question-linked revision • Source links and qualifications: SOURCES.md

Dementia: capacity and legal questions. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-61.

Credits and references: retained within the illustration.

III - 62

What is consultation-liaison psychiatry? Discuss how to plan for an unconscious patient brought by local police from CL psychiatry point of view? [2+8]

2 + 8 | GERIATRIC, CONSULTATION-LIAISON AND TRANSCULTURAL PSYCHIATRY

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 Definition	One block, then move: the marks are in part b
4 The sequence	Resuscitate, history from police, examine, investigate
2 Psychiatric causes	A diagnosis of exclusion, with its discriminating signs
2 Duties	Consent, documentation, and the police duty

THE DEFINITION

Psychiatry practised at the interface with the rest of medicine: psychiatric illness in the physically ill, physical illness presenting psychiatrically, and the behaviour, capacity and communication problems that a general hospital generates.

STEP	WHAT IS DONE	WHY	WEIGHT
Resuscitate	Airway, breathing, circulation, glucose, thiamine first where alcohol is likely, naloxone for an opioid picture	Nothing psychiatric happens before this	**Never psychiatric first**
History from the police	Where and how found, position, container or note, smell, time last seen	The only history available	Record it verbatim
Examine	Injuries, needle marks, pupils, tone, reflexes, neck stiffness, focal signs, toxidrome	Separates structural from toxic	Document injuries for the record
Investigate	Electrolytes, renal and liver function, gases, toxicology, imaging, and lumbar puncture or electroencephalogram if indicated	Encephalitis and non-convulsive status hide here	**Electroencephalogram when nothing else explains it**
Then psychiatry	Catatonic stupor, dissociative unresponsiveness, depressive stupor, malingering	Exclusion, in that order	The lorazepam challenge sits here

- **Signs that point away from a structural cause.** Resistance to eye opening, an intact eyelash reflex, avoidance of the falling hand, normal caloric responses and a normal electroencephalogram. These are described, and never used to accuse.
- **The duties around an unidentified patient.** Treat under the emergency doctrine, document everything including injuries, inform the police in writing, trace family through the hospital and the police, and record capacity and consent as they change. The Act also places a duty on a police officer to take a wandering person with apparent mental illness under protection and bring them for assessment.

WHAT EARNS THE MARKS

- **Definition in one line, then the answer moves.** Two marks do not deserve a paragraph.
- **Resuscitation and investigation placed ahead of every psychiatric hypothesis.**
- **The psychiatric differential given as exclusions,** with the discriminating signs named rather than gestured at.

SEE ALSO Slot III - 65 models of consultation-liaison psychiatry Slot III - 60 the Indian model and intensive-care referral

SPRINT Day 29, consultation-liaison and geriatric psychiatry

III - 63

What are the physiological changes in sleep in elderly persons? Discuss differential diagnosis of insomnia in the elderly. What are the nonpharmacological strategies to manage insomnia in elderly? [3+3+4]

3 + 3 + 4 | GERIATRIC, CONSULTATION-LIAISON AND TRANSCULTURAL PSYCHIATRY

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

3	**Physiological change**	The baseline the differential is measured against
3	**The differential**	Four causes, worked as a sieve
3	**Non-pharmacological**	Ranked, with the first-line named
1	**What is not done**	One honest line about hypnotics

WHAT AGEING DOES TO SLEEP

The circadian signal weakens and advances: sleep and waking both come earlier. Slow wave sleep falls markedly, rapid eye movement a little and sooner, arousals multiply, efficiency drops. The need changes little; taking it in one block does.

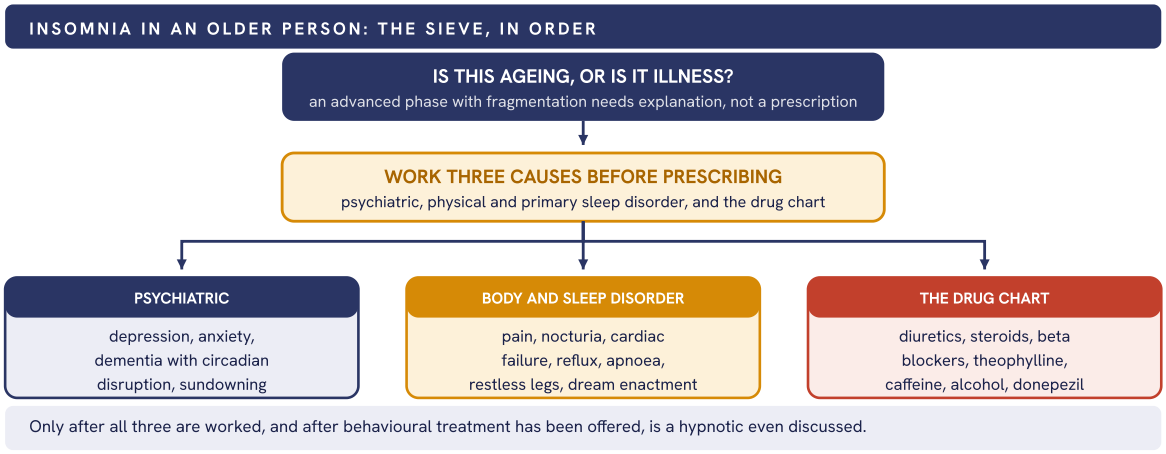


Fig 063.1 The drug chart gets a lane of its own, being the cause least often examined.

- **The non-pharmacological answer, ranked.** Cognitive behavioural therapy for insomnia first: stimulus control, sleep restriction, cognitive work and relaxation, with sleep hygiene as an adjunct and never as the whole treatment. Then timed evening light for an advanced phase, daytime activity, restricted napping, and treatment of pain and nocturia.
- **What is not done.** A hypnotic as the first act. Benzodiazepines and Z drugs in this age group buy a modest gain in sleep at the price of falls, fracture, confusion and dependence.

WHAT EARNS THE MARKS

- **Normal ageing described before any pathology.**
- **The differential worked as a sieve,** with the drug chart counted as a cause.
- **Behavioural therapy named as first-line,** with sleep hygiene demoted to an adjunct.

SEE ALSO Slot III - 64 delivering the behavioural sleep treatment Slot III - 66 geriatric depression **SPRINT** Day 29, consultation-liaison and geriatric psychiatry

WEAVE 100 · PAPER III · G06

63 / 64 • SLEEP IN OLDER ADULTS

Ageing, differential diagnosis & a guideline-informed treatment pathway



AGEING: less N3 deep sleep • more awakenings • earlier sleep timing

Chronic insomnia is not inevitable normal ageing.

Differential: pain / nocturia • depression / anxiety • OSA • RLS • RBD • circadian disorder • drugs / alcohol

REVISION SYNTHESIS — not an official protocol

1 ASSESS & TREAT CONTRIBUTORS

Sleep diary; daytime impact; medicines; cognition / falls; renal / hepatic disease and interactions.

2 CBT-I FIRST

Stimulus control + tailored sleep restriction / compression + cognitive work + relaxation.

Regular schedule, daylight and activity help; sleep hygiene alone is insufficient.

Adapt for frailty, falls, cognitive impairment and bipolar risk.

3 IF STILL IMPAIRED → SHARED DECISION ON A LIMITED MEDICATION TRIAL

Choose by sleep complaint, comorbidity, local availability and safety; set review / stopping plan.

OPTION / TARGET	GUIDELINE POSITION + CAUTION
LOW-DOSE DOXEPIN • maintenance	AASM 2017 weak support; VA/DoD 2025 suggests. US ≥65: start 3 mg, max 6 mg/night. Higher antidepressant doses add anticholinergic risk.
DORAs • onset / maintenance, agent-dependent	Suvorexant: AASM 2017 maintenance. VA/DoD 2025 supports class; Europe 2023 supports. Check next-day sedation, CYP3A interactions; avoid in narcolepsy.
RAMELTEON • onset	AASM 2017 weak support. Europe 2023 does not recommend; VA/DoD 2025: insufficient evidence. Check hepatic disease / interactions.
PROLONGED-RELEASE MELATONIN	Europe 2023: up to 3 months at age ≥55. AASM 2017 advises against melatonin for chronic insomnia. Formulation and guideline matter.
BZDs / Z-DRUGS	Some adult guidelines support selected agents; Beers 2023 advises avoidance in older adults because of delirium, falls and fractures. Not routine geriatric choices.
TRAZODONE / ANTIHISTAMINES / ANTIPSYCHOTICS	Not routine insomnia treatment. AASM / VA advise against trazodone; avoid anticholinergic antihistamines and quetiapine solely for sleep.

4 REVIEW BENEFIT + DAYTIME FUNCTION + FALLS → CONTINUE ONLY IF JUSTIFIED; TAPER WHEN APPROPRIATE

ACP 2016 / AASM 2021: CBT-I first. **IPS geriatric CPG 2018:** non-drug care; discusses low-dose doxepin and ramelteon. General-adult recommendations require a geriatric safety overlay.

Detailed recommendation matrix, doses and citations in companion notes • User review pending

Sleep in older adults Q63-Q64. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-63.

Credits and references: retained within the illustration.

III - 64

Discuss the sleep changes in elderly. Write the non-pharmacological approaches for management of sleep problems in them. [5+5]

5 + 5 | GERIATRIC, CONSULTATION-LIAISON AND TRANSCULTURAL PSYCHIATRY

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

3	**Normal ageing**	Architecture, timing and continuity, each named
2	**Not ageing**	Three findings that are disorders, not decades
4	**Delivery**	The flowchart: diary, prescription, three components
1	**In dementia**	The same measures, delivered by the carer

THE QUESTION BEHIND THE QUESTION

Two things are being asked. Which sleep changes are ordinary ageing, and so need explanation rather than treatment; and what can be done without a drug. Answering the first well is what makes the second credible to a family expecting a tablet.

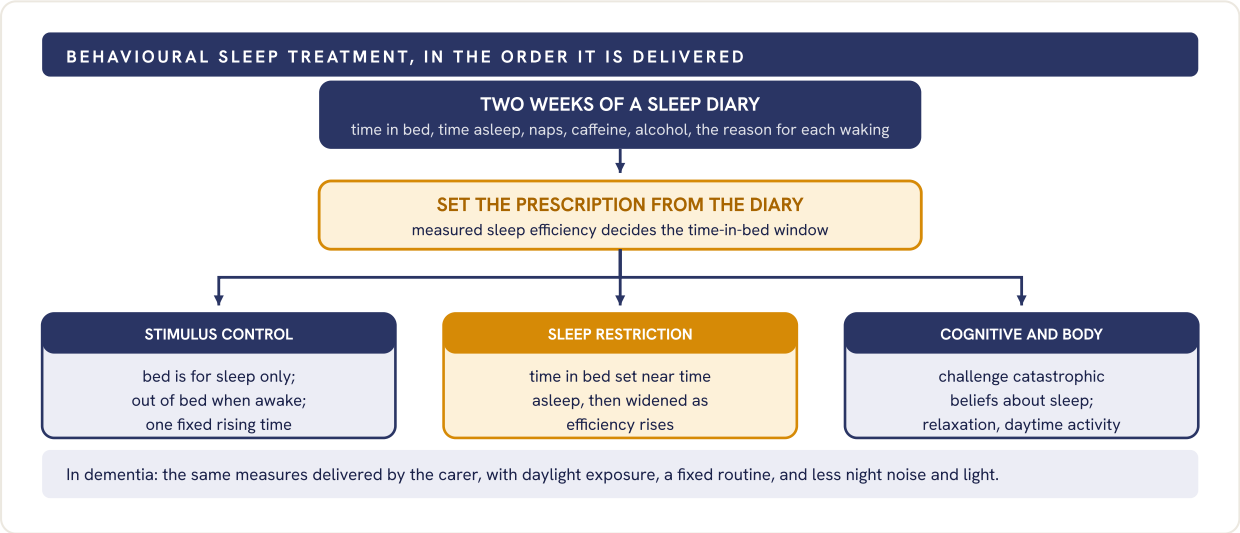


Fig 064.1 The diary comes before the prescription: the window is calculated from measured sleep.

- **Normal against pathological, stated first.** Earlier sleep and waking, less slow wave sleep, more arousals and lower efficiency are ageing. Loud snoring with witnessed apnoea, an urge to move the legs at night, and acting out dreams are disorders, and are treated rather than explained away.
- **Why this is not the soft option.** Behavioural treatment outperforms hypnotics at follow-up, carries no fall or fracture risk, and its gains persist after the course ends.

WHAT EARNS THE MARKS

- **Normal ageing separated from disorder,** with named disorders on the pathological side.
- **The components named individually,** not lumped together as "sleep hygiene".
- **The dementia and institutional adaptation included,** since that is where most of these patients are.

SEE ALSO Slot III - 63 the differential of insomnia in the elderly Slot III - 66 geriatric depression **SPRINT**

Day 29, consultation-liaison and geriatric psychiatry

III - 65

What is consultation-liaison psychiatry? Discuss the different models. [2+8]

2 + 8 | GERIATRIC, CONSULTATION-LIAISON AND TRANSCULTURAL PSYCHIATRY

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	The definition	One block, no more: eight marks are below it
2	The axis	State what the classification divides on
4	The models	Drawn, each with what it costs and what it buys
2	Which fits India	Name the constraint, not the ideal

THE DEFINITION

Psychiatry practised at the interface with the rest of medicine: psychiatric illness in the physically ill, physical illness presenting psychiatrically, and the behaviour, capacity and communication problems a general hospital generates.

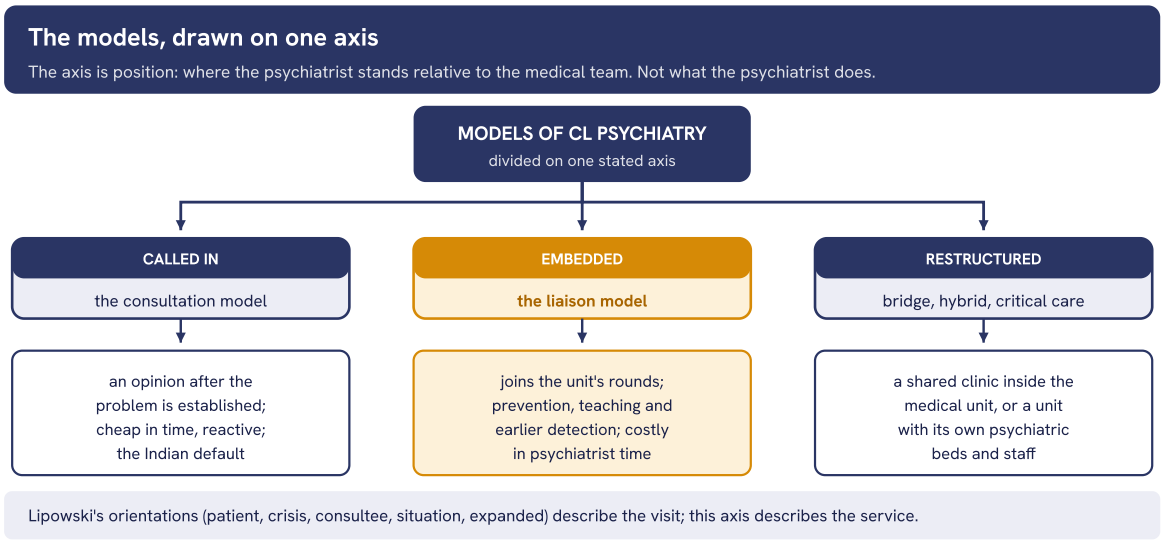


Fig 065.1 One axis, three positions, and under each the cost as well as the benefit. A tree here, so no table: the classification is the answer.

- **Which fits Indian practice.** The consultation model dominates, because one psychiatrist covers a whole hospital. Liaison survives where a specialty funds it, in oncology, transplant, obstetric and epilepsy services. The honest answer names the constraint rather than recommending the ideal.

WHAT EARNS THE MARKS

- **The axis stated before the models.** A list of model names with no axis reads as recall.
- **Every model given its cost as well as its benefit.** An incomplete tree loses more than a plain list would.
- **The Indian answer named, with the reason.** Recommending liaison without saying who would staff it is the weak ending here.

SEE ALSO Slot III - 60 the Indian model and intensive-care referral Slot III - 62 the unresponsive patient **SPRINT** Day 29, consultation-liaison and geriatric psychiatry

WEAVE 100+ / PAPER III

Consultation– liaison psychiatry models

Match the service model to the clinical setting and referral need.

Domain	Revision points
Consultation	Case-based specialist opinion requested by the treating team; clear formulation and practical recommendations.
Liaison	Sustained relationships, ward rounds, education and shared care; improves integration beyond individual referrals.
Proactive/ integrated	Identify likely needs early and embed psychiatric expertise within medical pathways.
Key tasks	Diagnostic clarification, capacity assessment, risk management, treatment interactions and continuity across discharge.
Good referral	Specify the question, urgency, relevant medical facts and what has already been tried.

COMMUNICATION

Explain the formulation to the patient and primary team; assign responsibility and a review point.

Weave Sprint Paper III; see source register

III 60.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Consultation-liaison psychiatry models. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-65.

Credits and references: retained within the illustration.

III - 66

Clinical features and challenges in management of geriatric depression. [4+6]

4 + 6 | GERIATRIC, CONSULTATION-LIAISON AND TRANSCULTURAL PSYCHIATRY

DNB, KUHS - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2	How it presents	Different from younger adults, in named ways
2	Two special forms	Cognitive impairment, and the vascular subtype
4	The pathway	The flowchart: screen, stratify, treat by severity
2	Prescribing	The challenge, stated as a principle

HOW IT PRESENTS DIFFERENTLY

Less complaint of sadness, more somatic preoccupation, anxiety, and agitation or retardation. Guilt and nihilistic delusions are commoner in late life. Early waking, weight loss, and a higher suicide rate with more lethal methods and less warning.

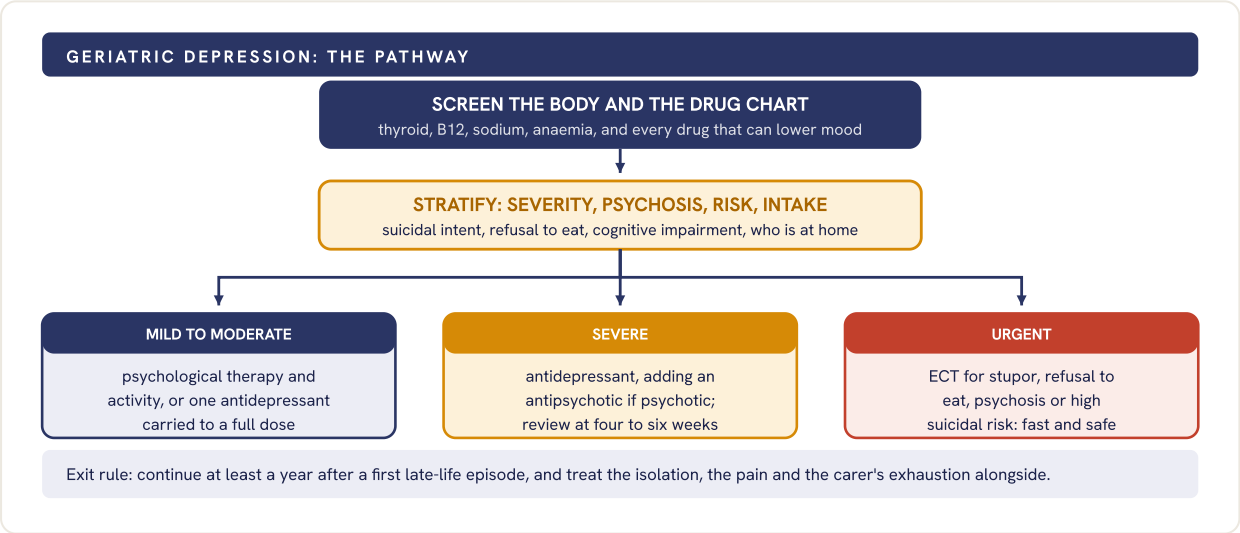


Fig 066.1 The body and the drug chart sit above the fork, not beside it.

- **Two forms worth naming.** Depression with reversible cognitive impairment, where effort is poor but recognition is preserved and the complaint is louder than the deficit; and vascular depression, of late onset, with executive dysfunction, white matter change and a poorer drug response.
- **The prescribing challenge, as a principle.** Start low and go slow, but arrive at a full dose for a full duration: undertreatment is the commoner error at this age. Watch hyponatraemia, falls, QT prolongation, and anticholinergic burden summed across the whole chart rather than drug by drug.

WHAT EARNS THE MARKS

- **The presentation described as different from younger-adult depression,** in named ways rather than as "atypical".
- **Undertreatment named alongside start low and go slow.** Quoting only the caution is the half answer.
- **ECT placed as fast and safe in late life,** not as a last resort after everything else has failed.

SEE ALSO Slot III - 63 insomnia in the elderly Slot III - 61 medicolegal aspects of dementia **SPRINT** Day 29, consultation-liaison and geriatric psychiatry

WEAVE 100 · PAPER III · G07



Geriatric depression. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-66.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · G11

GERIATRIC POLYPHARMACY

Prescribing cascades • interactions • organ function • safer review

"Medication count is a signal; appropriateness is the question."

Polypharmacy is often defined as ≥5 medicines, but necessary combinations can be appropriate.



PRESCRIBING CASCADE

Before adding a drug, ask: could this be an adverse effect?

ANTIPSYCHOTIC → e.g. for agitation or psychosis

PARKINSONISM → drug-induced extrapyramidal symptoms

ANTICHOLINERGIC → e.g. for tremor or rigidity

CONFUSION / RETENTION → worsening cognition and urinary retention

BURDENS OF POLYPHARMACY

Anticholinergic load → confusion, constipation, urinary retention, blurred vision

Sedative load → falls, impaired attention, respiratory depression

Complex regimens → errors, poor adherence, cost and loss of function

COMMON HIGH-RISK PAIRS

Lithium + NSAID / ACE inhibitor / ARB / thiazide	lithium toxicity risk	SSRI + NSAID / antithrombotic	bleeding risk
Opioid + benzodiazepine	sedation / respiratory depression	Valproate + lamotrigine	higher lamotrigine exposure; rash risk
SSRI / SNRI + diuretic	hyponatraemia risk	Multiple QT-prolonging drugs + low K / Mg	arrhythmia risk

ORGAN FUNCTION MATTERS

RENAL: use drug-specific eGFR / CrCl guidance; normal creatinine can mislead in low muscle mass.

HEPATIC: check disease severity and product guidance; no universally safe SSRI.

CARDIAC: orthostasis, pulse, QT risk, electrolytes and interactions; ECG when indicated.

A PRACTICAL MEDICATION REVIEW

1. **RECONCILE** — All prescriptions, OTC, supplements, alcohol; actual use, indication, duration and prescribers.
2. **MATCH TO GOALS** — Benefit now? Time to benefit? Duplication? Omission? Patient priorities, frailty and burden.
3. **AGREE CHANGES** — Prioritise highest harm / lowest benefit; simplify; shared decisions with the person and appropriate supporters.
4. **DEPRESCRIBE SAFELY** — One interpretable change at a time when feasible; taper dependence / withdrawal-prone drugs; record a restart or rescue plan.
5. **MONITOR & COMMUNICATE** — Symptoms, function, withdrawal / relapse, falls, cognition and relevant tests; one updated medication list.

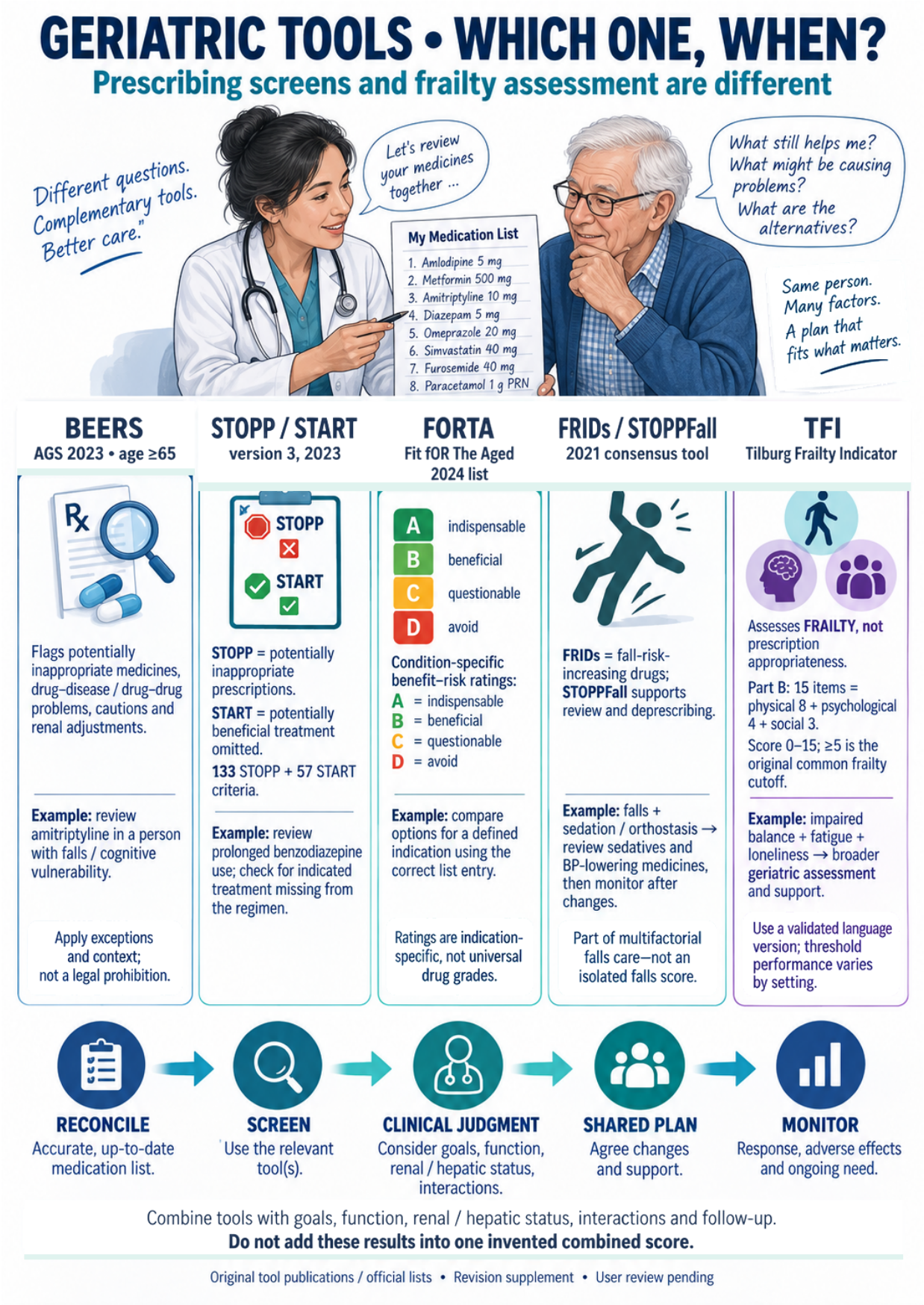
New confusion: assess delirium and medical causes urgently. Support hearing, vision, dexterity and access.

Companion tool sheet: Beers / STOPP–START / FORTA / FRIDs / TFI • User review pending

Geriatric polypharmacy. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-66.

Credits and references: retained within the illustration.

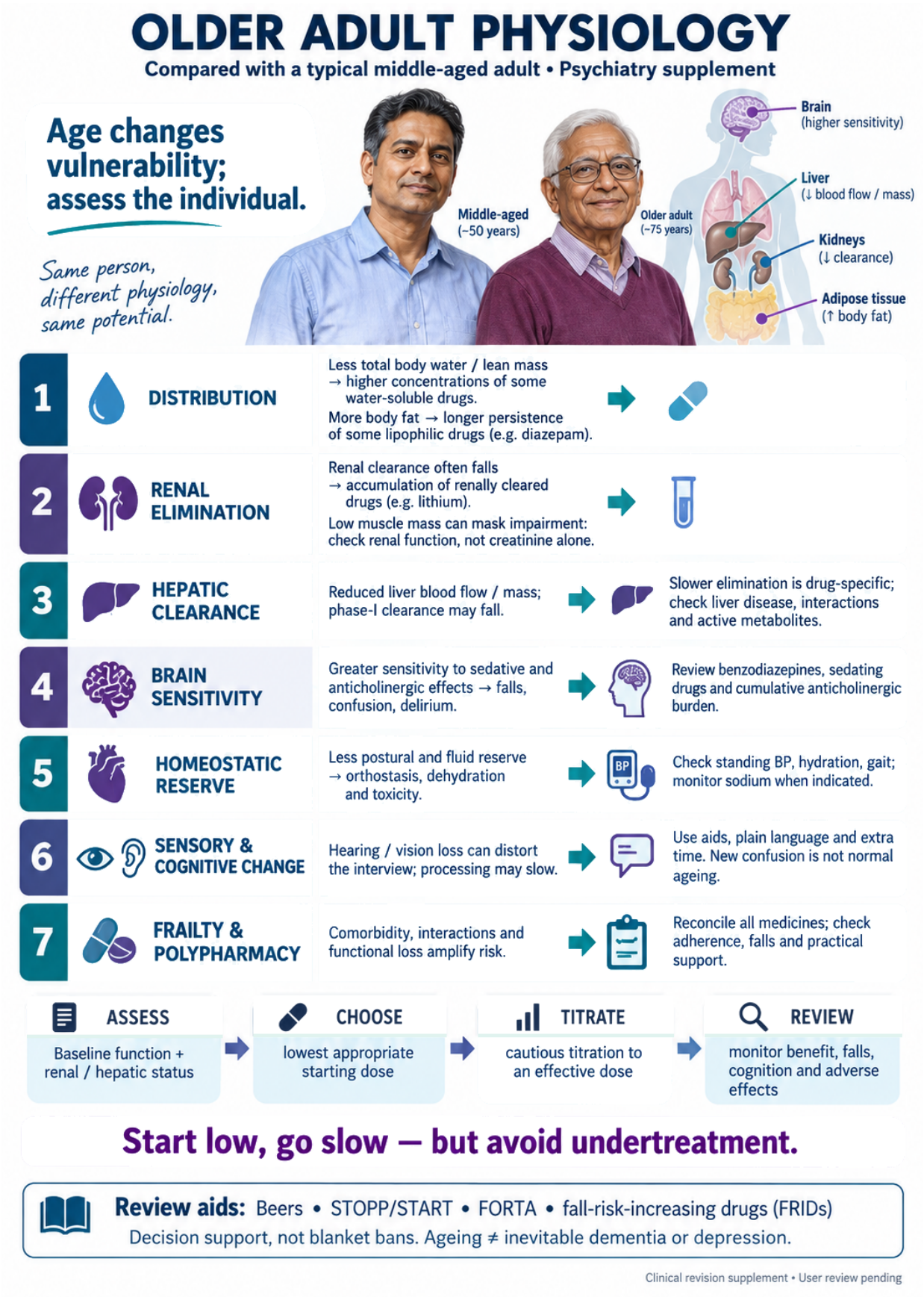
WEAVE 100 · PAPER III · G12



Geriatric tools. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-66.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · G02



Older adult physiology. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Geriatric, consultation-liaison and transcultural psychiatry.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · G13

LATE-ONSET & VERY-LATE-ONSET PSYCHOSIS

A new psychosis in later life needs a cause — not an age-based assumption

DEFINITION



LOS: schizophrenia onset 40–60 years
VLOSLP: schizophrenia-like psychosis beginning after 60

International consensus descriptors; broad late-life psychosis also includes secondary and affective causes.

EPIDEMIOLOGY

2018 meta-analysis: schizophrenia incidence after age 65 ≈ **7.5 per 100,000** person-years across included studies; very high heterogeneity. Not an Indian prevalence estimate.

CLINICAL FEATURES

Often systematised persecutory / partition delusions; auditory and other hallucinations.

Formal thought disorder and negative symptoms may be less prominent than in early-onset schizophrenia.

Assess insight, distress, function, mood and cognition; do not infer diagnosis from one symptom.



Perceived threat can feel very real.

Listen. Consider causes. Plan carefully.

DIFFERENTIAL DIAGNOSIS: REDIRECT THE DIAGNOSIS

ACUTE / FLUCTUATING INATTENTION	DELIRIUM
COGNITIVE DECLINE / FLUCTUATIONS + VISUAL HALLUCINATIONS / PARKINSONISM	DEMENTIA, especially DLB
MARKED MOOD EPISODE	DEPRESSION / MANIA WITH PSYCHOSIS
DRUGS / SUBSTANCES	steroids, dopaminergic drugs, anticholinergics, intoxication / withdrawal
OTHER	sensory impairment, epilepsy, stroke / structural disease, metabolic / endocrine / infectious causes

MANAGEMENT PATHWAY

1 SAFETY + ENGAGEMENT
Assess suicide, aggression, self-neglect, vulnerability; calm interview, hear the person's account, involve appropriate supports.

2 HISTORY + WORK-UP
Collateral timeline; all medicines / substances; physical and neurological exam; cognition, hearing and vision; targeted blood tests and brain imaging as indicated.

3 TREAT THE CAUSE + SUPPORT
Correct medical / sensory contributors; reduce isolation; routines, practical help and adapted psychological work.

4 IF PRIMARY PERSISTENT PSYCHOSIS
Individualised antipsychotic trial when warranted; low starting dose, slow titration to benefit—not automatic risperidone or quetiapine for everyone.
Check renal / hepatic function, interactions, orthostasis, ECG / QT, metabolic effects, EPS and falls.

5 REVIEW OVER TIME
Symptoms + function + adverse effects + adherence; reassess cognition and diagnosis.

CAUTION | **Suspected DLB:** severe antipsychotic sensitivity.
Dementia-related psychosis: discuss stroke / mortality risk.

International consensus 2000 • Stafford et al. 2018 • Clinical revision • User review pending

Late-onset psychosis. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Geriatric, consultation-liaison and transcultural psychiatry.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · G14

BIPOLAR • SUBSTANCE USE • ANXIETY

Older adults • what changes in assessment and treatment?

CLINICAL APPROACH IN LATER LIFE

VERSUS YOUNGER ADULTS

BIPOLAR DISORDER



New symptoms in later life – think broadly

- **New mania** → seek drugs / steroids, stroke, delirium and neurodegeneration; distinguish a sustained mood episode from fluctuating confusion.
- **Treat by phase and prior response.** Lithium, valproate or an appropriate antipsychotic may be used; lamotrigine has a role in depressive relapse prevention, not acute mania.
- **Lithium:** levels, renal function, thyroid / calcium, hydration and interactions.
- **Valproate:** liver function, blood count / platelets; assess sedation, tremor and gait. No universally safest mood stabiliser.
- **Sleep / rhythm stabilisation**, psychoeducation, relapse plan; avoid antidepressant monotherapy in bipolar I.

- More medical / cognitive comorbidity.
- New late-life onset increases concern for secondary causes.
- Lower clearance and interactions narrow the therapeutic margin.



SUBSTANCE-USE DISORDERS



Ask directly – look for the clues

- **Ask directly** about alcohol, tobacco, prescribed sedatives, opioids and OTC drugs; falls, poor sleep and cognitive change may be the clues.
- **Assess** intoxication, withdrawal, nutrition, pain, loneliness and suicide risk.
- **Alcohol withdrawal:** benzodiazepines remain first-line when indicated, with monitored age / liver-adjusted care and thiamine.
- **Relapse prevention:** psychological treatment plus naltrexone or acamprosate when suitable; check opioid use / liver risk or renal function respectively.
- **Offer smoking-cessation treatment**; opioid-use disorder needs evidence-based addiction care. Taper dependent sedatives gradually.

- Harm may occur at lower exposure.
- Medication interactions and falls weigh more heavily.
- Retirement may hide role failure; ask beyond work-related consequences.



ANXIETY DISORDERS



Look for medical and functional causes

- **Somatic symptoms can dominate;** evaluate arrhythmia, thyroid disease, breathlessness, pain, drugs and withdrawal.
- **Assess** depression, cognition and functional avoidance.
- **Adapt CBT**, graded exposure and relaxation; strengthen practical / social support.
- **SSRI / SNRI** when indicated; monitor sodium, bleeding, BP / QT and falls according to the drug and patient.
- **Buspirone** may suit GAD. Benzodiazepines are not routine long-term treatment.

- More overlap with medical illness and sensory loss.
- Health, dependency and bereavement worries.
- Slower titration, accessible therapy and closer adverse-effect review.



SHARED SAFETY: sensory aids • capacity for the decision • medication reconciliation • renal / hepatic review • falls / cognition • patient goals

ISBD • ASAM • IPS geriatric anxiety • Revision supplement • User review pending

Bipolar substance use and anxiety. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Geriatric, consultation-liaison and transcultural psychiatry.

Credits and references: retained within the illustration.

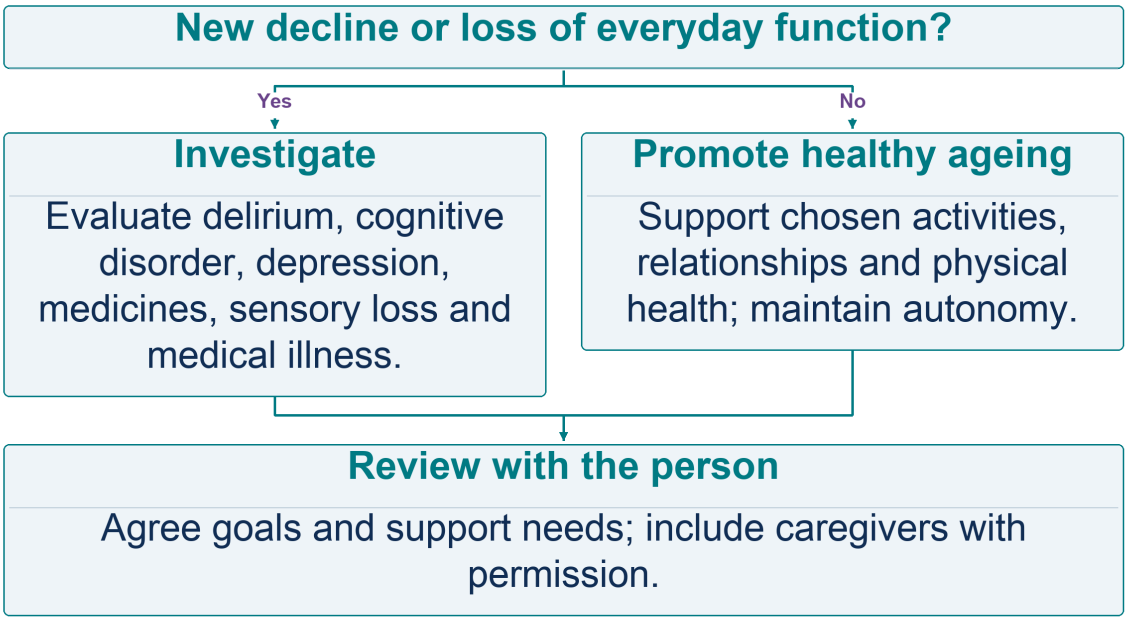
WEAVE 100+ / PAPER III

Normal ageing and psychosocial needs

Age-related change is not synonymous with disease or dependence.

Domain	Revision points
Expected variation	Slower processing and retrieval may occur; vocabulary and accumulated knowledge may remain strong.
Function	Assess actual daily activities rather than infer inability from age.
Context	Retirement, bereavement, loneliness, income, housing, caregiving and accessibility affect wellbeing.
Protective factors	Meaningful roles, social connection, exercise, sensory support and opportunities for choice.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 59.2 • Supplement • Source links and qualifications: SOURCES.md

Normal ageing and psychosocial needs. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Geriatric, consultation-liaison and transcultural psychiatry.

Credits and references: retained within the illustration.

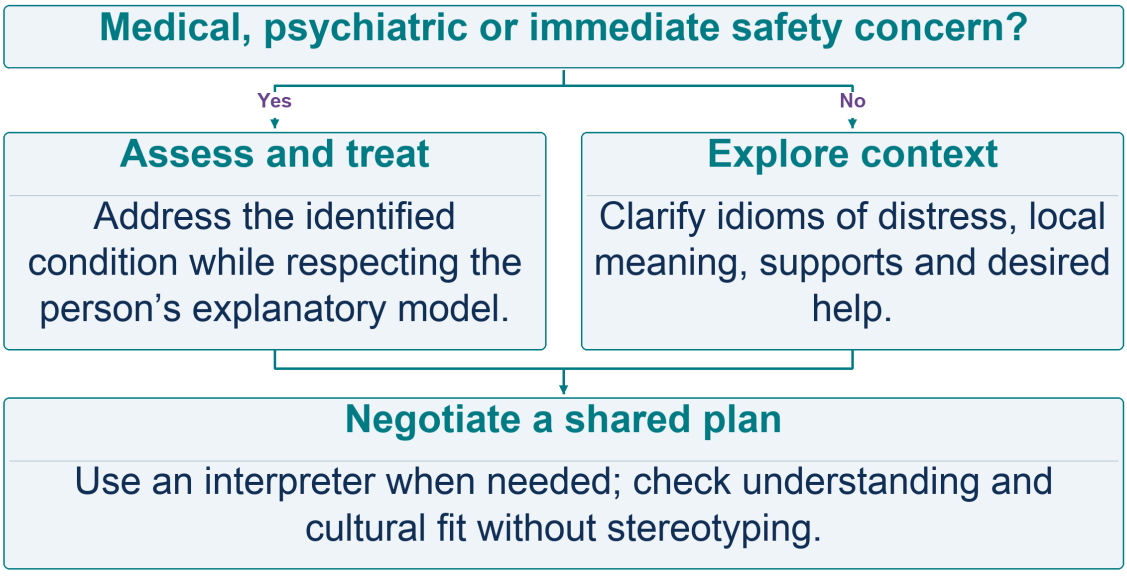
WEAVE 100+ / PAPER III

Cultural formulation and syndromes

Ask what the experience means before deciding what it represents.

Domain	Revision points
Formulation	Identity, explanatory model, stressors/ supports, help-seeking and clinician– patient cultural relationship.
Dhat presentation	Distress attributed to semen loss; assess mood, anxiety, sexual concerns and explanatory beliefs.
Koro / latah / amok	Genital-retraction fears; exaggerated startle/ echo phenomena; episodes of violent behaviour. Labels require contextual differential assessment.
Clinical stance	A culturally shared belief is not automatically delusional; culture also does not exclude a treatable disorder.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 65.3 • Supplement • Source links and qualifications: SOURCES.md

Cultural formulation and syndromes. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Geriatric, consultation-liaison and transcultural psychiatry.

Credits and references: retained within the illustration.

CULTURE & PSYCHIATRY

Questions 69–70 • Expression → Assessment → Treatment • Cultural effects

INDIVIDUALISTIC ORIENTATION: personal goals, independence, self-expression and privacy.

COLLECTIVISTIC ORIENTATION: interdependence, family obligations, group harmony and shared decisions.

Dimensions, not fixed categories. People may value both; **variation within societies is substantial. Ask about this person—never infer beliefs from nationality.**

EXPRESSION

How is distress experienced and communicated?

Idioms of distress: locally meaningful words, bodily complaints or relational difficulties.

Culture can shape symptom content; content alone does not establish a diagnosis.

Individualistic emphasis may frame distress around personal identity, achievement or autonomy.

Collectivistic emphasis may frame distress around family conflict, duty, belonging or reputation.

Emotional restraint or disclosure depends on audience, context, gender and generation.

Example: The same difficulty may be described as 'I feel hopeless' or 'My body feels exhausted' or 'I cannot fulfil my family role'. These are expressive forms—not diagnostic equivalents.

ASSESSMENT

Whose meaning and norms are being used?

Explore language, identity, explanatory beliefs, stressors, supports and help-seeking.

Use a trained interpreter when needed; check that translated questions retain their meaning.

Ask about cultural context, distress, impairment and the overall clinical picture.

Individualistic emphasis: explore privacy, personal goals and desired independence.

Collectivistic emphasis: explore family roles, support, expectations and who the person wants involved.

Arthur Kleinman's category fallacy: applying a diagnostic category without checking its meaning in the local context.

Example: Ask: 'What do you call the problem? What do you think caused it? What does your family think? What help would fit your needs?'

TREATMENT

What care fits this person's goals and circumstances?

Negotiate a shared understanding; explain treatment in familiar language and metaphors.

Individualistic emphasis: collaborative personal goals, choice, privacy and self-management.

Collectivistic emphasis: family or community support and relational goals—when the person wants them.

Autonomy can include choosing shared decisions. Family involvement does not automatically transfer decision-making authority.

Explore faith healing and other care respectfully; address harmful practices and treatment delays.

Adapt communication and delivery without abandoning effective treatment.

Example: Ask: 'Who would you like involved? What would improvement look like? What worries you about this treatment?'

OTHER DIMENSIONS TO EXPLORE: power distance and clinician authority • stigma and disclosure • religion and spirituality • gender and generation • education, poverty, caste and discrimination • migration and language.

MIGRATION NOTE: consider loss of networks, acculturative stress, discrimination and access barriers. Lower own-group neighbourhood density is associated with higher psychosis rates in some minority populations; effects vary by group and setting.

CULTURAL FORMULATION INTERVIEW (CFI): definition of the problem • perceived causes • context and support • coping and past help-seeking • current help-seeking and care preferences.

HOW CULTURE INFLUENCES PSYCHOPATHOLOGY — WEN-SHING TSENG

PATHOGENIC
Contributes to the development of distress.
Example: semen-loss beliefs contributing to Dhat-related anxiety.

PATHOSELECTIVE
Patterns the form of a stress response.
Example: Amok is a classic historical example.

PATHOPLASTIC
Shapes symptom content or presentation.
Example: delusions involving spirits or surveillance technology.

PATHOELABORATING
Amplifies or elaborates a behavioural pattern.
Example: culturally elaborated startle responses in Latah.

PATHOFACILITATIVE
Makes a condition more frequent.
Example: permissive drinking norms increasing alcohol-related problems.

PATHOREACTIVE
Shapes responses to illness.
Example: stigma, support or interpreting distress as possession.

PROTECTIVE / SALUTOGENIC EFFECTS: belonging, meaning, social support and helpful coping. Additional protective perspective—not one of the book's six terms.

Ask, don't assume. Culture shapes care; it does not replace individual assessment.

Sources: American Psychiatric Association Cultural Formulation Interview; Wen-Shing Tseng cultural effects framework; tutor synthesis.

Culture and psychiatry. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Geriatric, consultation-liaison and transcultural psychiatry.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III • 59.2

Elder protection and maintenance law

LEGAL ACTS APPENDIX • Supplement • III Q 59; Q 61 dementia legal component

1 RECOGNISE ABUSE

Types	**Physical, psychological, sexual, financial/material abuse and neglect**; abandonment. Consider self-neglect separately.
Clues	Unexplained injury, fear, inconsistent accounts, poor hygiene/nutrition, missed care, medication misuse, sudden financial changes or controlling caregiver.
Assessment	Private respectful interview, collateral, physical/cognitive/mental assessment; assess immediate danger, capacity, dependence and caregiver strain.

2 MAINTENANCE & WELFARE ACT 2007

Who	Senior citizen: Indian citizen **≥60 years**. Parents may claim maintenance under the Act even if below 60, subject to its conditions.
Maintenance	Eligible parent/senior citizen unable to maintain self can seek maintenance from qualifying children/relatives through **Maintenance Tribunal**.
§23 property	Transfer subject to provision of basic amenities/physical needs, followed by refusal/failure: Tribunal may declare transfer **void at transferor's option**. Not every gift is automatically reversible.
§24	Abandonment of senior citizen by a person having care/protection is an offence.
Services	Provisions for old-age homes, healthcare and protection of life/property; implementation and state rules matter.

3 PSYCHIATRIC RESPONSE

Immediate danger/injury → urgent care and appropriate protection/police involvement

↓

Assess capacity and wishes → safe contact, accommodation, care access and financial protection

↓

Coordinate family/social work/legal aid/Tribunal → **document, follow up and reassess safety**

4 DEMENTIA & CAPACITY

No blanket loss	Dementia diagnosis does not abolish every decision. Assess consent, financial transactions and wills **separately**.
Support	Communication aids, trusted supports and least restrictive arrangements. Check coercion and conflicts of interest.
Planning	When capable: care preferences, finances, nominated support and valid legal arrangements. See 1.1 wills and 1.2 civil capacity.

5 ETHICAL BALANCE

Autonomy / safety	Explain options and lawful reporting limits; do not disclose indiscriminately or assume family is safe.
Broader Q 59	Combine with 59.1 for detailed clinical management. This sheet provides the **statutory protection pathway**, not a complete geriatric differential.

Maintenance and Welfare of Parents and Senior Citizens Act 2007 §§2, 4–9, 19–24; WHO elder-abuse guidance.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Elder protection and maintenance law. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Geriatric, consultation-liaison and transcultural psychiatry.

Credits and references: retained within the illustration.

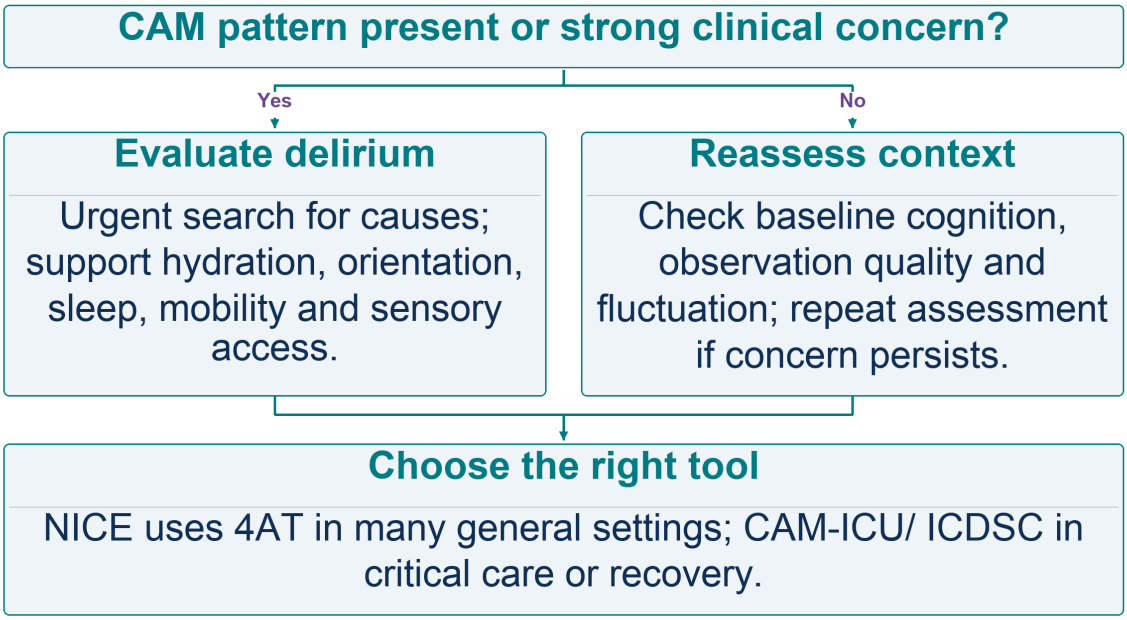
WEAVE 100+ / PAPER III

Confusion Assessment Method

Identify the delirium pattern, then find the cause.

Domain	Revision points
Feature 1	Acute onset and fluctuating course.
Feature 2	Inattention.
Feature 3	Disorganised thinking.
Feature 4	Altered level of consciousness.
CAM rule	Features 1 AND 2, plus either 3 OR 4, support delirium by the CAM algorithm.

DECISION PATHWAY



Weave Sprint geriatric assessment; NICE CG103 (2023 update).

III 60.3 • Supplement • Source links and qualifications: SOURCES.md

Confusion Assessment Method. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Geriatric, consultation-liaison and transcultural psychiatry.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

MMSE versus MoCA

Screening scores support assessment; they do not establish a diagnosis.

Feature	MMSE	MoCA
Maximum score	30 points.	30 points.
Emphasis	Orientation, registration/ recall, attention, language and construction.	Broader executive/ visuospatial tasks plus memory, attention, language and orientation.
Clinical use	Familiar global cognitive screen; may miss subtle executive problems.	Often useful when mild impairment or executive difficulty is suspected.
Interpretation	Consider education, language, hearing/ vision and testing conditions.	Consider version, education/ language adjustments and local norms.
Next step	Combine with informant history and daily functioning.	Abnormal score requires diagnostic evaluation, not automatic dementia labelling.

LIMIT

Avoid a universal cut-off across languages and populations. Acute illness, anxiety and poor sensory access can distort both.

USE

Use authorised forms and the required training/ licensing arrangements; this sheet does not reproduce test items.

Weave Sprint Paper III; see source register

III 61.3 • Supplement • Source links and qualifications: SOURCES.md

MMSE versus MoCA. Read across the labelled contrasts to distinguish the related concepts. Section companion: Geriatric, consultation-liaison and transcultural psychiatry.

Credits and references: retained within the illustration.

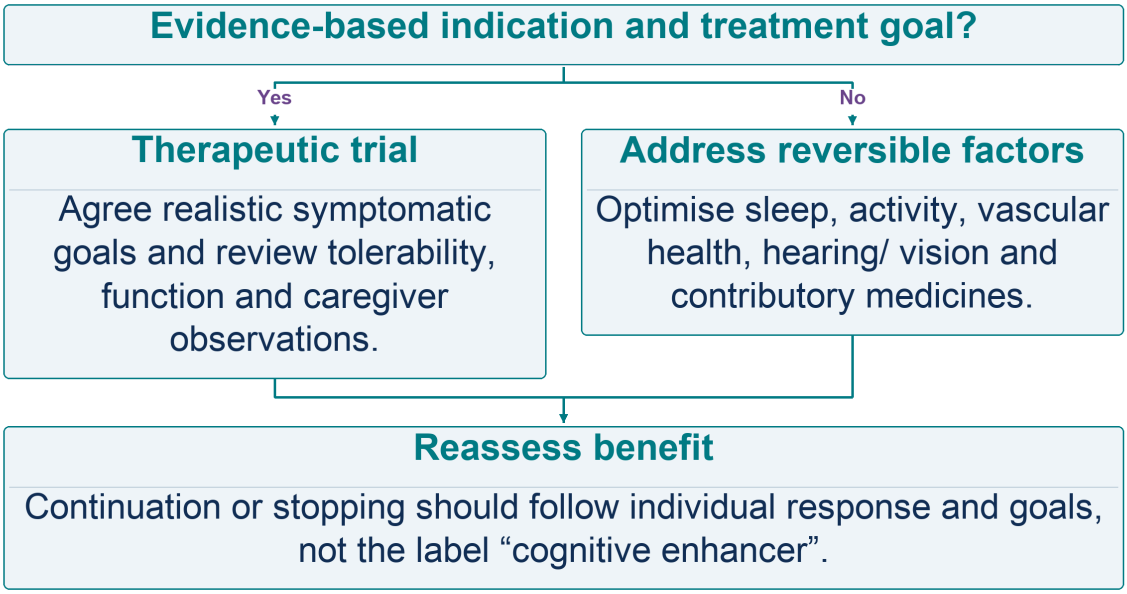
WEAVE 100+ / PAPER III

Cognitive enhancers and nootropics

Distinguish licensed symptomatic dementia treatment from enhancement claims.

Domain	Revision points
Cholinesterase inhibitors	Donepezil, rivastigmine and galantamine: diagnosis/ stage-specific roles; monitor GI effects, pulse, syncope and weight.
Memantine	NMDA antagonist with stage/ indication-specific use; consider renal function and tolerability.
Before prescribing	Confirm diagnosis and function; address delirium, depression, medicines and sensory impairment.
Nootropic claims	Claims for piracetam, supplements or enhancement in healthy people are not equivalent to established dementia indications.

DECISION PATHWAY



Weave cognition monographs; NICE NG97.

III 61.4 • Supplement • Source links and qualifications: SOURCES.md

Cognitive enhancers and nootropics. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Geriatric, consultation-liaison and transcultural psychiatry.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Pimavanserin

Serotonergic antipsychotic pharmacology with an indication-specific role.

Domain	Revision points
Mechanism	Predominantly 5-HT2A inverse agonist/ antagonist; no clinically meaningful D2 blockade.
US labelled role	Hallucinations and delusions associated with Parkinson's disease psychosis.
Advantages/ limits	Avoids direct dopamine blockade; not a general licence to treat all dementia-related psychosis.
Risks	QT prolongation, interactions and increased mortality warning in elderly people with dementia-related psychosis.
Review	Check reversible causes of hallucinations, existing Parkinson medicines, cognition and cardiovascular risk.

JURISDICTION

US labelling is not evidence of Indian approval or availability.

EXAM TRAP

Mechanistic selectivity does not make the medicine free of serious adverse effects.

Weave pimavanserin monograph; DailyMed NUPLAZID label.

Pimavanserin. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Geriatric, consultation-liaison and transcultural psychiatry.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Vortioxetine

Serotonin transporter inhibition plus receptor modulation.

Domain	Revision points
Mechanism	Serotonin reuptake inhibition with multiple serotonin-receptor actions.
Clinical role	Treatment of major depressive disorder; choose according to presentation and prior treatment response.
Practical points	Nausea is common; review interactions and tolerability during titration.
Safety	Serotonin syndrome, bleeding risk, hyponatraemia, mood switch and antidepressant suicidality warning.
Cognition	Some studies show cognitive benefits in depression; this does not make it an approved dementia treatment.

INTERACTIONS

Strong CYP2D6 inhibitors and enzyme inducers can alter exposure; follow the product-specific adjustment guidance.

SEXUAL FUNCTION

Sexual adverse effects may still occur; do not describe vortioxetine as universally free of them.

Weave vortioxetine monograph; DailyMed TRINTELLIX label.

III 66.5 • Supplement • Source links and qualifications: SOURCES.md

Vortioxetine. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Geriatric, consultation-liaison and transcultural psychiatry.

Credits and references: retained within the illustration.

AREA 08 OF 13 · P3-A10

ECT and neurostimulation

8	7.9%	III-67	III-74
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

HIGH 1 SINGLE 7

REVISION ORDER

The two ECT slots first: they are the ones a board is most likely to set. Then the non-convulsive devices as one group, because they are asked as a group. Ketamine and the subspecialty slot last.

WHAT IS IN THIS AREA

ECT indications and contraindications, unilateral ECT and electrode placement, rTMS, transcranial direct current stimulation, vagus nerve and deep brain stimulation, ketamine, interventional psychiatry as a subspecialty, and ECT inside a prevention and rehabilitation frame.

III - 67

Discuss indications and contraindications of Electro convulsive therapy. [10]

10 | ECT AND NEUROSTIMULATION | KNRUHS, RGUHS - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2 What it is	The treatment defined, and the law it is given under
3 Indications	By urgency first, then by diagnosis
3 Contraindications	None absolute; the risk list and what each changes
2 What decides it	Speed, refractoriness, consent, the Act's limits

THE DEFINITION

A generalised cerebral seizure of adequate duration, induced by a brief pulse stimulus to the scalp under general anaesthesia and muscle relaxation. Modified ECT is the only lawful form: the Mental Healthcare Act 2017, Section 95, bars ECT without anaesthesia and relaxants, and bars it for a minor except with guardian consent and the Board's prior permission.

- **Urgent, where delay is itself the danger.** Sustained high suicidal intent, refusal of food and fluids, stupor, malignant catatonia, severe puerperal illness, and neuroleptic malignant syndrome.
- **Established by diagnosis.** Severe depression, especially with melancholic or psychotic features; mania that is unresponsive or exhausting; catatonia of any cause; schizophrenia with catatonic or affective features, or persistent drug resistance.
- **There is no absolute contraindication.** Raised intracranial pressure with a space-occupying lesion comes nearest. Everything else is a risk to be quantified with the anaesthetist and consented to, not a bar.

DOMAIN	THE CONCERN	WHY IT MATTERS	WHAT CHANGES
Intracranial	Space-occupying lesion, raised pressure	Surge in cerebral blood flow and pressure	Neurosurgical opinion first
Cardiac	Recent infarct, unstable angina, arrhythmia	Vagal bradycardia, then a sympathetic surge	Cardiology input, rate control
Vascular	Aortic or cerebral aneurysm	Transient rise in arterial pressure	Pressure controlled through the fit
Endocrine	Pheochromocytoma	Catecholamine release	Alpha blockade before treatment
Ocular, respiratory	Retinal detachment, unstable airway disease	Pressure change, anaesthetic risk	Specialist opinion, then optimise

WHAT EARNS THE MARKS

- **The Act named, not implied.** Unmodified ECT is unlawful, and a minor needs guardian consent and the Board's prior permission.
- **Indications ordered by urgency before diagnosis.** The emergency list separates a top answer from a recalled one.
- **"No absolute contraindication" written as a sentence,** with raised intracranial pressure named as the nearest thing to one, and the amber rows read as modifiers of preparation rather than bars.

SEE ALSO Slot III - 73 unilateral ECT and electrode placement Slot III - 70 ECT across prevention and treatment

SPRINT Day 27, ECT and neurostimulation

WEAVE 100 · PAPER III · legacy-67.1

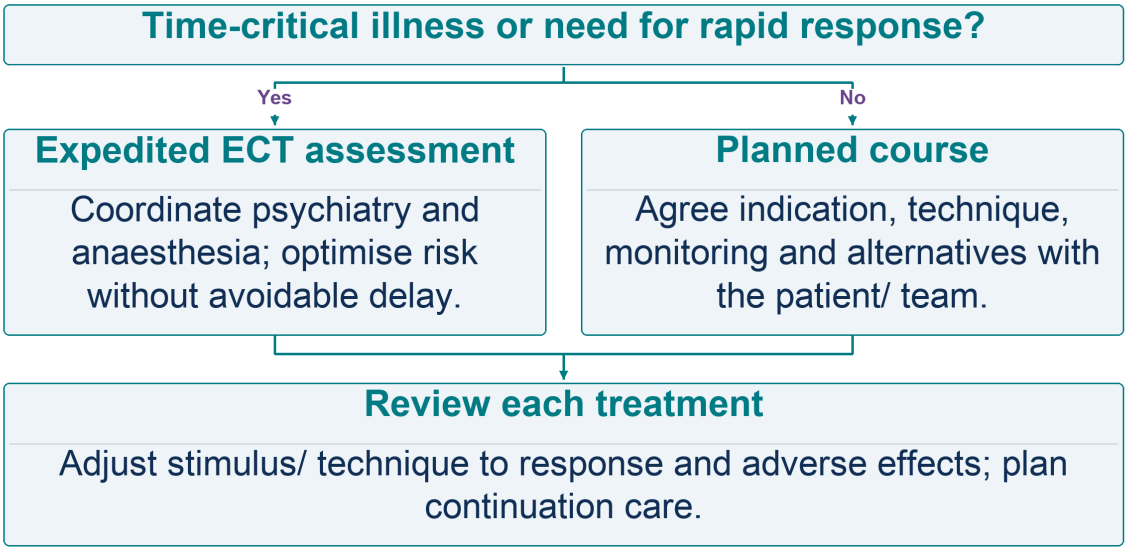
WEAVE 100+ / PAPER III

ECT: indications, preparation and monitoring

A structured assessment links expected benefit, risk and consent.

Domain	Revision points
Indications	Severe depression, catatonia, mania and selected psychotic illness; urgency and prior response influence the decision.
Preparation	Psychiatric/ medical and anaesthetic assessment; review medications, airway, cardiovascular status and baseline cognition.
Consent/ legal	Explain alternatives, benefits, anaesthesia and cognitive effects; apply MHCA safeguards and document consent/ capacity.
Monitoring	Anaesthetic monitoring, motor/ EEG seizure assessment, recovery and serial symptom/ cognitive review.

DECISION PATHWAY



Weave 100 III-67; IPS ECT clinical practice guideline, 2023.

III 67.1 • Question-linked revision • Source links and qualifications: SOURCES.md

ECT: indications, preparation and monitoring. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-67.

Credits and references: retained within the illustration.

III - 68

Transcranial direct current stimulation; Discuss the current status with evidences. [10]

10 | ECT AND NEUROSTIMULATION | KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	What it is	The method, the dose, and how it differs from rTMS
5	The evidence	Indication by indication, each with its study type
2	Where it stands	Regulation, safety, and Indian availability
1	What is unsettled	One honest sentence about the field

- **The method.** A weak constant current, usually 1 to 2 mA, passed between two scalp electrodes for 20 to 30 minutes daily. It does not induce a seizure and does not fire neurons; it shifts resting membrane potential, so the anode raises and the cathode lowers cortical excitability. Effects outlast the session through synaptic plasticity.
- **The usual montage.** Anode over the left dorsolateral prefrontal cortex, cathode over the right, given in a course of ten to twenty sessions. Portable, cheap, needs no anaesthesia, and can in principle be delivered outside a procedure room.

INDICATION	WHAT IS CLAIMED	EVIDENCE SO FAR	STATUS
Unipolar depression	Antidepressant effect as monotherapy or add-on	Several sham-controlled trials and meta-analyses of them	**Best supported use**
Auditory hallucinations	Fronto-temporal montage reduces voices	Small randomised trials, replication uneven	Promising, contested
Negative symptoms	Prefrontal anodal stimulation	Small trials, short follow-up	Trial stage
Craving in substance use	Reduced cue-induced craving	Short crossover studies, soft endpoints	Trial stage
Cognition, obsessive-compulsive disorder	Working memory, symptom reduction	Exploratory, heterogeneous montages	Promising only

STATUS: WHERE THIS SITS TODAY

Safety is the strong part of the record: no seizures at conventional dose, and adverse effects limited to itching, tingling and transient erythema under the pads. Efficacy is the weak part. Trials are small, montages and session counts differ, and blinding is imperfect. It is not an approved standalone treatment in Indian practice, and its place is adjunctive and largely within research and specialist settings. It does not displace ECT where speed matters, or rTMS where the evidence base is larger.

WHAT EARNS THE MARKS

- **Subthreshold, not suprathreshold.** Saying it modulates excitability rather than inducing firing is the sentence that shows the mechanism is understood.
- **Each indication tied to its study type.** A named use with no design behind it earns nothing on this archetype.
- **Status separated from promise,** and safety separated from efficacy.
- **One honest unsolved line:** heterogeneity of montage and dose is why the trials do not converge.

SEE ALSO Slot III - 69 rTMS principle and utility Slot III - 72 interventional psychiatry SPRINT Day 27, ECT and neurostimulation

III - 69

Discuss the principle of RTMS, indications and utility in clinical practice. [3+2+5]

3 + 2 + 5 | ECT AND NEUROSTIMULATION | DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

3 Principle	Induction, coil, depth, and how the dose is set
2 Indications	One established use, the rest ranked below it
3 Utility	Answered as a comparison with ECT, not as a list
2 Limits and safety	Seizure risk, the implant screen, durability

THE PRINCIPLE

A brief high current pulse through a coil on the scalp creates a rapidly changing magnetic field. The field crosses skull and scalp without attenuation and induces a secondary electric current in the cortex beneath it, which depolarises interneurons a few centimetres deep. This is Faraday induction, not conduction of electricity through the head. A figure of eight coil focuses the field, and the dose is set as a percentage of that person's resting motor threshold.

- **Frequency decides direction.** High frequency, 5 Hz and above, raises cortical excitability; 1 Hz lowers it. Intermittent theta burst is the short excitatory protocol, continuous theta burst the inhibitory one.
- **The depression protocol.** High frequency over the left dorsolateral prefrontal cortex, or 1 Hz over the right, on consecutive working days for four to six weeks. No anaesthesia, no seizure, no memory cost, so the patient drives home.
- **The one serious risk is a seizure.** Rare, and almost always during the session. Screen for ferromagnetic implants near the head, cochlear implants and implanted pulse generators. Hearing protection is worn.

USE	TARGET AND DIRECTION	EVIDENCE	WHERE IT SITS
Resistant depression	Left prefrontal, excitatory	Largest randomised base	**The established use**
Auditory hallucinations	Left temporoparietal, inhibitory	Several trials, modest effect	Adjunct
Obsessive-compulsive disorder	Supplementary motor, orbitofrontal	Smaller randomised trials	Adjunct in resistance
Negative symptoms, craving	Prefrontal, excitatory	Mixed and exploratory	Trial stage

Utility is judged against the alternative: slower and weaker than ECT, better tolerated, and useless when the patient cannot wait four weeks.

WHAT EARNS THE MARKS

- **Faraday induction named,** with the coil, the depth and the motor threshold. "Magnetic stimulation" without the induced current is a half answer.
- **Frequency mapped to direction of effect,** and the side that goes with each.
- **Utility written as a comparison with ECT.** Speed, severity and memory are the three axes an examiner is checking.
- **Seizure risk and the implant screen,** one line each, before the answer ends.

SEE ALSO Slot III - 68 transcranial direct current stimulation Slot III - 72 interventional psychiatry SPRINT Day 27, ECT and neurostimulation

III - 70

a) Describe terms prevention, treatment and rehabilitation in context of psychiatry. b) Impact of ECT in these terms. [5+5]

5 + 5 | ECT AND NEUROSTIMULATION | DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 **The axis**	Defined by when a service acts
3 **What each level does**	The content of all three, with examples
3 **ECT at each level**	Drawn: none, most, and indirect
2 **The honest limit**	Where ECT is not prevention at all

- **The axis.** Caplan placed a service by the moment it acts. Primary acts before onset and lowers incidence; secondary acts early and lowers prevalence by shortening the episode; tertiary acts after it and lowers disability.
- **Treatment is not a fourth level.** It is the instrument secondary prevention uses, and it counts as prevention only because it shortens the episode and prevents the next.

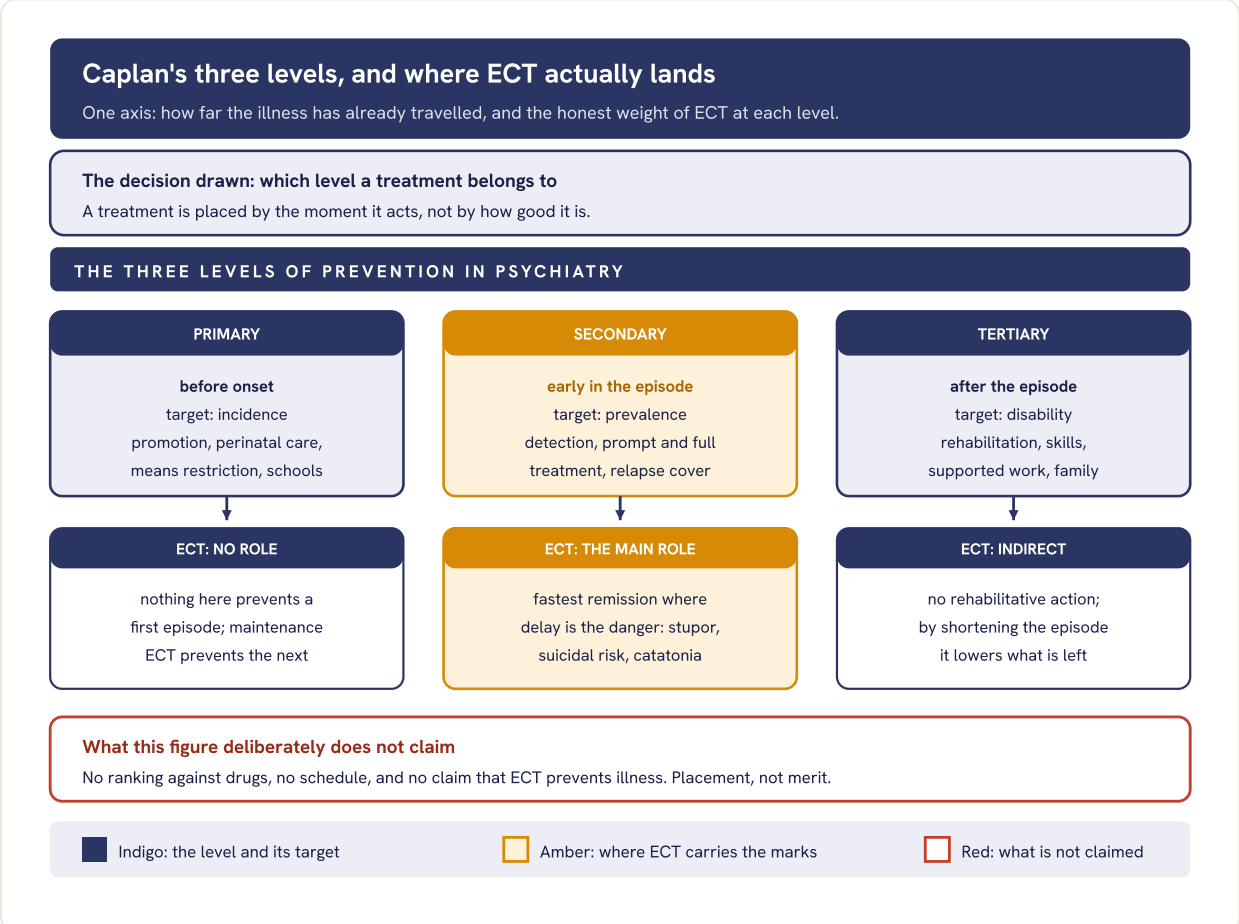


Fig 070.1 The levels read left to right as the illness advances, with ECT placed under each rather than praised in general.

WHAT EARNS THE MARKS

- **The axis stated before the levels, with Caplan named.**
- **ECT placed, not praised.** The answer that says it has no primary preventive role is the one that has understood part b.
- **Maintenance and tertiary answered honestly.** Maintenance ECT prevents the next episode, not the first, and ECT shortens the episode that rehabilitation must then repair.

SEE ALSO Slot III - 67 indications and contraindications of ECT Slot III - 73 unilateral ECT and electrode placement

SPRINT Day 39, community psychiatry and public health

III - 71

Vagus Nerve stimulation and Deep Brain Stimulation. [10]

10 | ECT AND NEUROSTIMULATION | RGUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	**Both defined**	Implanted, reversible, adjustable: that is the shared axis
3	**Vagus nerve stimulation**	Hardware, mechanism, use, adverse effects
3	**Deep brain stimulation**	Targets, use, adverse effects
2	**Selection and the law**	Who qualifies, and why this is not psychosurgery

THE DEFINITION

Two implanted neuromodulation treatments for severe treatment-resistant illness. Vagus nerve stimulation delivers chronic intermittent pulses to the left cervical vagus from a generator in the chest wall. Deep brain stimulation delivers continuous adjustable stimulation from electrodes placed stereotactically in a defined subcortical target. Neither destroys tissue, and both are reversible and adjustable. That is what separates them from the ablative operations they replaced.

FEATURE	VAGUS NERVE STIMULATION	DEEP BRAIN STIMULATION	WHAT FOLLOWS
Where it acts	Left cervical vagus, afferents to the brainstem and on to limbic cortex	Subcallosal cingulate, ventral capsule and striatum, nucleus accumbens	**Target choice is the whole of the second**
Onset	Slow: months, still improving at a year	Weeks, and adjustable at each visit	**Changes who can wait for it**
Psychiatric use	Adjunctive in resistant depression	Refractory obsessive-compulsive disorder best supported	Evidence is uneven in both
Adverse effects	Voice change, hoarseness, cough, breathlessness while stimulating	Haemorrhage, infection, hardware failure, hypomania at some targets	One is a nuisance, one is surgical
Neurological use	Refractory epilepsy	Parkinson disease, dystonia, tremor	Both entered psychiatry from neurology

- **Selection is the hard part.** Both require a documented, adequate trial of established treatments, a stable diagnosis, capacity, and formal multidisciplinary and ethical review. Neither answers a first refractory episode.
- **Not psychosurgery, in law.** The Mental Healthcare Act 2017, Section 96, reads on interventions designed to destroy brain tissue or its functioning, and requires informed consent and the Board's approval. Stimulation destroys nothing, so it falls outside that definition while still needing consent and oversight on ordinary grounds.

WHAT EARNS THE MARKS

- **Each defined by what is stimulated and where the hardware sits,** not by the abbreviation.
- **Reversible and adjustable, written as the reason these replaced ablative surgery.**
- **Onset separated:** months against weeks, and what that does to selection.
- **The legal line.** Destruction of tissue is what the psychosurgery provision turns on.

SEE ALSO Slot III - 72 interventional psychiatry Slot III - 69 rTMS principle and utility SPRINT Day 27, ECT and neurostimulation

WEAVE 100+ / PAPER III

VNS and DBS: where stimulation acts

Implanted interventions require specialist selection and long-term follow-up.

Feature	Vagus nerve stimulation	Deep brain stimulation
Anatomical target	VNS: cervical vagus nerve, typically left-sided.	DBS: electrodes in selected deep brain targets.
Hardware	Pulse generator connected to a peripheral nerve lead.	Pulse generator connected to intracranial leads.
Psychiatric use	Selected treatment-resistant depression; approval and access vary.	Selected severe refractory OCD in specialised programmes; depression remains investigational in many settings.
Key burdens	Surgery, device care, voice/ cough effects and delayed response.	Intracranial surgery, programming, neuropsychiatric effects and target-specific risks.

DEVICE AND LEAD SCHEMATIC



SCHEMATIC

Conceptual lead locations only; not a surgical map or a claim that all DBS targets are interchangeable.

Weave Sprint Paper III; see source register

III 71.1 • Question-linked revision • Source links and qualifications: SOURCES.md

VNS and DBS: where stimulation acts. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-71.

Credits and references: retained within the illustration.

III - 72

Write briefly about Interventional Psychiatry as a subspecialty of psychiatry. [10]

10 ECT AND NEUROSTIMULATION WBUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 What it is	Defined by how treatment is delivered, not by diagnosis
3 What it contains	Four families, an example in each
3 Why it separated out	Refractoriness, and what a procedure needs that a clinic lacks
2 What it demands	Skills, governance, and the honest evidence line

THE DEFINITION

The subspecialty that delivers device-based and procedure-based treatments for severe or treatment-resistant mental illness, in a setting built for anaesthesia, monitoring, consent and audit. Its unit of practice is a procedure with a dose, a checklist and a recovery period, rather than a prescription.

FAMILY	EXAMPLES	WHAT IS DELIVERED	SETTING
Convulsive	ECT, magnetic seizure therapy	An induced generalised seizure	Anaesthesia and recovery
Non-invasive modulation	rTMS, theta burst, transcranial direct current stimulation	Subconvulsive cortical modulation	Outpatient chair
Implanted modulation	Vagus nerve stimulation, deep brain stimulation	Chronic stimulation from implanted hardware	Theatre, then clinic
Procedural pharmacology	Intravenous ketamine, intranasal esketamine, intravenous clomipramine	A drug given under observation	Day care with monitoring

Amber marks the two families that cannot be delivered in an ordinary consulting room, which is the argument for a subspecialty.

- **Why it separated out.** A large share of depressive illness does not remit after two adequate drug trials. The treatments that answer that are procedures, and procedures need rooms, trained staff, checklists and outcome audit.
- **The failure mode is enthusiasm.** A device with a plausible mechanism and thin trials is still experimental. Ranking the families by evidence, rather than by novelty, is what a good answer does here.

WHAT EARNS THE MARKS

- **Defined by delivery, not by diagnosis.** Procedures rather than drug classes is the organising idea.
- **The four families named, with an example in each.** A list of devices with no grouping reads as recall.
- **The infrastructure argument.** Anaesthesia, monitoring, consent and audit is why this is a subspecialty and not a technique.
- **Evidence weight kept honest** across established, adjunctive and experimental.

SEE ALSO Slot III - 71 vagus nerve and deep brain stimulation Slot III - 74 ketamine in psychiatry SPRINT Day 27, ECT and neurostimulation

WEAVE 100+ / PAPER III

Interventional psychiatry: comparison

Match indication, evidence, invasiveness and service requirements.

Domain	Revision points
ECT	Anaesthesia and induced seizure; established role in severe mood illness and catatonia.
rTMS	Repeated magnetic stimulation without induced therapeutic seizure or routine anaesthesia; protocol/ indication matter.
tDCS	Weak scalp electrical current; evidence and regulatory status vary by indication and jurisdiction.
VNS / DBS	Implanted stimulation; narrow specialist indications, substantial selection and follow-up requirements.
Ketamine / esketamine	Pharmacological rapid-acting interventions with monitoring and eligibility requirements; not devices.

TRAP

“Non-invasive” does not mean risk-free; “newer” does not mean superior.

DECISION

Use diagnosis, urgency, treatment history, contraindications, availability and informed preference.

Weave Sprint Paper III; see source register

III 72.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Interventional psychiatry: comparison. Read across the labelled contrasts to distinguish the related concepts. Read with III-72.

Credits and references: retained within the illustration.

III - 73

Advantages of Unilateral Electroconvulsive Therapy and electrode placement for the procedure. [10]

10 | ECT AND NEUROSTIMULATION | RGUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 Why unilateral	Dominant hemisphere spared: the whole rationale
3 The placements	All three drawn, each with its surface landmark
3 Advantages	Cognitive, and stated as differences not as praise
2 The condition	Suprathreshold dosing, and when bitemporal still wins

THE RATIONALE

The right hemisphere is non-dominant for language in most people. Both electrodes over it still induce a generalised seizure, but current density over the left temporal structures that carry verbal memory is much lower. Same treatment, different cost to memory.

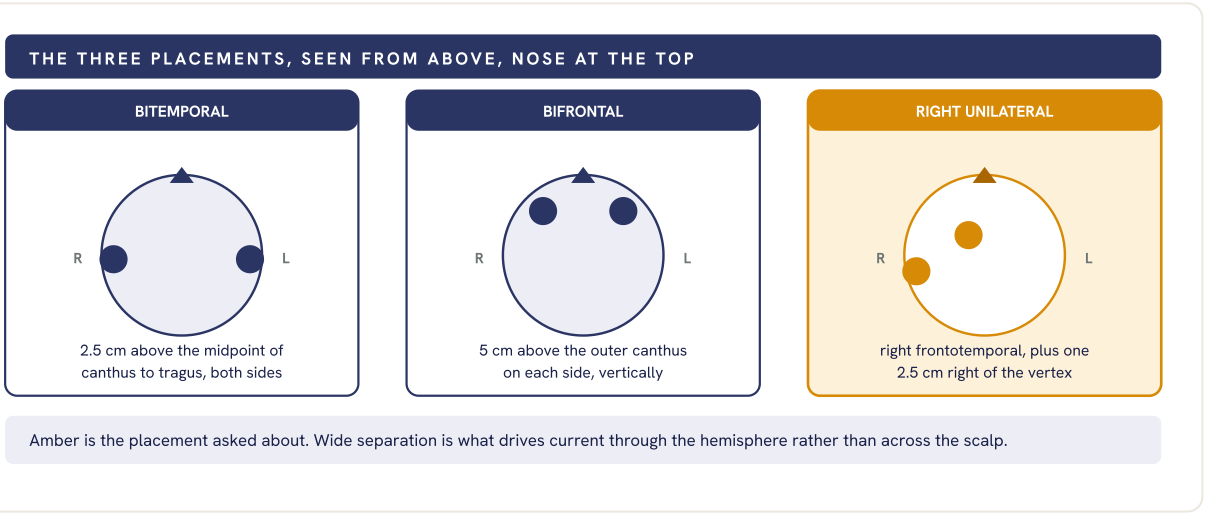


Fig 073.1 The d'Elia position is defined by the separation of the two electrodes as much as by either landmark.

- **The advantage is cognitive.** Less retrograde and anterograde memory impairment, shorter post-ictal disorientation and faster reorientation than bitemporal, at equal antidepressant efficacy when the dose is adequate.
- **The dose is the condition.** Unilateral works only well above seizure threshold, conventionally about six times it, so the threshold is titrated at the first session. Given near threshold it is a weak treatment with a good side effect profile, which is the worst of both. Bitemporal is still chosen where speed outweighs memory.

WHAT EARNS THE MARKS

- **Each placement given with its surface landmark,** not just its name.
- **The dose condition stated alongside the placement.** Unilateral without suprathreshold dosing is the commonest error here.
- **The advantage specified as memory and reorientation,** not vague tolerability.

SEE ALSO Slot III - 67 indications and contraindications of ECT Slot III - 70 ECT across prevention and treatment
SPRINT Day 27, ECT and neurostimulation

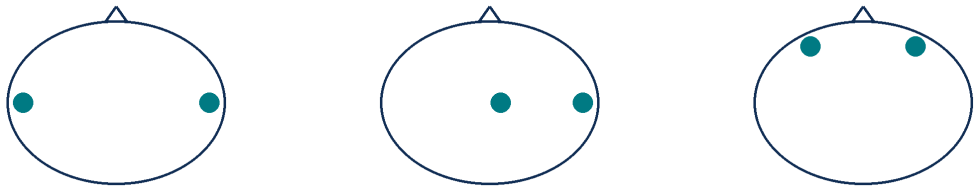
WEAVE 100+ / PAPER III

ECT electrode placement

Placement changes the efficacy– cognitive adverse-effect balance.

Domain	Revision points
Bitemporal	Bilateral temporal placement; often selected when rapid robust response is especially important.
Right unilateral	Electrodes on the right side; cognitive advantage depends on dose, pulse width and adequate treatment delivery.
Bifrontal	Bilateral frontal placement; an alternative technique with its own practical and evidence considerations.
Selection	Consider urgency, previous response, cognitive vulnerability, seizure threshold and stimulus dosing.

PLACEMENT SCHEMATIC



Nose points upward; right side of each drawing = patient's right.

SCHEMATIC

Top views below show relative locations only. They are not a placement protocol.

TRAP

Placement cannot be interpreted independently of pulse width and dose relative to seizure threshold.

Weave 100 III-73; IPS ECT guideline, 2023.

III 73.1 • Question-linked revision • Source links and qualifications: SOURCES.md

ECT electrode placement. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-73.

Credits and references: retained within the illustration.

III - 74

Ketamine in Psychiatry. [10]

10 ECT AND NEUROSTIMULATION RGUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	What it is	Receptor, origin, and why it changed the field
3	Mechanism	Blockade, glutamate surge, synaptic repair
3	Uses, dose, route	Each use with its dose and its time course
2	Limits	Durability, adverse effects, and control status

THE DEFINITION

A non-competitive antagonist at the NMDA glutamate receptor, in anaesthetic use since the 1960s and repurposed as a rapid-acting antidepressant. One subanaesthetic dose lifts mood within hours in illness that has not responded to conventional drugs, which broke the assumption that antidepressant action must take weeks.

USE	DOSE AND ROUTE	TIME COURSE	EVIDENCE
Resistant depression	Racemic ketamine 0.5 mg per kg intravenously over 40 minutes	Response in hours, peak near 24 hours	**Several randomised trials**
Resistant depression	Esketamine, intranasal, alongside an oral antidepressant	Slower and steadier than intravenous	Registration trials
Acute suicidal ideation	Single infusion, within an admission	Ideation falls faster than mood	**Short follow-up only**
Anaesthesia for ECT	Anaesthetic dose, by the anaesthetist	Does not raise seizure threshold	Long anaesthetic record

- **The mechanism as taught.** Blockade on inhibitory interneurons releases a glutamate surge, which drives AMPA receptor throughput, brain-derived neurotrophic factor release and mTOR signalling, and restores prefrontal synaptic connections within hours.
- **The problem is durability, not response.** The effect fades over three to seven days, so treatment is a course, commonly twice weekly, and the answer must say what maintains the gain afterwards.

PITFALL

Dissociation, a rise in blood pressure and pulse, nausea and transient anxiety are expected effects of a monitored dose. Cystitis, hepatobiliary injury and dependence belong to heavy recreational use. Confusing the two lists, or forgetting that it is a controlled substance, both lose marks.

WHAT EARNS THE MARKS

- **The receptor named, and the surge that follows it.** Antagonism alone does not explain an antidepressant effect.
- **Dose, route and time course written down,** not gestured at.
- **The anti-suicidal effect kept separate from the antidepressant effect.**
- **Durability named as the limitation,** with a maintenance plan implied.

SEE ALSO Slot III - 72 interventional psychiatry Slot III - 67 indications and contraindications of ECT SPRINT
Day 12, mood disorder pharmacotherapy and resistance

WEAVE 100 · PAPER III · legacy-74.1

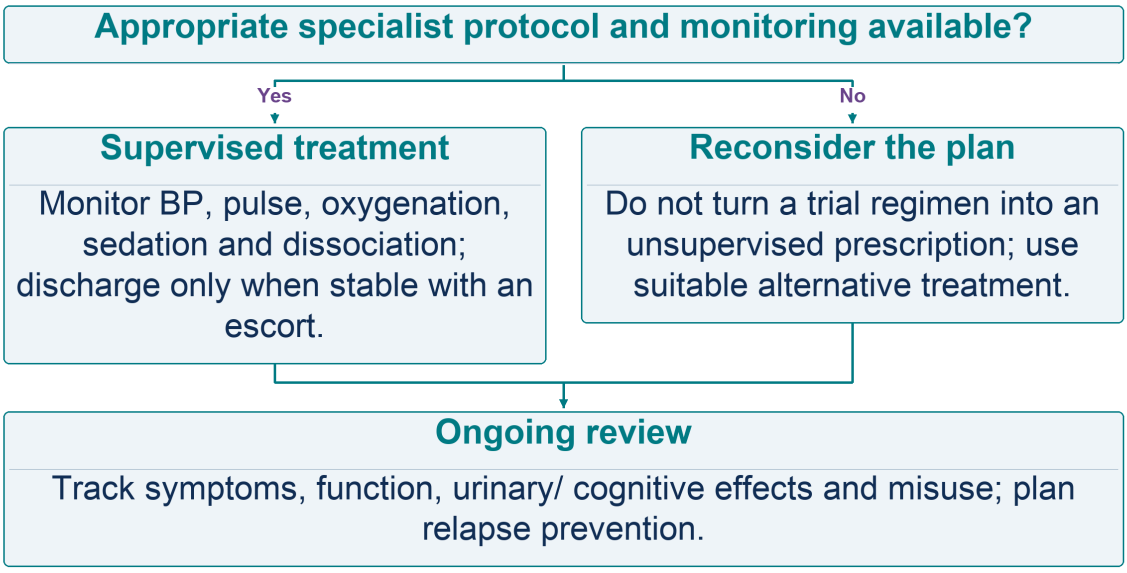
WEAVE 100+ / PAPER III

Ketamine: intravenous and oral routes

Racemic ketamine and intranasal esketamine have different evidence and protocols.

Domain	Revision points
Mechanism	NMDA antagonism with downstream glutamate/ plasticity effects; no single pathway fully explains the clinical response.
Intravenous	Common studied regimen: 0.5 mg/ kg over 40 minutes in a specialist monitored service; never a rapid antidepressant bolus.
Oral	First-pass metabolism and variable exposure; evidence is formulation-specific and mixed. No simple IV-to-oral dose conversion.
Before treatment	Confirm resistance; assess bipolarity, psychosis, cardiovascular health, substances, pregnancy and interacting medicines.

DECISION PATHWAY



DISTINCTION

Rapid reduction in suicidal thoughts is not proof of suicide prevention.

Paper II ketamine supplement II+119; CANMAT 2021; FDA ketamine safety communication.

III 74.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Ketamine: intravenous and oral routes. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-74.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

ECT across phases of care

An effective acute course needs a relapse-prevention plan.

Domain	Revision points
Acute course	Treat the presenting episode; track symptoms, function and cognition to guide course length.
Continuation ECT	Treatment after acute response to reduce early relapse, commonly within the following 6 months.
Maintenance ECT	Longer-term treatment for selected recurrent illness when benefit justifies burden and risk.
Combined care	Medication, psychological work, sleep/ routine, family support and rehabilitation remain relevant.
Individualisation	Schedule, duration and reassessment depend on relapse pattern, tolerability and patient preferences.

FOLLOW-UP

Document relapse warning signs, memory concerns, transport/ support and who reviews treatment.

TERMINOLOGY

“Prevention” and “rehabilitation” describe goals; they are not separate electrical techniques.

Weave Sprint Paper III; see source register

III 70.1 • Question-linked revision • Source links and qualifications: SOURCES.md

ECT across phases of care. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ECT and neurostimulation.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Mood stabilisers: clinical comparison

Agents differ in phase efficacy, monitoring and major risks.

Domain	Revision points
Lithium	Acute mania and maintenance; monitor serum levels, kidney/ thyroid function, calcium and interactions.
Valproate	Acute mania and maintenance in selected patients; liver/ platelet and metabolic monitoring; major reproductive risks.
Carbamazepine	Selected mania/ maintenance use; enzyme induction and interactions, blood/ liver/ sodium monitoring, serious rash risk.
Lamotrigine	Useful particularly for depressive relapse prevention; not an acute antimanic treatment; slow titration because of rash risk.
Selection	Episode polarity, prior response, comorbidity, reproductive plans, interactions and capacity for monitoring.

SAFETY

Avoid abrupt changes. Valproate alters lamotrigine exposure; use the corresponding slow titration schedule.

PREGNANCY

Do not treat the drugs as interchangeable: valproate carries major fetal/ developmental risks; seek specialist advice for all regimens.

Local Paper II bipolar/ lithium materials; NICE CG185; product-specific prescribing information.

III 72.10 • Supplement • Source links and qualifications: SOURCES.md

Mood stabilisers: clinical comparison. Read across the labelled contrasts to distinguish the related concepts. Section companion: ECT and neurostimulation.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

MST, CES and focused ultrasound

Different physical interventions: evidence and clinical availability are not interchangeable.

Domain	Revision points
Magnetic seizure therapy	Magnetic pulses induce a therapeutic seizure under anaesthesia; studied as a potentially more focal convulsive approach.
Cranial electrotherapy stimulation	Low-amplitude current via external electrodes; devices/ protocols vary and evidence is indication-specific.
Focused ultrasound	Focused acoustic energy; distinguish low-intensity neuromodulation from high-intensity lesioning.
Compare with ECT/ rTMS	MST is convulsive; rTMS is generally nonconvulsive. FUS is not an electrical stimulation technique.
Before use	Define indication, device/ protocol, evidence, regulatory status, consent and monitoring in the relevant jurisdiction.

EXAM TRAP

Do not call all three established routine treatments or assume one device's evidence applies to another.

EVIDENCE

Describe trial findings as trial findings; durability, cognition, safety and access require modality-specific appraisal.

Weave Sprint day 27: emerging neurostimulation; source register.

III 72.2 • Supplement • Source links and qualifications: SOURCES.md

MST, CES and focused ultrasound. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ECT and neurostimulation.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Psychosurgery

Know the target, the indication and the ethical safeguards.

Domain	Revision points
Cingulotomy	Lesions involving anterior cingulate region/ cingulum pathways.
Anterior capsulotomy	Targets anterior limb of the internal capsule connections.
Subcaudate tractotomy	Lesions in subcaudate white matter/ orbitofrontal connections.
Limbic leukotomy	Combines cingulotomy and subcaudate tractotomy principles.
Selection	Severe refractory illness after documented adequate treatments; multidisciplinary evaluation of benefit, cognition and risk.

INDIA — MHCA SECTION 96

Psychosurgery requires informed consent and approval of the concerned Mental Health Review Board.

DISTINCTION

Ablative surgery makes a lesion. DBS modulates a circuit through implanted stimulation; both require careful selection and follow-up.

Weave Sprint day 27; MHCA 2017 s96.

WEAVE 100 · PAPER III · legacy-72.4

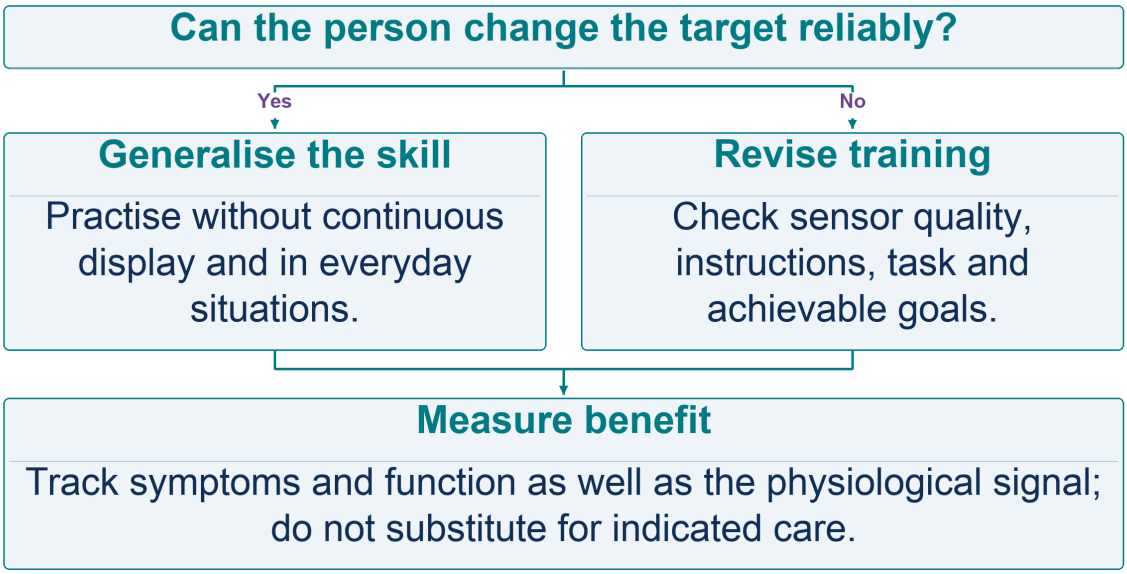
WEAVE 100+ / PAPER III

Biofeedback

Physiological signal → accessible feedback → learned self-regulation.

Domain	Revision points
Signal	Examples: muscle activity, skin temperature, electrodermal activity, respiration or heart-rate variability.
Feedback	A visual or auditory representation makes a usually unnoticed response observable.
Learning	Practise a strategy, observe the signal and adjust; avoid interpreting signal change as proof of diagnosis.
Clinical use	Application and evidence depend on the target condition, protocol and trained delivery.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 72.4 • Supplement • Source links and qualifications: SOURCES.md

Biofeedback. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ECT and neurostimulation.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Sensory deprivation

Reduced input can alter perception and arousal; context and duration matter.

Domain	Revision points
Definition	Marked reduction of sensory stimulation; distinguish laboratory isolation from voluntary flotation/ REST.
Possible effects	Changes in time sense, concentration, imagery and perception; distress or disorientation can occur.
Clinical claims	Relaxation findings in selected settings do not establish a general treatment for psychiatric disorders.
Ethical context	Consent, ability to stop, monitoring and avoidance of coercive deprivation are central.
Vulnerability	Consider distress, psychosis, dissociation, medical risk and the safety of the specific setting.

DO NOT CONFLATE

Sensory deprivation, sensory modulation and sleep deprivation are different procedures.

EXAM FRAME

Describe mechanism hypotheses and evidence limits, rather than presenting this as a routine prescription.

Weave Sprint Paper III; see source register

III 72.5 • Supplement • Source links and qualifications: SOURCES.md

Sensory deprivation. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ECT and neurostimulation.

Credits and references: retained within the illustration.

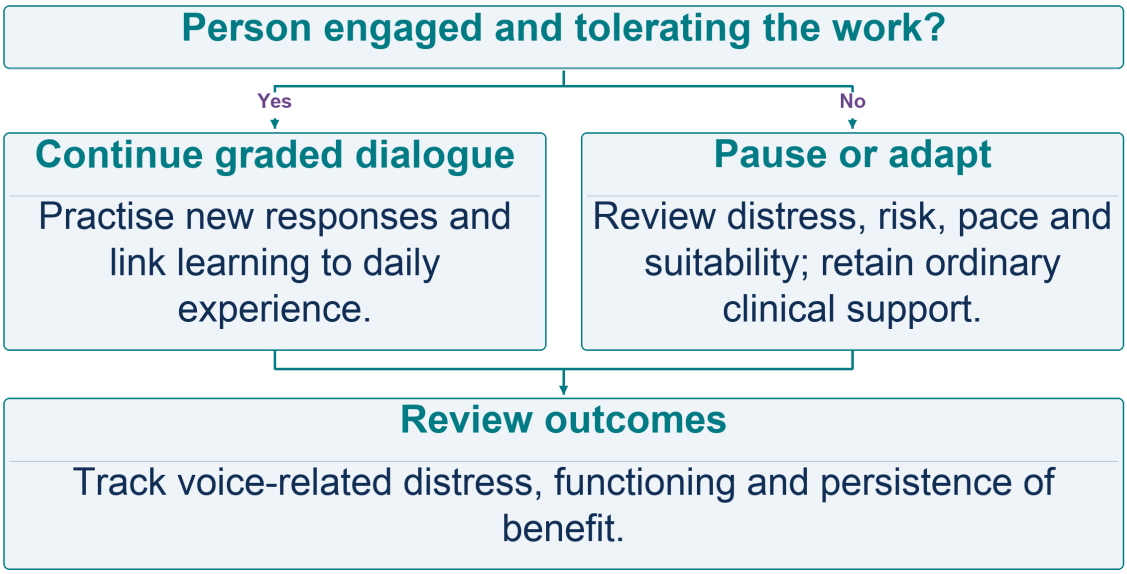
WEAVE 100+ / PAPER III

Avatar therapy

Therapist-supported dialogue with a digital representation of a distressing voice.

Domain	Revision points
Preparation	Collaboratively create the avatar and voice characteristics; establish goals and a safety plan.
Dialogue	Therapist voices the avatar and supports the person in responding more assertively.
Target	Distress, perceived power and the relationship with the voice; not a promise to eliminate all voices.
Context	Adjunct to ongoing care with trained delivery; assess readiness and monitor distress.

DECISION PATHWAY



Weave supplementary notes; NICE AVATAR early-value assessment; AVATAR2 trial.

III 72.6 • Supplement • Source links and qualifications: SOURCES.md

Avatar therapy. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ECT and neurostimulation.

Credits and references: retained within the illustration.

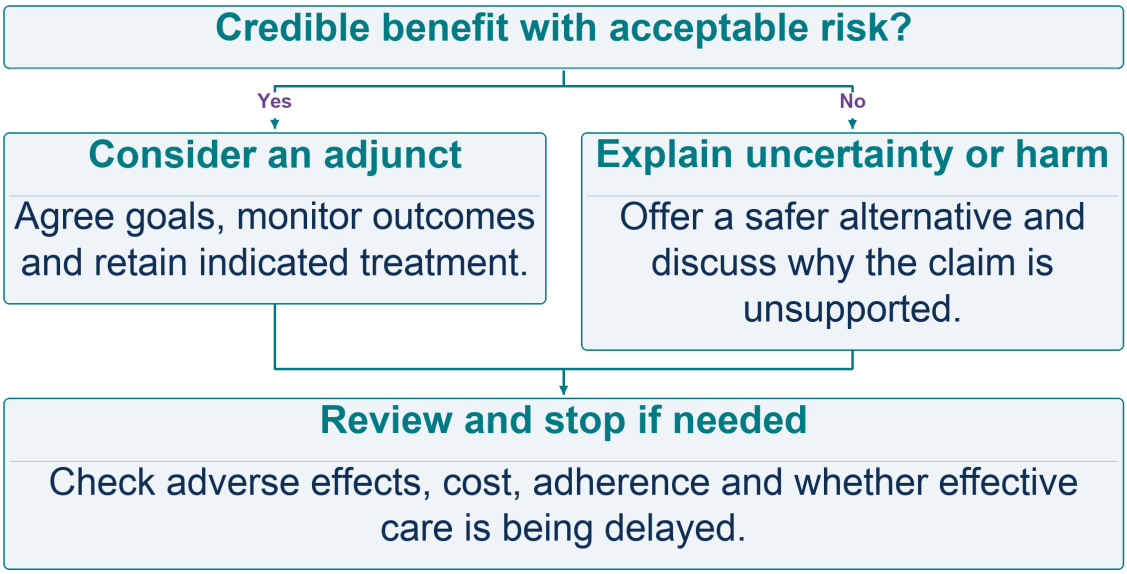
WEAVE 100+ / PAPER III

Complementary approaches

Evaluate a specific intervention for a specific outcome.

Domain	Revision points
Mind– body approaches	Yoga, mindfulness and relaxation may be adjuncts; distinguish structured protocols from generic wellness claims.
Nutritional/ herbal products	Check formulation, dose, contamination, interactions and evidence; natural does not mean safe.
Assessment	Ask nonjudgmentally about all products and practices to reduce undisclosed interactions.
Evidence questions	Randomisation, comparator, blinding, effect size, harms, publication bias and relevance to the patient.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 72.7 • Supplement • Source links and qualifications: SOURCES.md

Complementary approaches. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ECT and neurostimulation.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Cariprazine, lurasidone and asenapine

Compare receptor profile, administration and practical risks.

Domain	Revision points
Cariprazine	D3/ D2 partial agonist; long-lived active metabolites mean delayed steady-state and delayed adverse-effect resolution.
Lurasidone	D2/ 5-HT2A antagonist with serotonergic actions; take with at least 350 kcal of food.
Asenapine	Multireceptor antagonist; sublingual formulation dissolves under the tongue, not swallowed; avoid eating/ drinking for 10 minutes.
Shared review	Akathisia/ EPS, metabolic burden, sedation, orthostasis, interactions and adherence.
Selection	Use diagnosis, prior response, tolerability and the local product label; formulations are not automatically interchangeable.

INTERACTIONS

Cariprazine and lurasidone have important CYP3A4 interactions. Check the exact product label before adding an inhibitor or inducer.

EXAM TRAP

A relatively favourable metabolic profile does not remove the need for metabolic monitoring.

Weave drug monographs; current DailyMed product labels (see SOURCES.md).

Cariprazine, lurasidone and asenapine. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ECT and neurostimulation.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · legacy-72.9

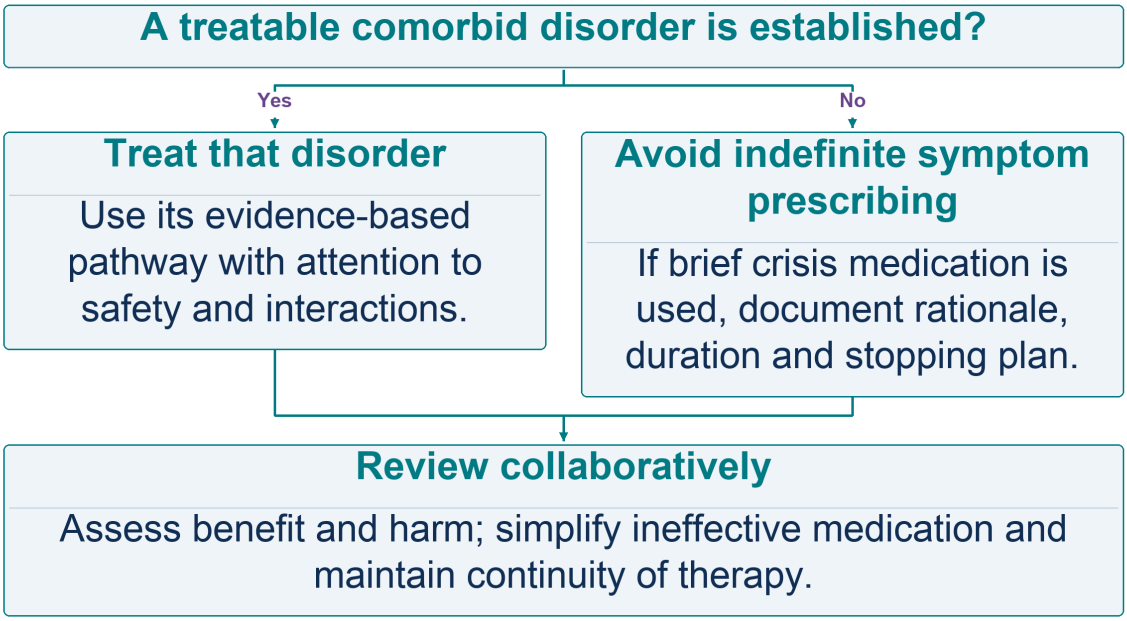
WEAVE 100+ / PAPER III

Medication in personality disorders

Treat defined targets and comorbidities; preserve psychotherapy as the main framework.

Domain	Revision points
Formulation	Distinguish enduring traits, acute crisis, comorbid disorder and medication adverse effects.
Targets	Specify symptom, severity, duration and desired outcome rather than prescribe for the personality label.
Risks	Overdose toxicity, dependence, disinhibition, polypharmacy and repeated reactive changes.
Psychological care	Structured psychotherapy and a consistent team plan address recurrent patterns and functioning.

DECISION PATHWAY



Weave personality-disorder material; NICE CG78.

III 72.9 • Supplement • Source links and qualifications: SOURCES.md

Medication in personality disorders. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: ECT and neurostimulation.

Credits and references: retained within the illustration.

AREA 09 OF 13 · P3-A11

Emergency psychiatry

7	6.5%	III-75	III-81
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

HIGH 2 · RECURRENT 1 · SINGLE 4

REVISION ORDER

Suicide risk assessment first, and reuse its structure for the three other suicide slots. Catatonia and NMS next, as one differential. Restraint last, and it is a short structured answer.

WHAT IS IN THIS AREA

Suicide risk assessment, suicide in children, deliberate self-harm in adolescents, family and mass suicide, catatonia, neuroleptic malignant syndrome and restraint.

III - 75

Discuss the assessment of suicide risk. [10]

10 EMERGENCY PSYCHIATRY KNRUHS, KUHS - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2 What is assessed	A formulation of drivers, not a probability
3 The interview	What is asked, and in what order
3 The domains	Static, dynamic, warning, contextual, protective
2 The output	Safety plan, means restriction, dated follow-up

WHAT IS BEING ASSESSED

Not a probability. A suicide risk assessment names this person's current drivers, their access to means, and what would have to change for them to be safer. The interview is itself the instrument, and asking directly about suicide does not plant the idea.

DOMAIN	WHAT IT COVERS	WHAT IT IS FOR	WEIGHT
Static	Previous attempt, chronic illness, family history, age and sex	Sets the baseline	**Previous attempt is the strongest single item**
Dynamic	Depression severity, hopelessness, psychosis, intoxication, pain, insomnia	Treatable	**Where the plan actually acts**
Warning signs	Rehearsal, final acts, giving things away, sudden calm, stated intent	Shifts over hours	Drives the immediate decision
Contextual	Access to means, isolation, recent loss, discharge, debt	Partly removable	Means restriction sits here
Protective	Dependants, responsibilities, faith, help-seeking, engagement	Modifies risk	Never a reason to discharge on its own

- **The interview, in order.** Normalise, then thoughts, then intent, then plan, then preparation and rehearsal, then access to means, then what has held them back so far. Corroborate with a relative wherever possible.
- **Instruments support, they do not decide.** Structured tools are described here, not reproduced. They organise the interview; they do not carry the decision.

PITFALL

Sorting people into low, medium and high risk does not predict who will die, and a low-risk label has been used to justify discharge. Assess drivers and modify them rather than grading and filing. A no-suicide contract is not a safety plan and has no evidence behind it.

WHAT EARNS THE MARKS

- **Risk written as a formulation with named drivers,** not as a category.
- **The direct questions written out in order,** with the myth about planting the idea answered.
- **Means restriction and a dated follow-up carried into the disposition.** An assessment that ends at a label is unfinished.

SEE ALSO Slot III - 80 adolescent with deliberate self-harm Slot III - 79 suicide in children **SPRINT** Day 18, impulse-control disorders and suicide

III - 76

Enumerate catatonic symptoms and describe the management of Catatonia. [10]

10 | EMERGENCY PSYCHIATRY | KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 **The signs**	Enumerated in groups, not as one long list
2 **Recognition**	Screening, and the workup that must run alongside
4 **The pathway**	The flowchart: stop, challenge, titrate, escalate
2 **The malignant form**	What changes when fever and rigidity appear

- **Catatonia is a syndrome, not a diagnosis.** It occurs in mood disorder more often than in schizophrenia, and in medical, neurological and autoimmune illness, so it is screened for rather than waited for.
- **The challenge test is diagnostic and therapeutic at once.** A partial response within ten minutes of 1 to 2 mg of lorazepam supports the diagnosis and starts the treatment.

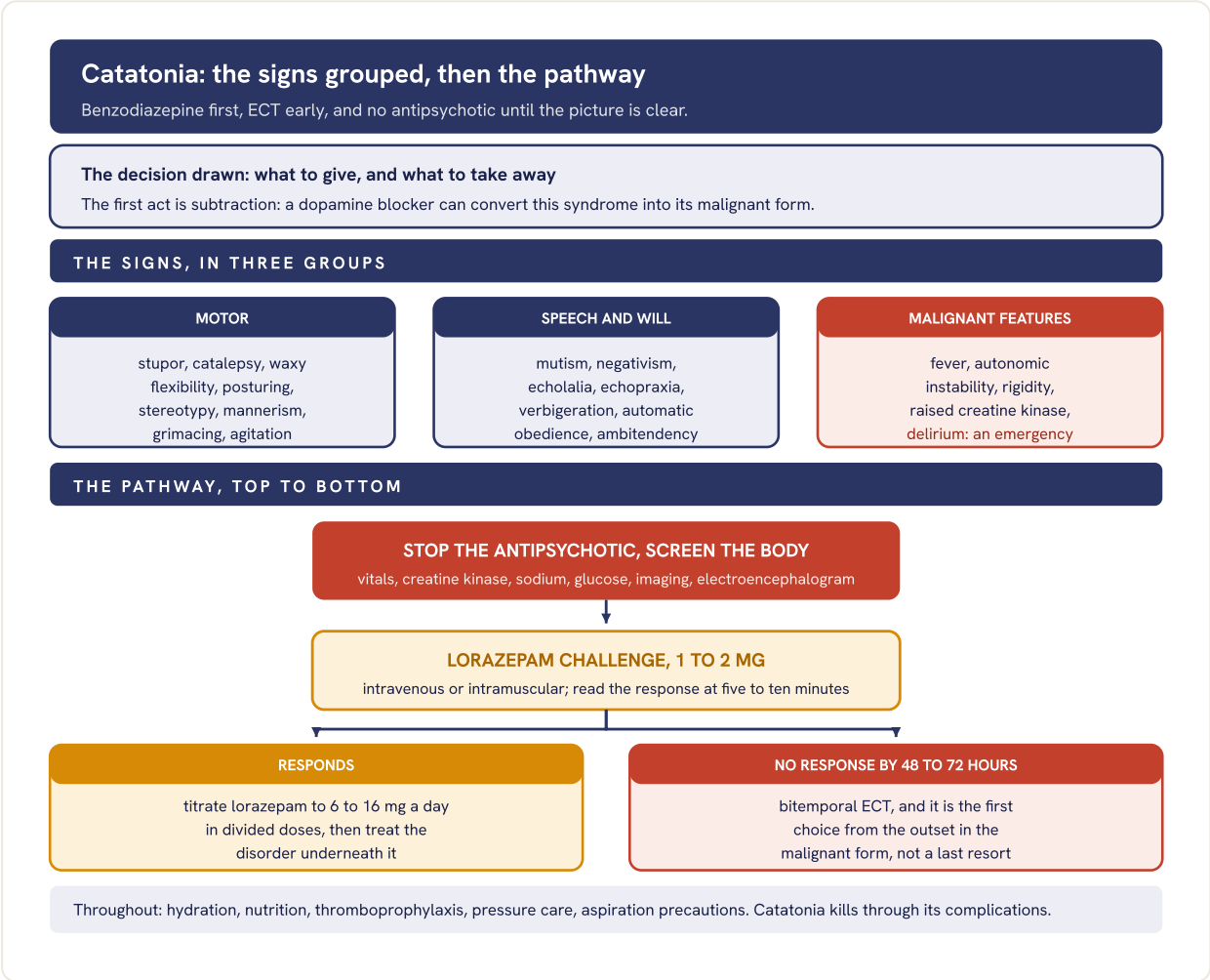


Fig 076.1 Signs above, pathway below, the two branches decided by one challenge dose.

PITFALL

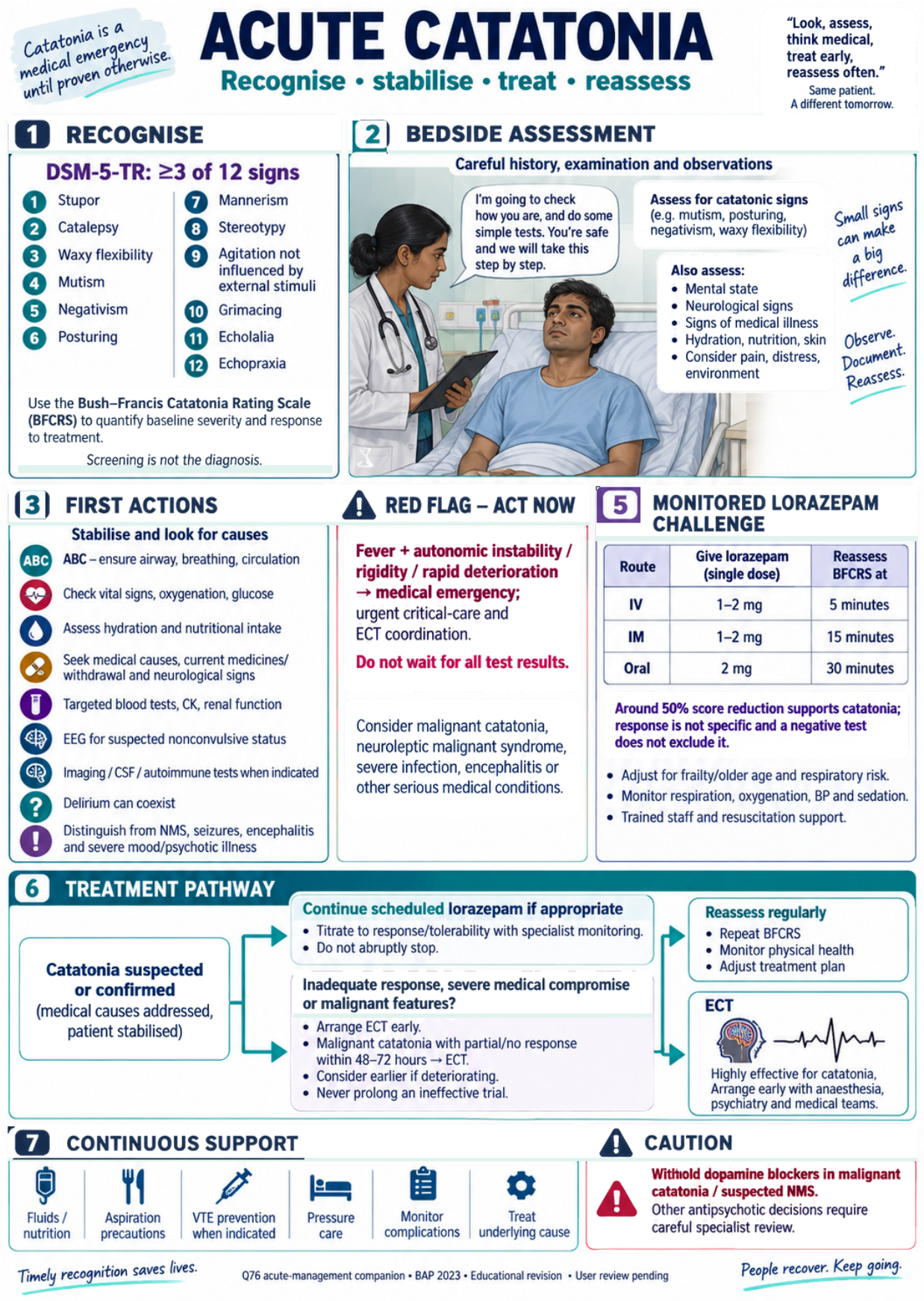
Malignant catatonia and neuroleptic malignant syndrome overlap so closely that some regard them as one condition. With fever, rigidity and autonomic instability, stop the antipsychotic and move to ECT early.

WHAT EARNS THE MARKS

- **The signs enumerated in groups.** Twelve names in one undifferentiated list reads as recall.
- **The lorazepam challenge with its dose, route and reading time.**
- **ECT placed early and named as first choice in the malignant form,** with supportive care written down because immobility is what kills.

SEE ALSO Slot III - 77 neuroleptic malignant syndrome Slot III - 67 indications and contraindications of ECT **SPRINT** Day 10, other psychotic disorders and catatonia

WEAVE 100 · PAPER III · E07



Acute catatonia - detailed emergency pathway. Follow the labelled sequence and connections, then reconstruct the diagram from memory. Read with III-76.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Catatonia: signs and differential

A psychomotor syndrome that can accompany psychiatric or medical illness.

Domain	Revision points
Core signs	Stupor, mutism, negativism, posturing, catalepsy, waxy flexibility, stereotypy, mannerism, grimacing, agitation and echophenomena.
Recognition	Observe spontaneous behaviour and examine deliberately; quantify with a structured scale such as BFCRS.
Differential	Delirium, nonconvulsive status, NMS, serotonin syndrome, akinetic mutism and severe neurological disease.
Medical associations	Consider encephalitis, seizures, metabolic disease, substances and medication changes; catatonia is not specific to schizophrenia.

URGENT

Fever, autonomic instability, rigidity, dehydration or rapidly deteriorating function require urgent medical assessment.

TRAP

Delirium and catatonia can coexist; a single sign or a negative challenge does not settle the diagnosis.

Weave Sprint Paper III; see source register

III 76.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Catatonia: signs and differential. Read across the labelled contrasts to distinguish the related concepts. Read with III-76.

Credits and references: retained within the illustration.

III - 77

Neuroleptic malignant syndrome [10]

10 EMERGENCY PSYCHIATRY KUHS - 3 APPEARANCES, 3 OF 78 SESSIONS

SKELETON

2 Definition	The tetrad, and its time relation to the drug
3 Risk and laboratory	Who gets it, and what supports the diagnosis
3 What must be excluded	There is no confirmatory test, so exclusion is the work
2 Management and after	In order, ending with the rechallenge rule

THE DEFINITION

An idiosyncratic and potentially fatal reaction to dopamine blockade: hyperthermia, generalised lead pipe rigidity, altered sensorium and autonomic instability, arising within two weeks of a dopamine antagonist being started or raised, or of a dopamine agonist being withdrawn.

AXIS	WHAT IS FOUND	WHAT IT IS FOR	WEIGHT
Risk	High potency or parenteral antipsychotic, rapid titration, agitation, dehydration, catatonia, prior episode	Dates the exposure	The drug history dates the syndrome
Laboratory	Creatine kinase often above 1000 units per litre, leucocytosis, low serum iron, myoglobinuria, acidosis	Supports	There is no confirmatory test
Complications	Rhabdomyolysis, acute kidney injury, aspiration, venous thromboembolism, coagulopathy	Sets the monitoring	These, not the fever, kill
Exclusions	Serotonin syndrome, malignant catatonia, malignant hyperthermia, anticholinergic toxicity, infection, heat stroke	Each is treated differently	Exclusion is the diagnosis

- **Management, in order.** Stop the antipsychotic and any lithium or anticholinergic; move to a monitored bed; cool, hydrate and correct electrolytes; add bromocriptine or amantadine, and dantrolene where rigidity and creatine kinase are extreme; ECT where the picture is refractory or overlaps with malignant catatonia.
- **Rechallenge is part of the answer.** Wait at least two weeks after full resolution, choose a lower potency agent, start low, titrate slowly, and monitor temperature and creatine kinase.

WHAT EARNS THE MARKS

- **The tetrad named as a tetrad,** with its time relation to the drug in the same sentence.
- **"No confirmatory test" written down,** with the laboratory findings placed as supporting rather than diagnostic.
- **The rechallenge rule,** which most answers never reach.

SEE ALSO Slot III - 76 catatonia and its management Slot III - 67 indications and contraindications of ECT SPRINT Day 9, antipsychotics and adverse effects

III - 78

Role of psychiatrist in family suicide. How it is different from mass suicide. What are preventive factors. [10]

10 EMERGENCY PSYCHIATRY MUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 **Both defined**	Name the axis, and say the boundary is contested
4 **The grid**	Domain by domain, with the discriminators marked
2 **The role in each**	Individual work against population work
2 **Prevention**	Population measures, means restriction named first

- **The terms, and the honesty they need.** Usage is not settled. Family suicide describes a household dying together, commonly with one dominant instigator and dependants who cannot truly consent. A suicide pact is a mutual agreement, usually between two adults. Mass suicide is a larger group outside a household, moving together under a belief or a leader. Saying the boundaries are contested is a mark, not a hedge.

DOMAIN	FAMILY SUICIDE	MASS SUICIDE	WHAT SETTLES IT
The group	One household, bound by kinship	A congregation or crowd, unrelated	**Kinship against ideology**
The driver	Debt, dishonour, illness in a dominant member, despair over dependants	Belief, charismatic leadership, group contagion	**Private shame against shared belief**
Consent	Children and dependants cannot consent, so the deaths are homicide in law	Adults usually consenting, coercion variable	The legal reading differs entirely
How it reaches care	Through an index patient or a survivor	Through media and community alarm	Different entry point
The role	Risk assessment, safeguarding the dependants, treating the index illness	Public health, media liaison, contagion control, postvention	**Individual work against population work**

PREVENTIVE FACTORS

Means restriction first: pesticide regulation and secure storage carry the largest effect in Indian data. Then debt relief and distress schemes where indebtedness is the driver; responsible media reporting, since detailed coverage of method and place drives imitation; gatekeeper training and accessible helplines; and the Mental Healthcare Act 2017, Section 115, which presumes severe stress in anyone who attempts suicide and removes the criminal shadow that kept families from asking for help.

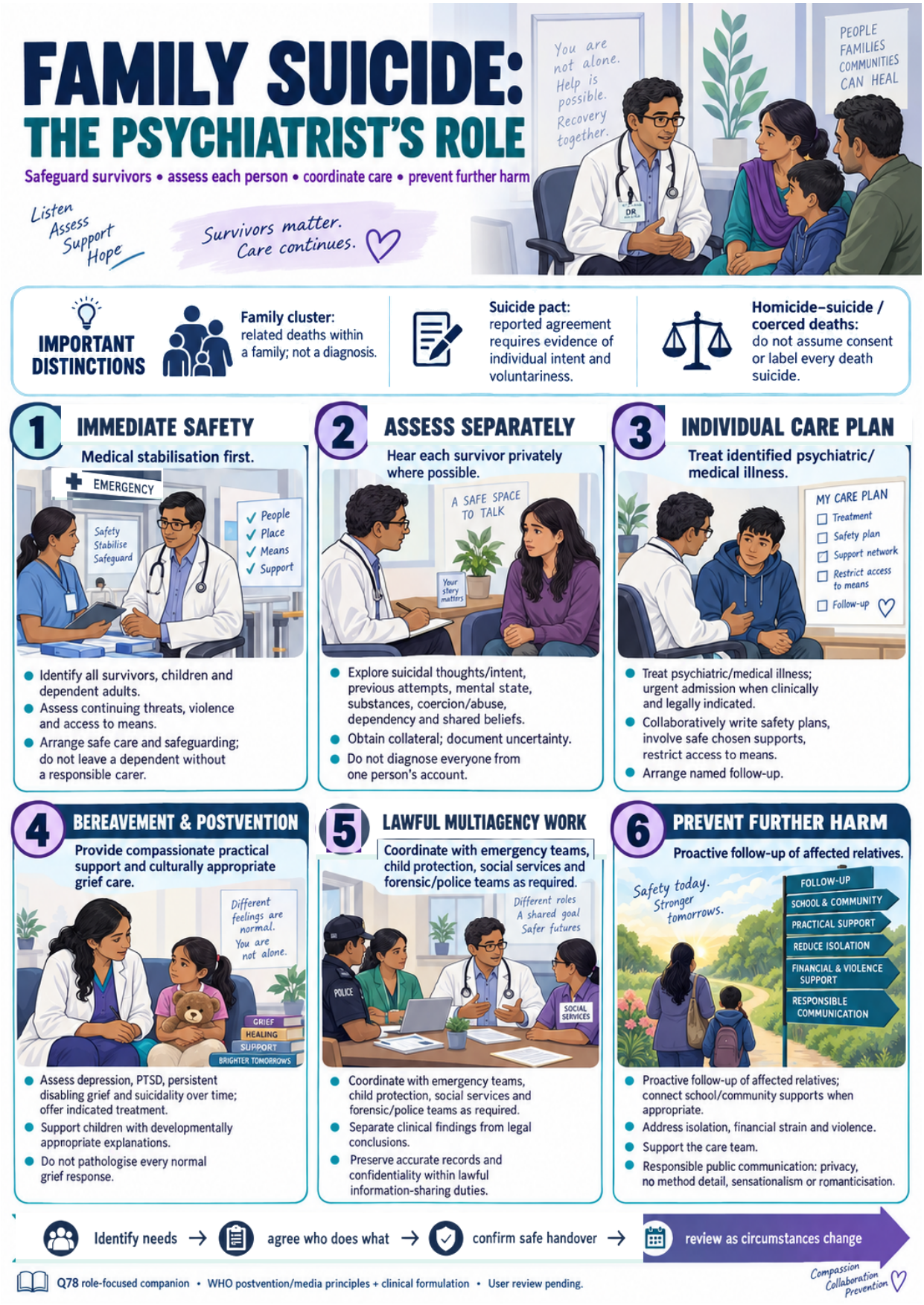
WHAT EARNS THE MARKS

- **Both terms defined before the grid,** with the contested boundary stated in one line.
- **The consent difference made explicit.** Dependent children turn a family death into a homicide question, and that changes everything downstream.
- **Prevention answered at population level,** with means restriction named first rather than last.

SEE ALSO Slot III - 75 assessment of suicide risk Slot III - 79 suicide in children SPRINT

Day 18, impulse-control disorders and suicide

WEAVE 100 · PAPER III · E08



Family suicide - psychiatrist role and postvention. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-78.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Family and mass suicide: concepts

Describe the event carefully without assuming every death was voluntary.

Domain	Revision points
Family cluster	Multiple deaths within a family may involve a pact, coercion, homicide– suicide or distinct acts.
Mass suicide	Multiple deaths linked by a shared setting, belief or group process; intent and coercion require investigation.
Assessment themes	Interpersonal control, shared beliefs, major stressors, mental illness, substance use and access to lethal means.
Response	Protect survivors and children, coordinate emergency/ forensic assessment and offer bereavement support.
Prevention	Recognise threats and coercion, reduce access to means, strengthen support and use responsible communication.

TRAP

Do not label homicide or coerced death a “suicide pact” without evidence.

COMMUNICATION

Avoid sensationalism, detailed methods or romanticising the group or event.

Weave Sprint Paper III; see source register

III 78.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Family and mass suicide: concepts. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-78.

Credits and references: retained within the illustration.

III - 79

Suicide in children. [10]

10 EMERGENCY PSYCHIATRY RGUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	The developmental frame	Why it is rare early and rises through adolescence
3	Risk factors	By domain, and where each one is elicited
3	How it presents	Atypical, and what that does to the interview
2	What is done	Treat, restrict means, plan, refer, follow up

THE DEVELOPMENTAL FRAME

Suicide is rare before puberty and rises steeply across adolescence. The rarity is developmental rather than protective: a younger child's grasp of death as final and irreversible is incomplete, methods are less available, and intent is harder to hold over time. The rise tracks the arrival of mood disorder, impulsivity, autonomy and access.

DOMAIN	WHAT RAISES RISK	WHERE IT IS FOUND	WEIGHT
Psychiatric	Depression, previous attempt, substance use, conduct problems, neurodevelopmental conditions	Direct interview	**Previous attempt is the strongest item**
Family	Bereavement, parental mental illness, family history of suicide, conflict, harsh discipline	Carer interview	Corroboration is essential
Adversity	Physical, sexual and emotional abuse, neglect, bullying including online	Alone, without the carer	**Surfaces only in a private interview**
Situational	Examination failure, humiliation, relationship breakdown, pesticide or medicines at home	Home and school enquiry	Means restriction acts here

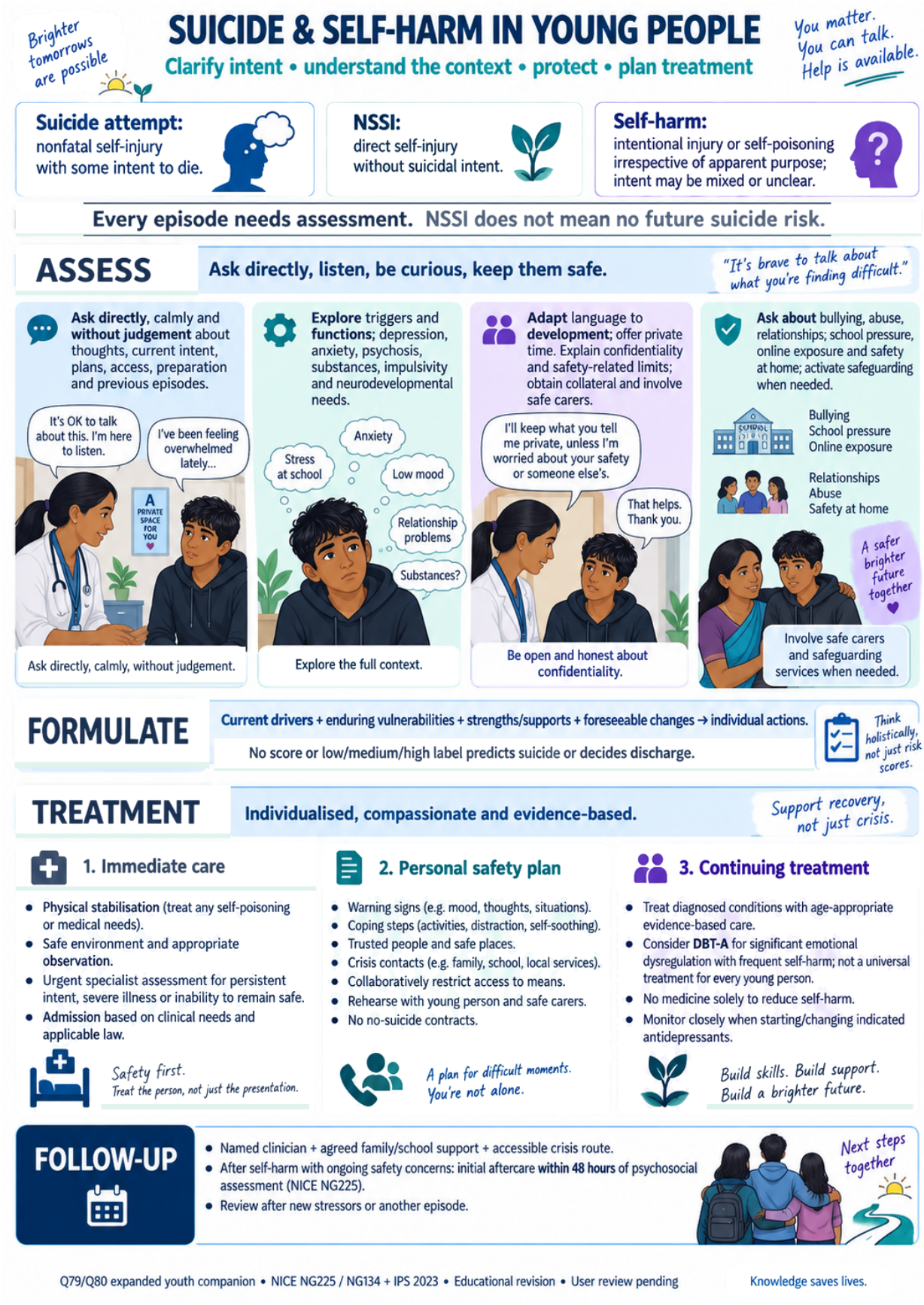
- **Presentation is atypical.** Irritability, behavioural change, falling school performance, somatic complaints and withdrawal more often than a stated wish to die. Direct enquiry is still needed, in the child's own words.
- **What is done.** Treat the disorder, restrict the means at home with the carer present, write a safety plan with both, involve the school, and refer for safeguarding where abuse is disclosed. Follow up within a week, not a month.

WHAT EARNS THE MARKS

- **The developmental frame stated before the risk list.** It converts a list into an explanation.
- **The child interviewed alone, written as a step.** Abuse and bullying surface nowhere else.
- **Means restriction at home and a named follow-up interval,** written into the plan rather than implied.

SEE ALSO Slot III - 80 adolescent with deliberate self-harm Slot III - 75 assessment of suicide risk SPRINT
Day 18, impulse-control disorders and suicide

WEAVE 100 · PAPER III · E09



Suicide and self-harm in young people - Q79-Q80. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-79.

Credits and references: retained within the illustration.

III - 80

Evaluation of an adolescent with deliberate self-harm [10]

10 EMERGENCY PSYCHIATRY KUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 The sequence	Medical first, alone second, carer third
3 The act	Intent read from what was done, not from what is said
3 Person, context, function	Why this act, in this person, on this day
2 Disposition and duties	Admit or discharge, and what the law requires

THE SEQUENCE

Medical stabilisation first, and psychosocial assessment once the acute effects of the act have cleared. Interview the adolescent alone before interviewing the carer, and say at the start what will be kept private and what will not. An assessment done through a parent, or done while the patient is still drowsy, is not an assessment.

AXIS	WHAT IS EXAMINED	THE OPENING QUESTION	WEIGHT
The act	Planning, precautions against discovery, method, expectation of death, final acts, regret now	"What did you think would happen?"	Intent is read from the act
The person	Depression, psychosis, substance use, neurodevelopmental condition, previous self-harm	"Has this happened before?"	Repetition predicts repetition
The context	Family conflict, abuse, bullying, examination pressure, relationship breakdown	"What was happening that day?"	Where the plan will act
The function	Affect regulation, communication, escape, self-punishment	"What did it do for you?"	Separates self-harm from an attempt

- **Two constructs, not one.** Non-suicidal self-injury regulates affect and tends to repeat; a suicide attempt intends death. They coexist in the same adolescent, and the management differs, so the distinction is drawn explicitly rather than assumed.
- **The duties that follow.** The Mental Healthcare Act 2017, Section 115, presumes severe stress and bars prosecution. Sexual abuse disclosed in the interview triggers a mandatory report under the Protection of Children from Sexual Offences Act 2012. A child unsafe at home is a child protection referral, not a discharge.

WHAT EARNS THE MARKS

- **The order stated:** medical, then the adolescent alone, then the carer, with confidentiality framed at the start.
- **Intent inferred from the act,** with the markers named rather than gestured at.
- **Disposition written out:** means restriction, a carer conversation, a safety plan and a dated follow-up.

SEE ALSO Slot III - 75 assessment of suicide risk Slot III - 79 suicide in children SPRINT Day 18, impulse-control disorders and suicide

III - 81

Use of restraints in Psychiatric Emergencies. Advantages and Complications. [10]

10 | ASKED AT 7 MARKS | EMERGENCY PSYCHIATRY

TN-MGRMU - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2 **What restraint is**	Four kinds, named separately
2 **The legal frame**	What the Act bars outright, and what it permits
3 **Advantages**	Time-limited and purpose-bound, never general
3 **Complications**	Physical, psychological, and at service level

THE DEFINITION AND THE LAW

Restraint covers physical holding, mechanical devices, chemical restraint by rapid tranquillisation, and seclusion. The Mental Healthcare Act 2017 prohibits chaining in any form under Section 95, and under Section 97 bars seclusion and solitary confinement outright while permitting physical restraint only as the last means of preventing imminent harm, authorised by the psychiatrist in charge, recorded, reported to the Board, and never used for punishment or staff convenience.

AXIS	ADVANTAGE CLAIMED	COMPLICATION	WEIGHT
Immediate safety	Prevents assault, absconding and self-injury in the minutes before treatment acts	Positional asphyxia, aspiration, fracture, nerve and soft tissue injury during the hold	**Prone holding is the one that kills**
Enabling care	Permits examination, venous access and essential treatment	Rhabdomyolysis, venous thromboembolism, pressure injury, dehydration, hyperthermia	**Duration multiplies every risk**
Predictability	A rehearsed, time-limited procedure beats an unplanned struggle	Retraumatisation, loss of trust, disengagement, especially after abuse	Recorded in the relationship too
Service level	Buys time for de-escalation and for medication to work	Becomes a substitute for staffing, training and ward design	Rising rates are a service defect

- **What makes it defensible.** De-escalation attempted and recorded first; the least restrictive option; a named time limit with review; continuous observation with airway, circulation and posture monitored; the indication documented; and a debrief with the patient afterwards.
- **Chemical restraint is restraint.** Rapid tranquillisation carries over-sedation, respiratory depression, hypotension, dystonia and QT prolongation, and is governed by the same rules as a mechanical device. Calling it treatment does not exempt it.

WHAT EARNS THE MARKS

- **The four kinds named separately,** with the Act's prohibitions stated exactly rather than paraphrased as "restraint is discouraged".
- **Advantages written as time-limited and purpose-bound,** never as general benefits.
- **Physical complications separated from psychological ones,** with positional asphyxia named.

SEE ALSO Slot III - 76 catatonia and its management Slot III - 77 neuroleptic malignant syndrome **SPRINT** Day 25, Mental health legislation and forensic psychiatry

WEAVE 100 · PAPER III · legacy-81.1

WEAVE 100+ / PAPER III • 81.1

Restraint in psychiatric emergencies

LEGAL ACTS APPENDIX • III Q 81 • indications, safeguards, advantages and complications

1 DEFINE & START WITH ALTERNATIVES

Physical restraint	Restricts movement to prevent immediate harm. **Last resort**, not routine care, punishment or a response to staff shortage.
Before restraint	De-escalate; calm environment; address pain, delirium, intoxication and unmet needs; offer appropriate treatment; call trained help.

2 LEGAL DECISION • MHCA §97

Imminent and immediate harm to person/others? Alternatives insufficient?

No → continue less restrictive care

Yes → only available means; **psychiatrist in charge authorises**

Minimum necessary restraint for **shortest necessary duration** → ongoing reassessment → stop promptly

3 NON-NEGOTIABLE SAFEGUARDS

Prohibited	**Seclusion / solitary confinement and chaining**. No punishment, deterrence or staff-shortage justification.
Document now	Method, nature, reason, alternatives attempted, authorisation, start/stop times and clinical response.
Observe	Regular ongoing clinical supervision; airway, breathing, circulation, consciousness, skin/limbs, vital signs and distress. Avoid dangerous positioning or pressure.
Communicate	Inform NR about **every episode within 24 h**. Include episodes in **monthly Board report**.
Review	Debrief person/team; address trauma, triggers and prevention; document why restraint ceased or continued.

4 BENEFITS vs HARMS

Potential benefit	Temporary prevention of serious immediate injury; permits urgent assessment/treatment when no safer option exists.
Physical harms	Asphyxia, aspiration, injury, impaired circulation, pressure damage, dehydration, rhabdomyolysis and thromboembolism.
Psychological harms	Fear, humiliation, retraumatisation, anger, damaged alliance and avoidance of care.
Service harms	Staff injury, escalation, legal liability and normalisation of coercion.

5 RELATED LAW: §94 IS SEPARATE

Emergency care	Urgent treatment only for defined emergencies; **NR consent where available**; ≤72 h or assessment at MHE, whichever earlier. Declared-disaster exception and §114 modifications exist.
Not a shortcut	Emergency treatment does not cancel restraint safeguards; **no ECT under §94**. Sedation requires its own clinical justification and monitoring.

DE-ESCALATE → JUSTIFY → AUTHORISE → MONITOR → STOP → REVIEW

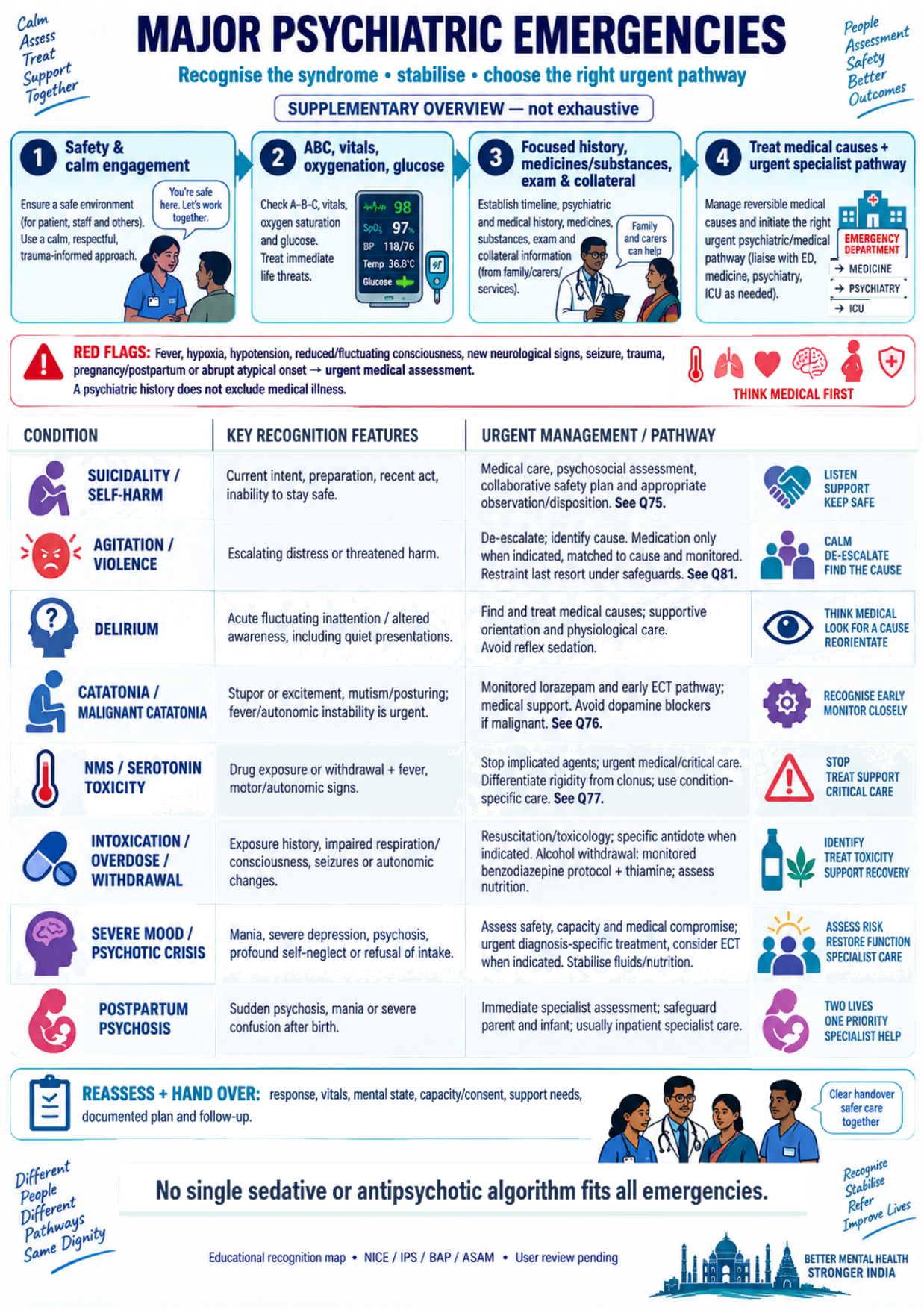
Mental Healthcare Act 2017, India Code. Standard national time limits shown; §114 modifies specified regions.

Exam revision • Checked 19 Sep 2026 • Full source links and qualifications in source record

Restraint in psychiatric emergencies. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-81.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · E10



Supplement Major psychiatric emergencies. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Emergency psychiatry.

Credits and references: retained within the illustration.

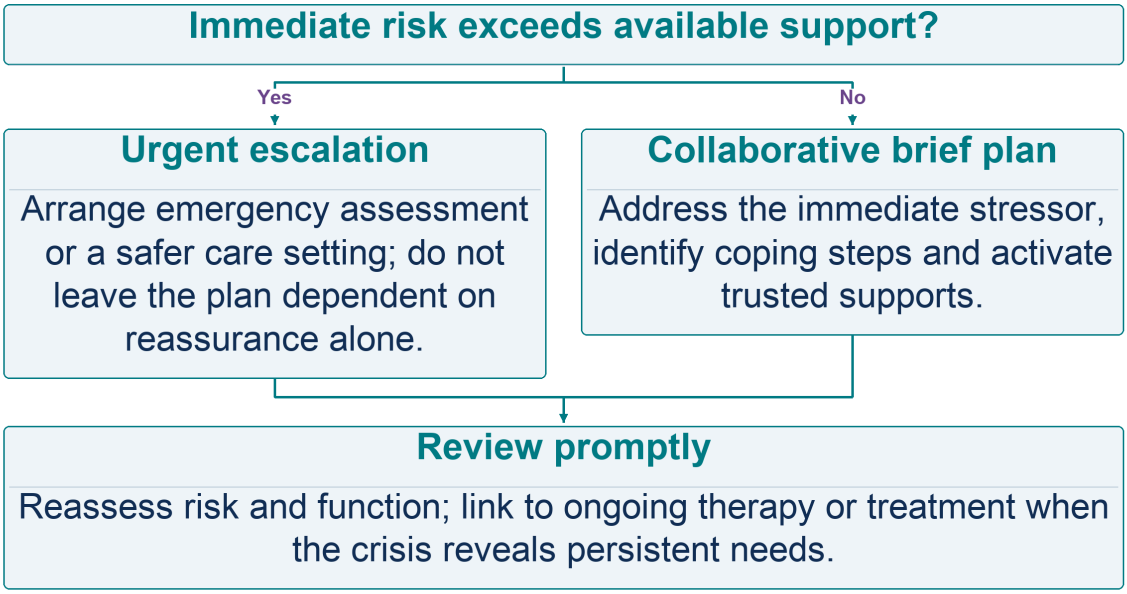
WEAVE 100+ / PAPER III

Crisis intervention

Restore safety and workable coping around a time-limited crisis.

Domain	Revision points
Assessment	Precipitant, current meaning, coping failure, supports, substances and psychiatric/ medical state.
Goals	Immediate safety, emotional containment, practical priorities and mobilisation of support.
Methods	Active listening, collaborative problem definition, small feasible actions and a written follow-up plan.

DECISION PATHWAY



DISTINCTION

Crisis intervention is not compulsory emotional debriefing or a promise that one session resolves the underlying disorder.

Weave Sprint Paper III; see source register

III 75.2 • Supplement • Source links and qualifications: SOURCES.md

Crisis intervention. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Emergency psychiatry.

Credits and references: retained within the illustration.

AREA 10 OF 13 · P3-A12

Perinatal and women's mental health

7	6.3%	III-82	III-88
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

HIGH 1 SINGLE 6

REVISION ORDER

One classification of postpartum illness answers five of these seven slots, so build it once and reuse it. The bonding slot and the assessment slot are the two that need their own material.

WHAT IS IN THIS AREA

Postpartum psychosis in two slots, postpartum depression, postpartum blues, assessment in the postpartum period, the psychiatric disorders of pregnancy and childbirth, and the effect of postpartum illness on infant-mother bonding.

III - 82

Describe the assessment of mental illness during postpartum period. [10]

10 PERINATAL AND WOMEN'S MENTAL HEALTH KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	What is different here	Four things a general assessment does not carry
3	Timing and the body	Onset dates the syndrome; the puerperium is a medical risk period
3	The interview	The mother, the infant, and the household around them
2	Red flags	What moves this to the same day

WHAT MAKES THIS ASSESSMENT DIFFERENT

Four things a general psychiatric assessment does not carry: the timing of onset relative to delivery, a deliberate physical screen because the puerperium is a period of high medical risk, the infant as a second patient, and a safety triad of suicide, harm to the infant, and neglect.

AXIS	WHAT IS ASKED OR DONE	WHY	WEIGHT
Timing	Onset in the first days, within two weeks, or later in the first year	The syndromes separate on timing	**The first discriminator**
Physical	Temperature, pulse, pressure, bleeding, haemoglobin, thyroid, glucose, infection screen	Sepsis, eclampsia, thyroiditis and anaemia all present as mental change	**Confusion is organic until proved otherwise**
The infant	Feeding, weight, who is caring, bonding, and thoughts about the infant	The infant's safety is part of the assessment	Asked directly, without alarm
Screening	Brief postnatal instruments, described here and not reproduced	Finds what an open question misses	Never a substitute for the interview

- **The interview, adapted.** Ask about her sleep separately from the infant's; ask about intrusive thoughts of harm in a way that makes them safe to disclose; ask how she judges her own competence. Take a collateral history from the partner and the household, since symptoms are under-reported by the mother herself.
- **Red flags for same-day action.** New or rapidly changing symptoms, perplexity or confusion, pervasive guilt or hopelessness, estrangement from the infant, and any thought of harm to herself or the infant carrying intent.

WHAT EARNS THE MARKS

- **Timing used as the first discriminator,** before any symptom list.
- **The physical screen written as a step,** not assumed to have been done by obstetrics.
- **The infant assessed as a second patient,** with the direct question about harm asked and recorded.

SEE ALSO Slot III - 83 postpartum psychosis Slot III - 88 postpartum blues **SPRINT** Day 28, perinatal and women's mental health

WEAVE 100+ / PAPER III

Postpartum blues, depression and psychosis

Timing helps, but severity and reality testing determine urgency.

Syndrome	Clinical pattern	Response
Blues	Transient tearfulness and emotional lability in early postpartum days; usually settles within 2 weeks.	Support, sleep and reassessment if persistent or severe.
Depression	Sustained depressive syndrome with distress/ impairment; may include anxiety or intrusive thoughts.	Assess risk and offer severity-appropriate treatment.
Psychosis	Abrupt mood/ psychotic symptoms, marked confusion or behavioural change, often early postpartum.	Psychiatric emergency: urgent specialist assessment and safety plan.
Key distinction	Unwanted ego-dystonic intrusive thoughts differ from delusional conviction or intent.	Explore carefully rather than assuming risk from a thought alone.

EMERGENCY

Suicidality, thoughts of harming the infant with intent, psychosis or inability to provide safe care need urgent action.

Weave Sprint Paper III; see source register

III 82.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Postpartum blues, depression and psychosis. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-82.

Credits and references: retained within the illustration.

III - 83

Postpartum Psychosis. [10]

10 PERINATAL AND WOMEN'S MENTAL HEALTH KNRUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 Definition	Onset in days, and the frequency quoted as a range
3 Phenomenology	Fluctuating, perplexed, and often about the infant
3 Where it belongs	An affective illness, and who is most at risk
2 Differential and course	Delirium excluded; episode and illness judged apart

THE DEFINITION

An acute psychotic episode arising almost always within the first two weeks after delivery, most within the first few days, and classically quoted at one to two per thousand deliveries. It is a psychiatric emergency, because of the risk of suicide and of harm to the infant.

- **The picture is unstable.** Kaleidoscopic and changing hour to hour, with perplexity and clouding that resemble delirium, delusions and hallucinations often concerning the infant, and disorganisation. Insomnia and restlessness are usually the first signs the family notices.
- **It is mostly a bipolar illness.** Most episodes are affective, and most women either have or later declare bipolar disorder. Treatment and prophylaxis follow that reading rather than a schizophrenia reading, and saying so is the mark.

AXIS	WHAT IS FOUND	WHY IT MATTERS	WEIGHT
Risk	Bipolar disorder, previous puerperal episode, primiparity, sleep loss, family history, a stopped mood stabiliser	Decides who is watched	**Bipolar disorder carries the highest risk**
Differential	Delirium from sepsis, eclampsia, thyroid or electrolyte disturbance, substance withdrawal	The presentations overlap	**Confusion is investigated, not assumed**
Course	Onset in days, resolution over weeks with treatment, recurrence in a later puerperium	Sets prophylaxis	High enough to plan for
Outcome	Good for the episode, with continuing risk of further affective illness	Answers the prognosis part	Episode and illness differ

WHAT EARNS THE MARKS

- **Onset timed in days,** with the frequency given as a quoted range rather than a bare number.
- **The bipolar reading stated,** because it drives both treatment and prophylaxis.
- **Delirium excluded explicitly.** Perplexity is the shared feature, and the physical causes are the ones that kill quickly.

SEE ALSO Slot III - 85 aetiology and management of postpartum psychosis

Slot III - 82 assessment in the postpartum period SPRINT Day 28, perinatal and women's mental health

WEAVE 100 · PAPER III · legacy-83.1

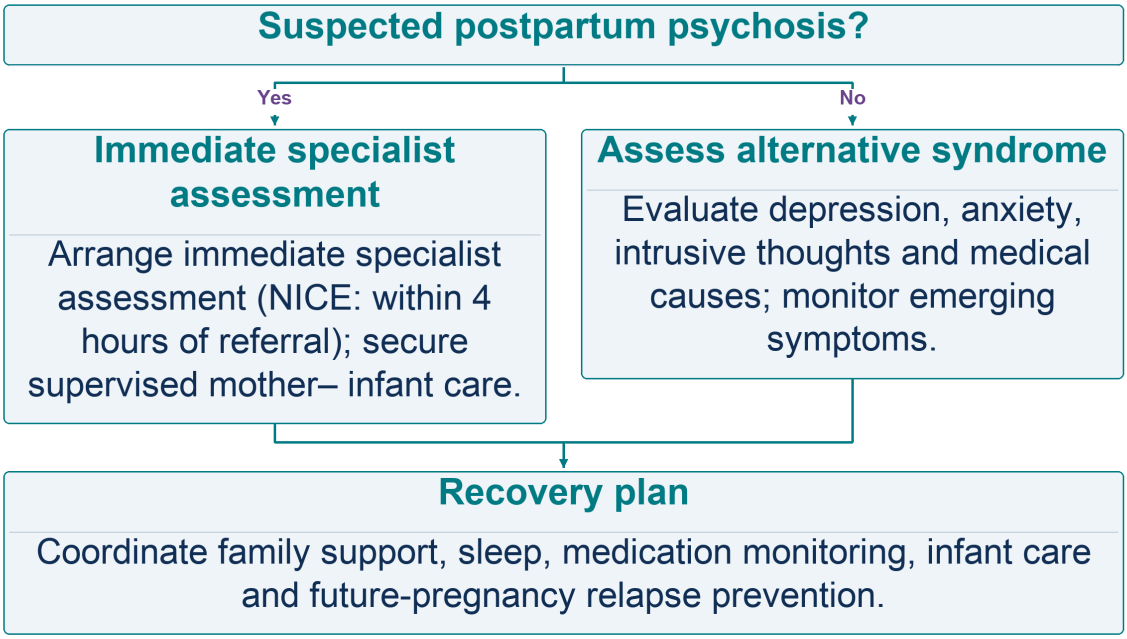
WEAVE 100+ / PAPER III

Postpartum psychosis: emergency care

Protect the mother and infant while treating the acute illness.

Domain	Revision points
Assessment	Mood, psychosis, confusion, sleep, suicidality, infant-related beliefs and capacity; obtain collateral history.
Exclude contributors	Medical/ obstetric illness, delirium, substance exposure and medication effects.
Treatment	Specialist antipsychotic/ mood-stabilising treatment; ECT may be appropriate in severe or urgent presentations.
Infant feeding	Discuss medication exposure, sleep protection and feeding options individually; involve paediatric/ perinatal expertise.

DECISION PATHWAY



Weave 100 III-83; NICE CG192 recommendation 1.5.12.

III 83.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Postpartum psychosis: emergency care. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-83.

Credits and references: retained within the illustration.

III - 84

Psychiatric disorders associated with pregnancy and child birth [10]

10 PERINATAL AND WOMEN'S MENTAL HEALTH KUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	The axis	A timeline from conception to the end of the first year
3	Antenatal	Half the answer, and the half most candidates skip
3	Postnatal	The three syndromes, separated on timing
2	Loss and context	Bereavement after loss, and the Indian risk picture

THE FRAME

Pregnancy is not protective. Ordering the answer by time, from conception to the end of the first postnatal year, turns a list into a map, and it is also how a clinician actually thinks: what is likely now, in this woman, at this point.

PERIOD	WHAT OCCURS	WHAT IS SPECIFIC	WEIGHT
Antenatal	Depression, anxiety, tokophobia, obsessive-compulsive disorder, relapse on stopping medication, substance use	As common as post-natal depression, less often detected	The commonest missed diagnosis
Around delivery	Acute stress and post-traumatic stress after a frightening or complicated delivery	The event drives it, not the hormones	Ask about the deliv-ery itself
First two weeks	Blues, and puerperal psychosis	Timing separates them	Confusion moves it out of blues
First year	Depression, anxiety with intrusive harm thoughts, bonding disorder	Overlaps with ordi-nary exhaustion	Function is the test
Pregnancy loss	Grief, depression and anxiety after miscar-riage, stillbirth or termination	Often unacknowl-edged by the family	Named loss, named grief

- **The Indian context belongs in this answer.** Son preference, intimate partner and dowry-related violence, early marriage, anaemia and undernutrition, and limited say in decisions all raise risk. The joint household can protect or crowd, depending on the relationships inside it.
- **The commonest error is starting at delivery.** Half the material is antenatal, and an answer that opens with the blues has already given away those marks.

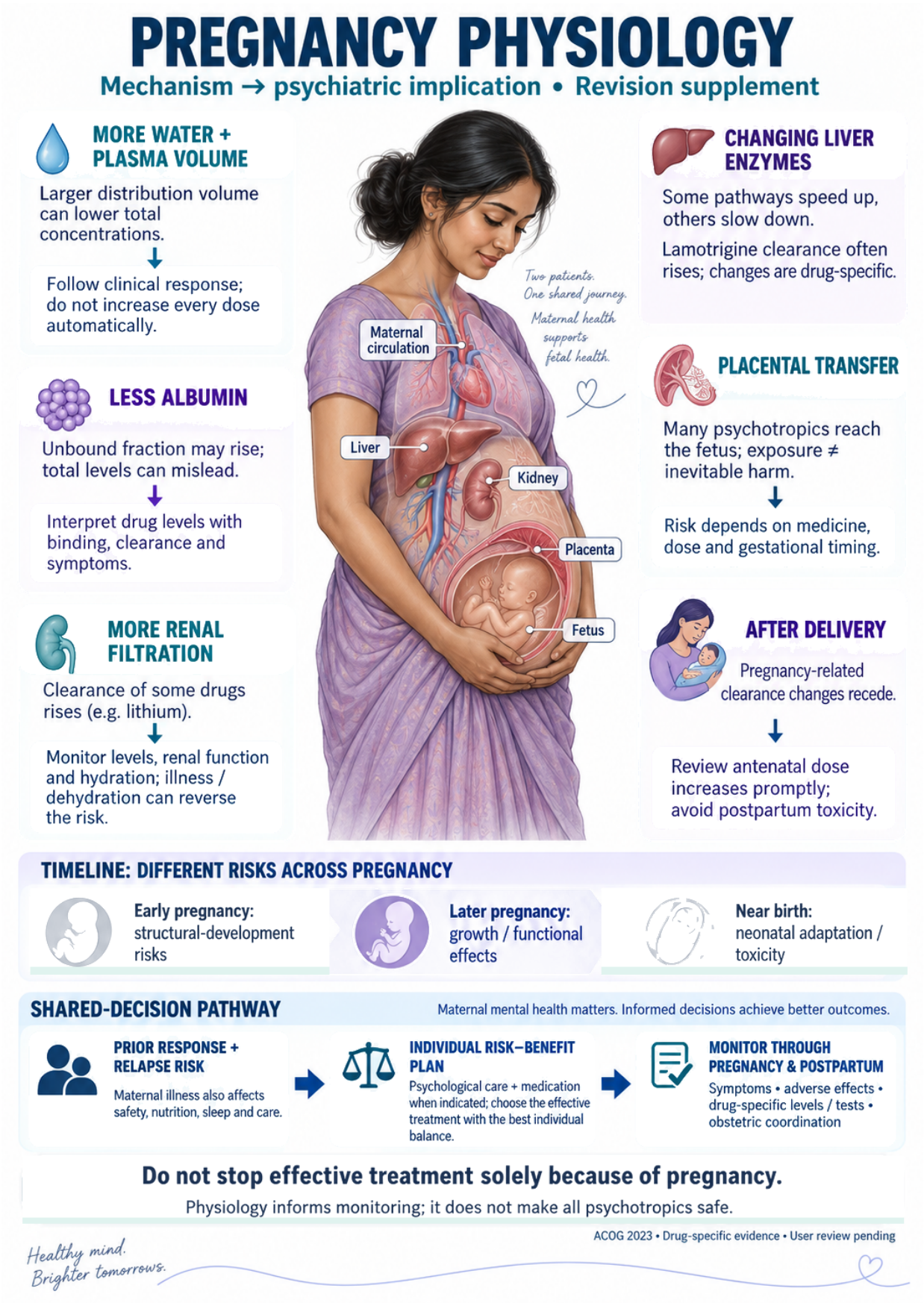
WHAT EARNS THE MARKS

- **A timeline used as the organising axis,** stated before the first disorder is named.
- **Antenatal illness given real weight,** not one sentence on the way to the puerperium.
- **Pregnancy loss included,** since most answers stop at a live birth.

SEE ALSO Slot III - 86 postpartum depression Slot III - 88 postpartum blues SPRINT

Day 28, perinatal and women's mental health

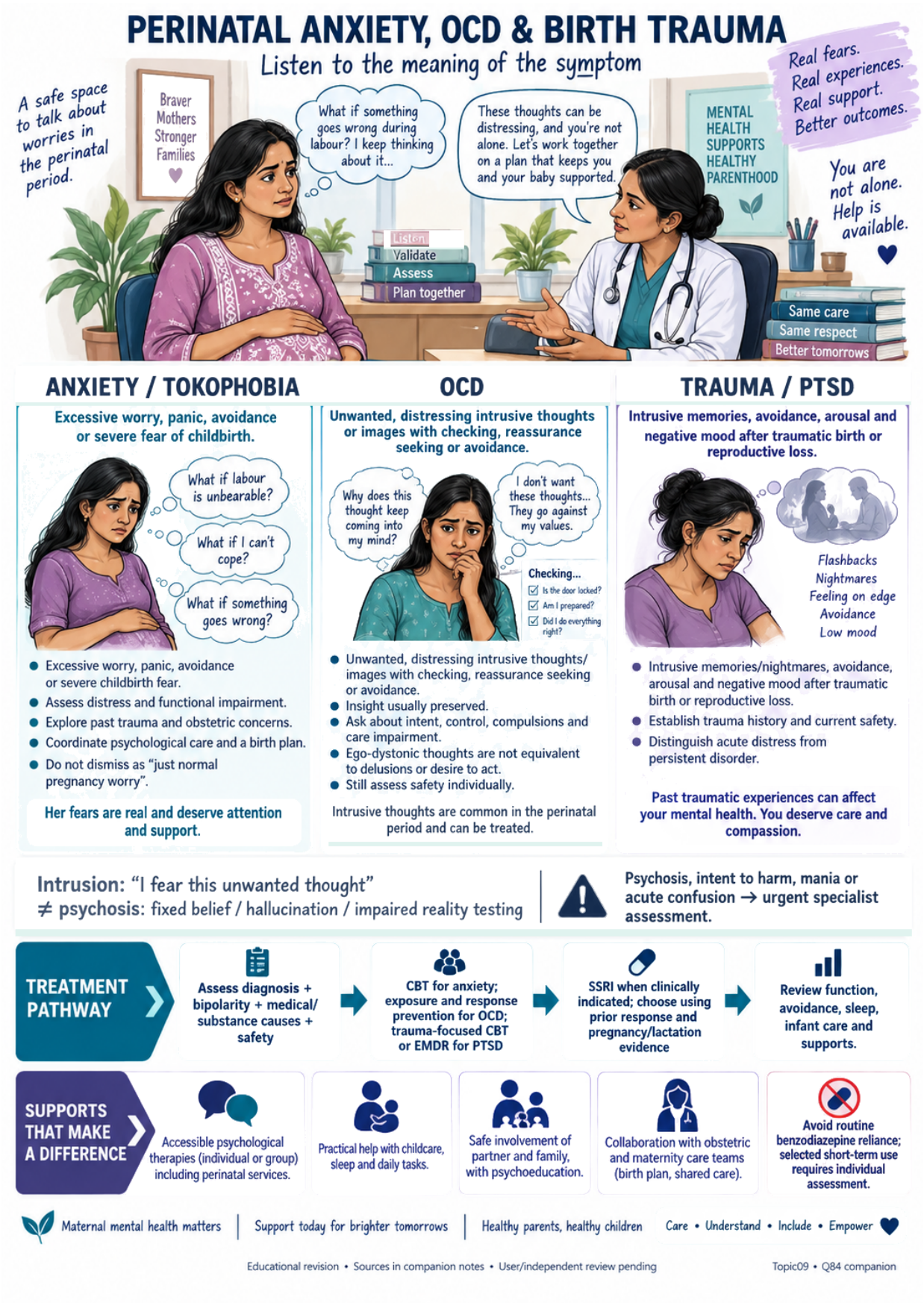
WEAVE 100 · PAPER III · W01



Pregnancy physiology. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-84.

Credits and references: retained within the illustration.

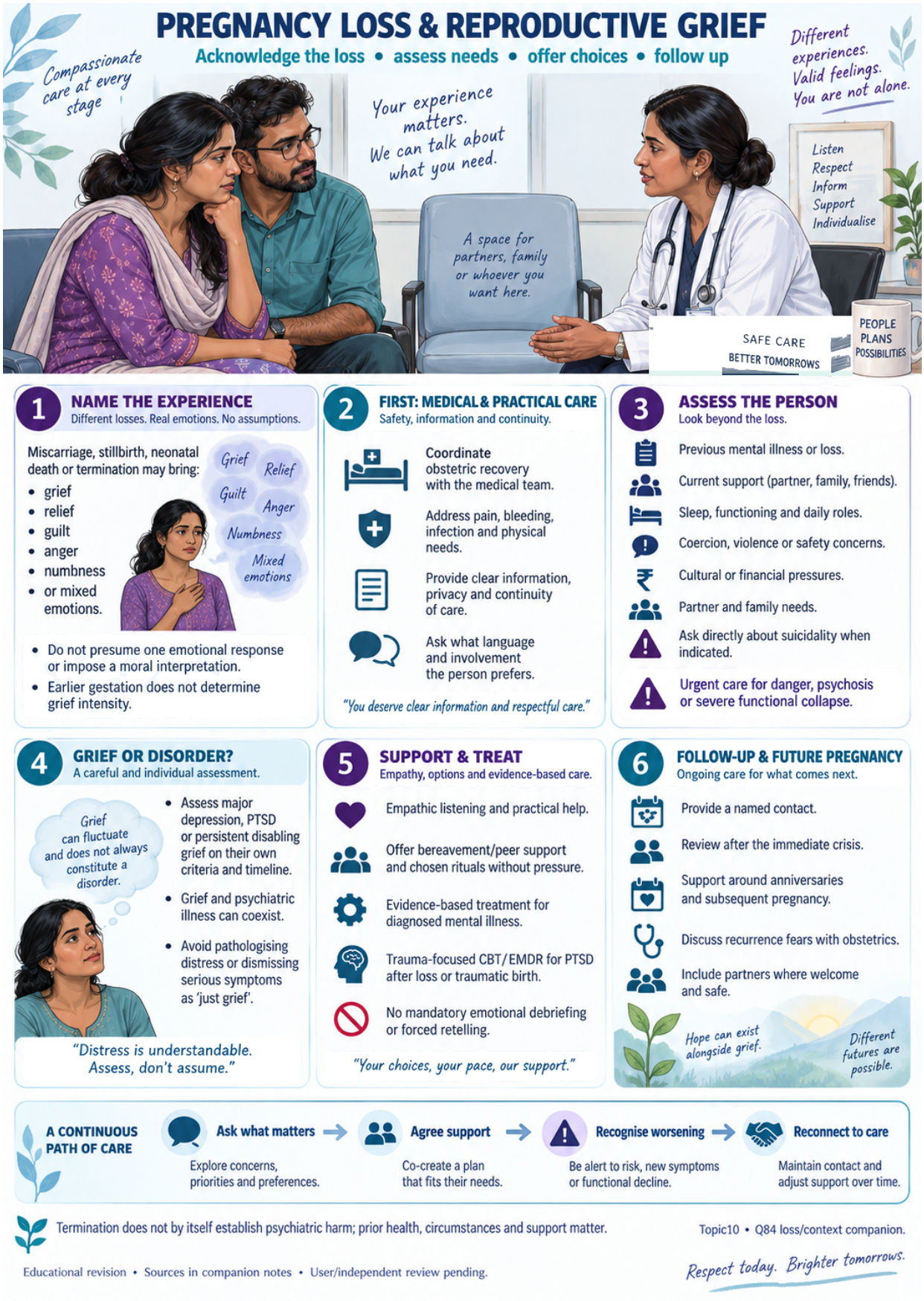
WEAVE 100 · PAPER III · W09



Perinatal anxiety OCD and birth trauma. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-84.

Credits and references: retained within the illustration.

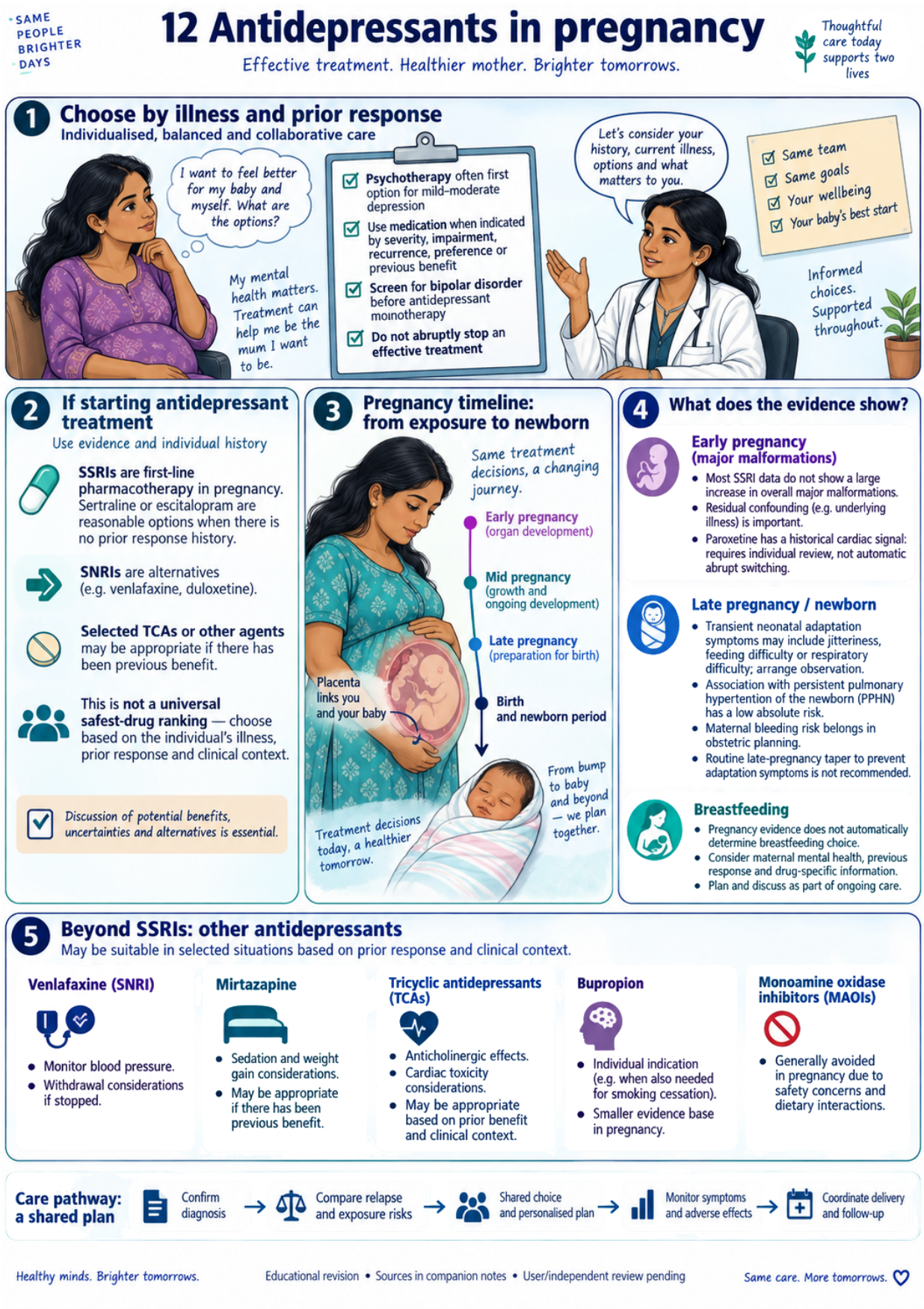
WEAVE 100 · PAPER III · W10



Pregnancy loss and reproductive grief. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-84.

Credits and references: retained within the illustration.

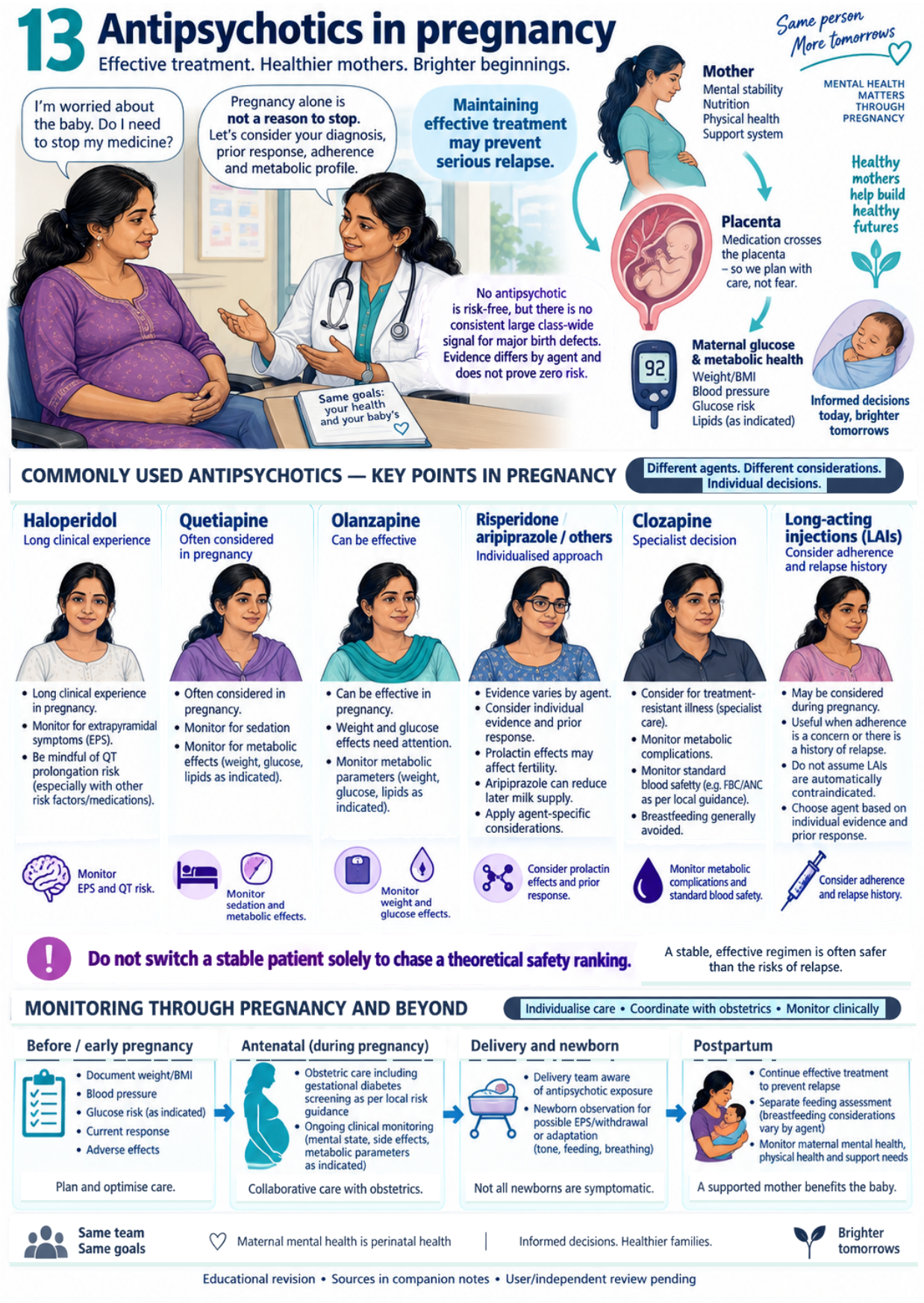
WEAVE 100 · PAPER III · W12



Antidepressants in pregnancy. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-84.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · W13



Antipsychotics in pregnancy. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-84.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · W14



Mood stabilisers in pregnancy. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-84.

Credits and references: retained within the illustration.

III - 85

Describe the clinical features, aetiology and management of post-partum psychosis. [10]

10 PERINATAL AND WOMEN'S MENTAL HEALTH

KUHS, NTRUHS - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2	Clinical features	One line each, ending with the two risks
3	Aetiology	Three groups, with the strongest predictor named
4	Management	The flowchart: admit, exclude, treat, escalate
1	Next time	Prophylaxis before the next delivery

- **The features, one line each.** Onset within days of delivery; insomnia and restlessness first; a fluctuating, perplexed picture with clouding; delusions and hallucinations often about the infant; disorganisation; and rapid change from hour to hour.
- **Two risks are asked about by name.** Suicide, and harm to the infant. Both are asked directly, recorded, and used to set the level of observation rather than left as an impression.

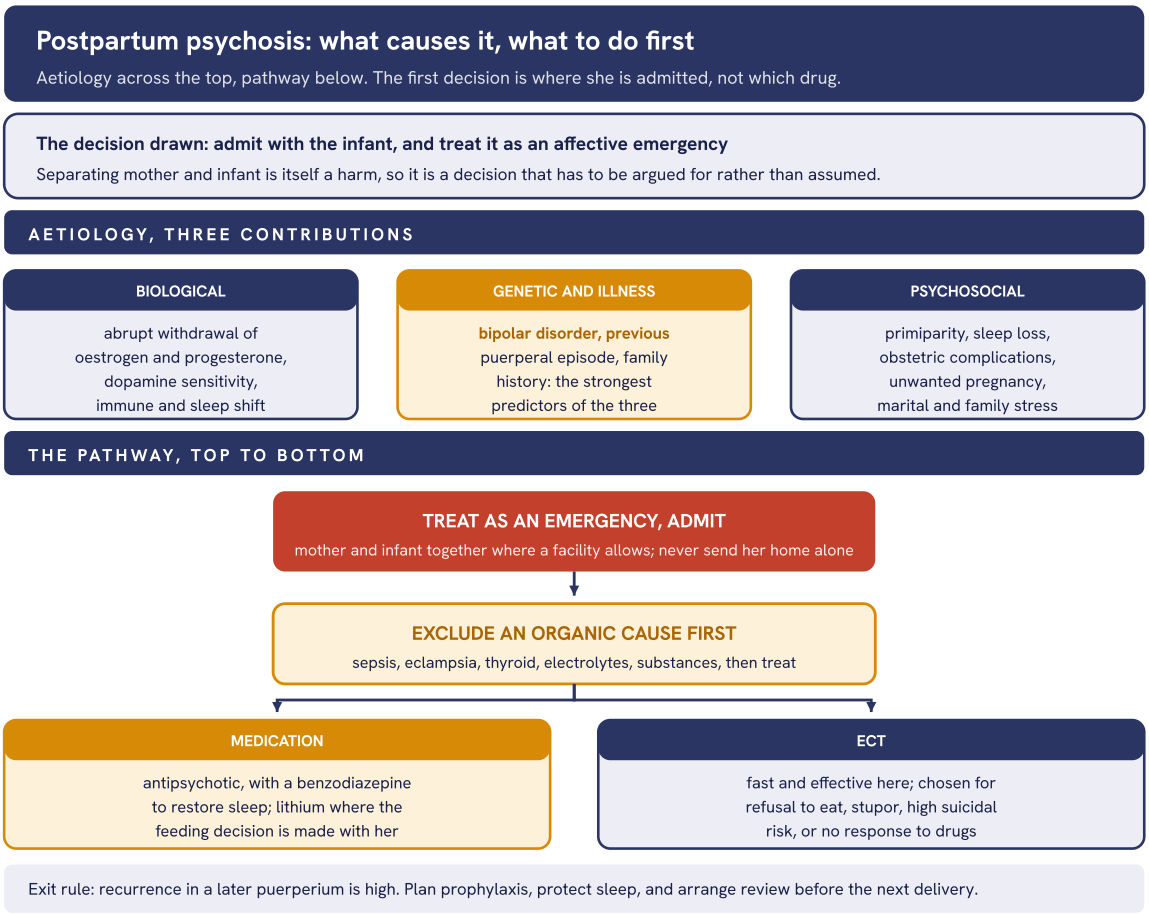


Fig 085.1 Aetiology above, pathway below, with medication and ECT as parallel options rather than a sequence.

WHAT EARNS THE MARKS

- **Aetiology answered in three groups,** with the bipolar loading named as the strongest single predictor.
- **Admission written as the first management step,** with the infant considered rather than assumed away.
- **ECT placed as a real early option,** not a footnote, and prophylaxis for the next pregnancy stated before the answer ends.

SEE ALSO Slot III - 83 postpartum psychosis as an entity Slot III - 86 postpartum depression **SPRINT** Day 28, perinatal and women's mental health

III - 86

Describe the clinical features and management of postpartum depression. [10]

10 | PERINATAL AND WOMEN'S MENTAL HEALTH | KUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 **Clinical features**	The ones specific to this setting
2 **The neighbours**	Blues one side, psychosis the other
4 **Management**	The flowchart: screen, stratify, treat
2 **Feeding, follow-up**	Lactation principle, and how long to continue

WHAT SEPARATES IT FROM ITS NEIGHBOURS

Blues peaks around the fifth day and settles within a fortnight untreated. Depression persists past two weeks, impairs function, and carries guilt and unwanted intrusive thoughts about the infant. Psychosis adds perplexity, delusions and loss of insight.

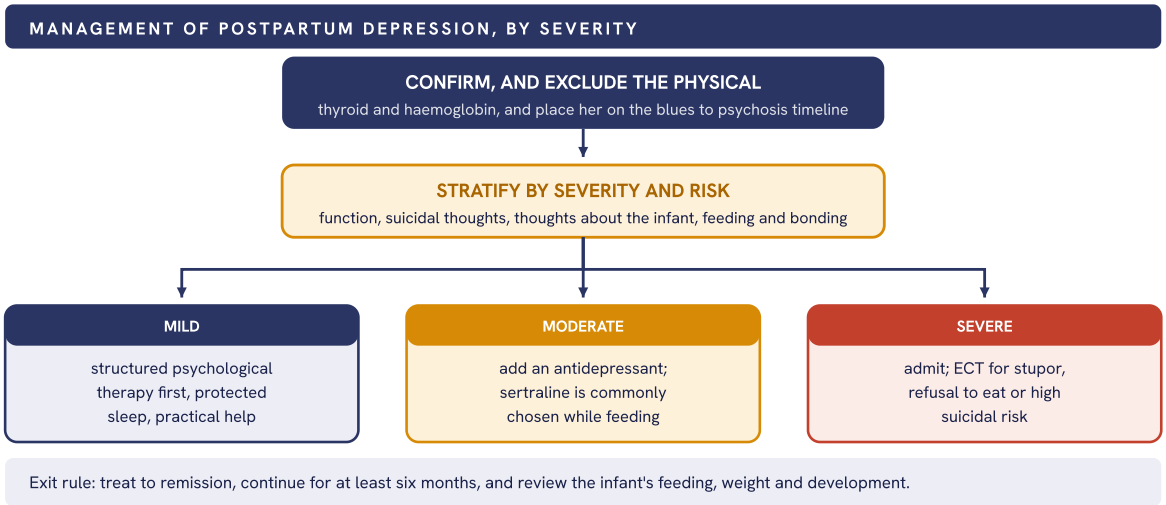


Fig 086.1 Severity chosen before treatment, with the physical screen above the fork so it cannot be skipped.

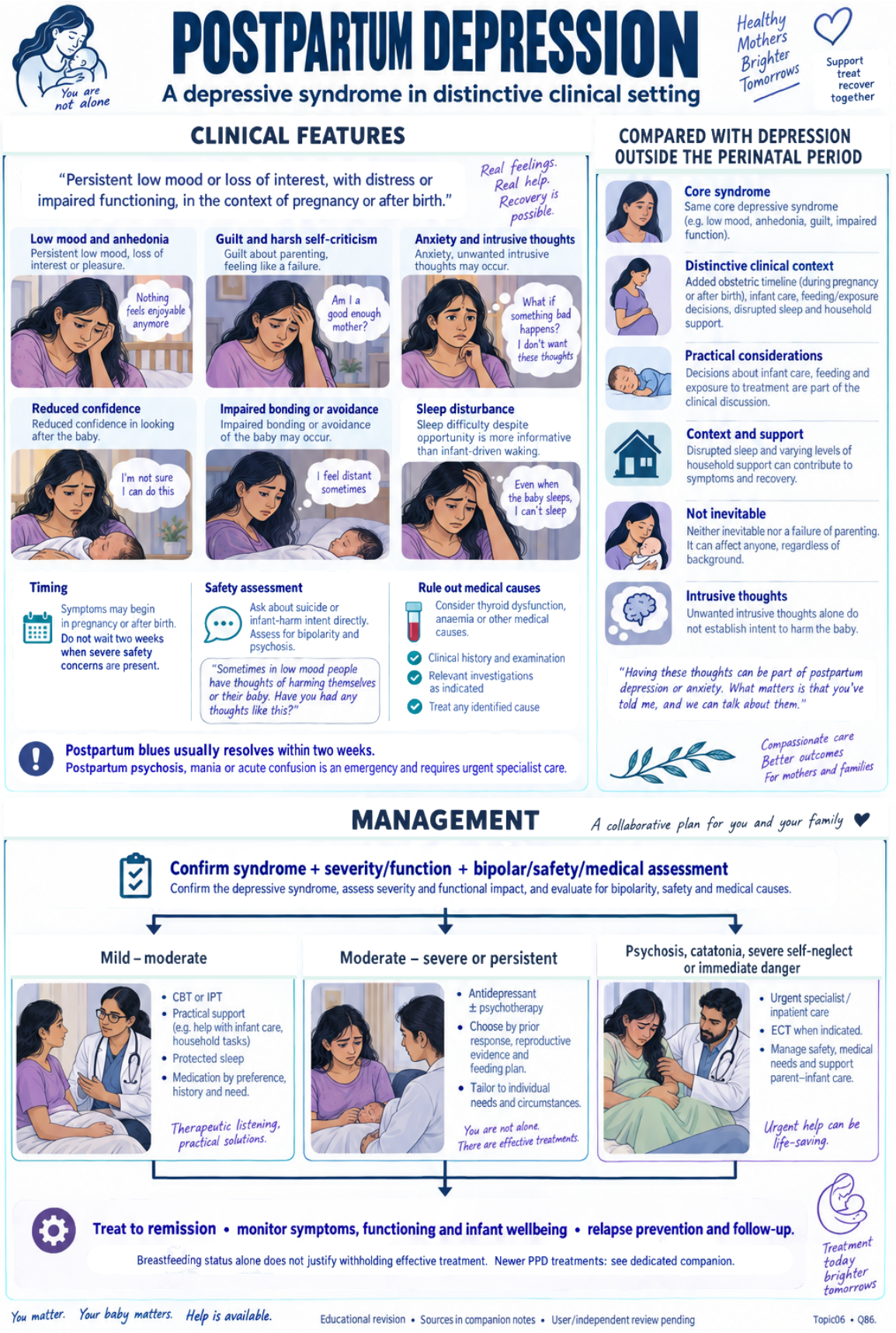
- **The features that are specific.** Guilt attached to being a bad mother; unwanted intrusive harm thoughts; sleep disturbance beyond what the infant explains; poor bonding; and reduced pleasure in the baby rather than in life generally.
- **The lactation principle, not a drug list.** Choose the agent with the most data and the lowest relative infant dose, use the lowest effective dose, and monitor the infant. A mother taken off treatment to protect feeding is the worse outcome for both.

WHAT EARNS THE MARKS

- **The three postnatal syndromes separated on timing and function** before treatment is named.
- **Severity used to choose the treatment,** with therapy first at the mild end rather than a drug for everyone.
- **Lactation answered as a principle with the infant monitored,** not as a memorised list.

SEE ALSO Slot III - 88 postpartum blues Slot III - 87 postpartum illness and bonding **SPRINT** Day 28, perinatal and women's mental health

WEAVE 100 · PAPER III · W06



Postpartum depression and management. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-86.

Credits and references: retained within the illustration.

III - 87

Influence of Postpartum psychiatric disorders on the process of Infant-Mother Bonding. [10]

10 | PERINATAL AND WOMEN'S MENTAL HEALTH | RGUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	**Bonding defined**	And separated from attachment, which is the infant's side
3	**Disorder by disorder**	What each one does to the interaction itself
3	**What the infant carries**	Attachment, development, behaviour, growth
2	**Buffer and repair**	What protects, and why treating the mother is not enough

THE TWO WORDS ARE NOT INTERCHANGEABLE

Bonding is the mother's emotional tie to her infant, present or absent from the first days. Attachment is the infant's developing tie to a caregiver, built over the first year. They run on different clocks, and postnatal illness can damage the first while the second is still being formed.

DISORDER	WHAT IT DOES TO THE INTERACTION	WHAT THE INFANT MEETS	WEIGHT
Depression	Withdrawal, flat affect, less looking, talking and contingent response, or an intrusive over-stimulating style	An unpredictable partner	**Reduced contingent response is the mechanism**
Anxiety and obsessional illness	Intrusive harm thoughts drive avoidance of bathing, changing, or being alone with the infant	A carer who withdraws from care	Avoidance, not aggression
Psychosis	Delusional misidentification, or delusional beliefs about the infant	Real risk, and a broken tie	**The only one with an immediate safety question**
Substance use, severe personality difficulty	Inconsistent availability and poor supervision	Neglect and unpredictability	Overlaps with safeguarding

- **What the infant carries forward.** Insecure and disorganised attachment, poorer cognitive and language development, more behavioural difficulty, and, where care is compromised, faltering growth. Severity and chronicity predict this better than the diagnostic label does.
- **What buffers, and what repairs.** A second responsive caregiver, marital support and freedom from poverty all buffer, and in a joint household that second caregiver is often the protective factor. Treating the mother's illness is necessary and not sufficient: add dyadic and video-feedback work, admit mother and infant together where possible, and involve the family.

WHAT EARNS THE MARKS

- **Bonding and attachment defined separately at the start.** Using them interchangeably costs the first two marks.
- **The mechanism named as reduced contingent responsiveness,** not as "the mother is sad".
- **The repair line.** Treating the illness alone does not restore the relationship, so dyadic work is named explicitly.

SEE ALSO Slot III - 86 postpartum depression Slot III - 85 aetiology and management of postpartum psychosis

SPRINT Day 28, perinatal and women's mental health

WEAVE 100 · PAPER III · W11



Mother-infant bonding and attachment. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-87.

Credits and references: retained within the illustration.

III - 88

Post partum blues. [10]

10 PERINATAL AND WOMEN'S MENTAL HEALTH RGUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 Definition and timing	Three numbers: onset, peak, resolution
2 Frequency and cause	Common enough to be a variation, not a disorder
3 Features	Defined as much by what is absent as by what is present
3 Management and significance	No drug, and the safety net that follows

THE DEFINITION

A transient disturbance of mood in the first days after delivery, beginning around the third day, peaking near the fifth, and settling by the tenth to fourteenth without treatment. It is quoted classically as affecting between half and four fifths of mothers, which places it among normal variations rather than among disorders.

FEATURE	WHAT IS SEEN	WHAT IS NOT SEEN	WEIGHT
Mood	Tearfulness, lability, irritability, anxiety, feeling overwhelmed	Sustained low mood that does not lift with company or good news	Reactivity is preserved
Timing	Day three to five, gone by day ten to fourteen	Onset later, or lasting past two weeks	Duration is the discriminator
Function	Feeding, caring and sleeping continue	Inability to care for the infant or herself	Function stays intact
Cognition and risk	Insight retained throughout	Guilt, hopelessness, confusion, delusions, thoughts of harm	Any of these changes the diagnosis

- **Why it happens.** The abrupt fall in oestrogen and progesterone after placental separation, on a background of exhaustion, pain, disturbed sleep and a changed role. No treatment acts on this, and none is needed.
- **Management is explanation and support.** Normalise it, give the mother and the family the time course, protect her sleep, arrange practical help, and review. No antidepressant. Reassurance is offered in a way that still leaves her able to come back.

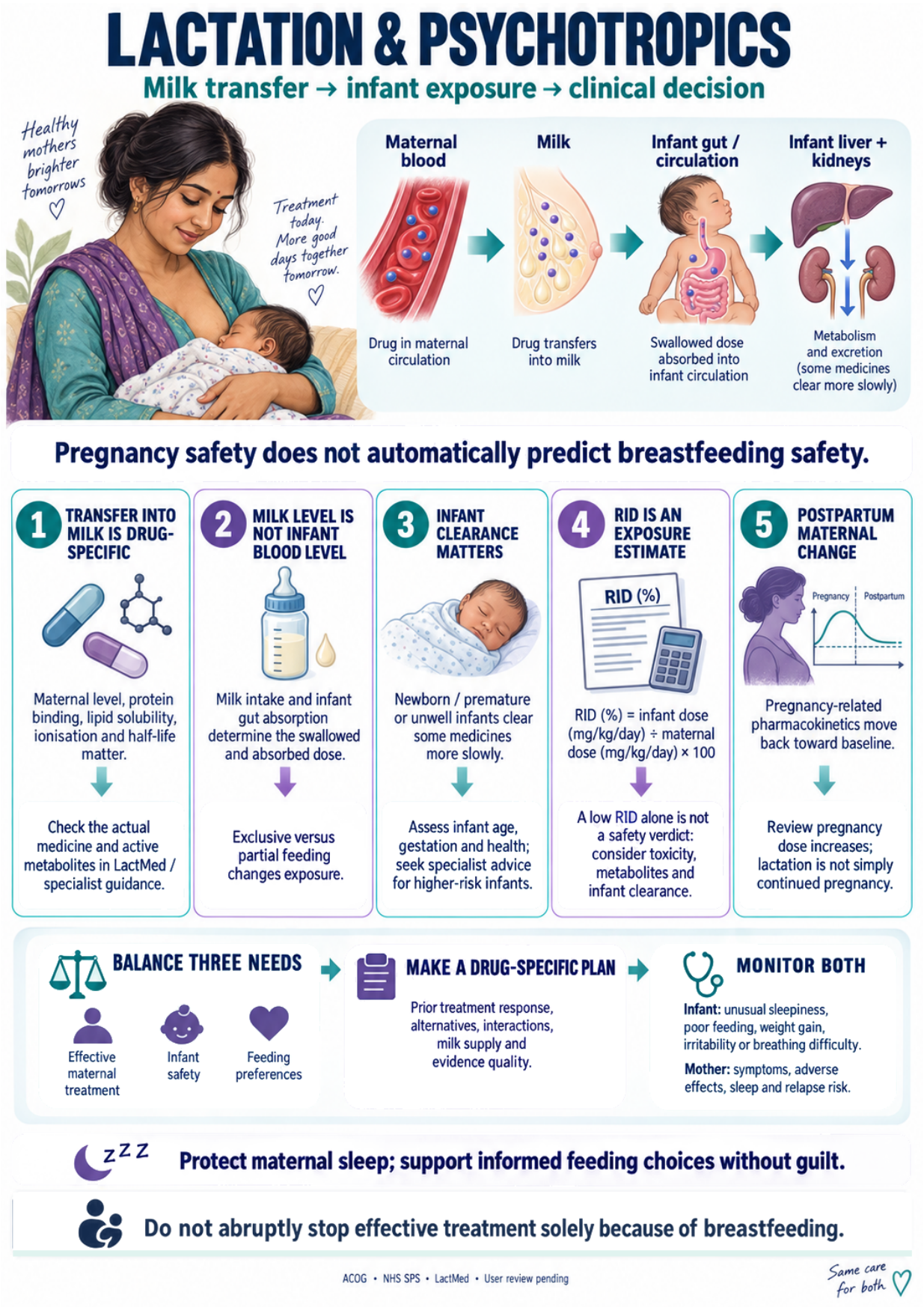
WHAT EARNS THE MARKS

- **The timing given as three numbers:** onset, peak and resolution. Vague timing is what separates a half answer here.
- **Defined by what it lacks** as much as by what it shows.
- **The safety net stated.** Blues that outlasts two weeks, deepens, or adds confusion is a different diagnosis, and blues is itself a risk marker for later depression.

SEE ALSO Slot III - 86 postpartum depression Slot III - 83 postpartum psychosis SPRINT

Day 28, perinatal and women's mental health

WEAVE 100 · PAPER III · W02



Lactation and psychotropics. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · W03

PRECONCEPTION & PRESCRIBING DECISIONS

Plan for illness control, pregnancy and the first postpartum weeks



1 PLANNING PREGNANCY

Get informed. Plan together.



- **Establish diagnosis** and current **phase** of illness.
- **Previous severe episodes.**
- Prior **perinatal illness.**
- **Response** to treatment and **relapse after stopping.**
- **Review all prescriptions,** OTC medicines and substances (including alcohol and recreational).
- Discuss **reproductive goals** and **contraception** until a plan is agreed.

PLANNING HELPS CHOICES NOT CHANCES

2 ALREADY PREGNANT ON TREATMENT

Review early, without blame.



- Establish **gestational timing** and actual **exposure.**
- **Review promptly,** without blame.
- **Do not abruptly stop effective** medication or assume an exposure requires termination.
- **High-risk drugs** need urgent **specialist review** and a supervised alternative plan.

SUPPORT FIRST SOLUTIONS TOGETHER

3 NEW ILLNESS IN PREGNANCY

Assess. Treat. Both lives matter.



- **Full assessment including bipolarity,** severity and safety.
- **Psychological** care when appropriate.
- **Effective medication** when indicated.
- **Treating illness is part of fetal and maternal care.**

Maternal mental health is fetal health

4 SHARED DECISION

Your values. Our expertise. A plan.



- Compare risks of **untreated illness, treatment and switching.**
- Consider **prior efficacy,** reproductive evidence, patient preference and access to care.
- Aim for **effective treatment.**
- Avoid **unnecessary polypharmacy** and subtherapeutic dosing.

INFORMED DECISIONS STRONGER TOGETHER

DECISION FLOW: BRINGING IT TOGETHER

Current treatment effective?

- **Yes** → **Assess reproductive risk + relapse history** — Continuation may be best
- **No** → **Optimise diagnosis/treatment with perinatal specialist**

→ **Agreed monitoring, obstetric coordination and written plan** — Clear roles. Regular review. Adjust as needed.

A plan today for a safer tomorrow

AROUND DELIVERY AND THE POSTPARTUM PERIOD: CHECKLIST

Symptom warning signs	Levels where indicated	Newborn observation	Feeding options	Protected sleep	Named contacts	Early follow-up	Relapse prevention
For relapse or recurrence (e.g, mood, sleep, anxiety, psychosis).	Consider monitoring relevant drug levels when appropriate.	Inform neonatal team about in utero exposure. Observe as advised.	Discuss breastfeeding and infant feeding in line with current guidance.	Plan support for rest, especially in the early weeks.	Provide crisis and routine contact details.	Arrange prompt postpartum review.	Continue plan, review stressors, strengthen support.

CAUTION – KEY POINTS

- **Valproate:** major reproductive risk; **urgent specialist review.** Do not make abrupt **unsupervised changes.**
- **Pregnancy or breastfeeding alone is not a reason to withhold treatment.**
- **Folate and obstetric screening follow individual guidance; supplements do not cancel medication risks.**



Educational revision • Sources in companion notes • User/independent review pending Topic03.

Preconception counselling and prescribing. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

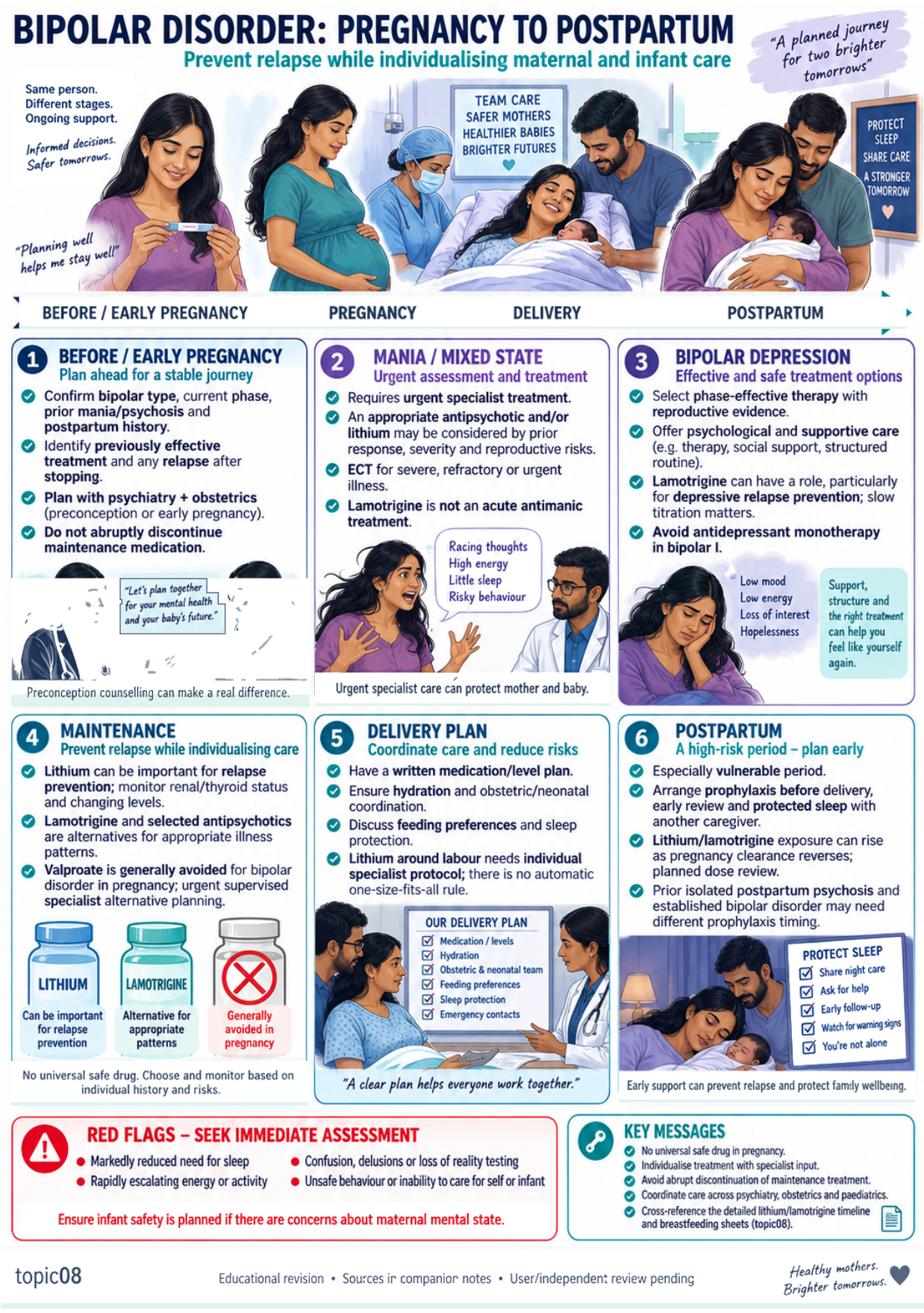
WEAVE 100 · PAPER III · W04



Perinatal psychiatric assessment. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · W08



Bipolar disorder in pregnancy and postpartum. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · W15



Lithium and lamotrigine perinatal timeline. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

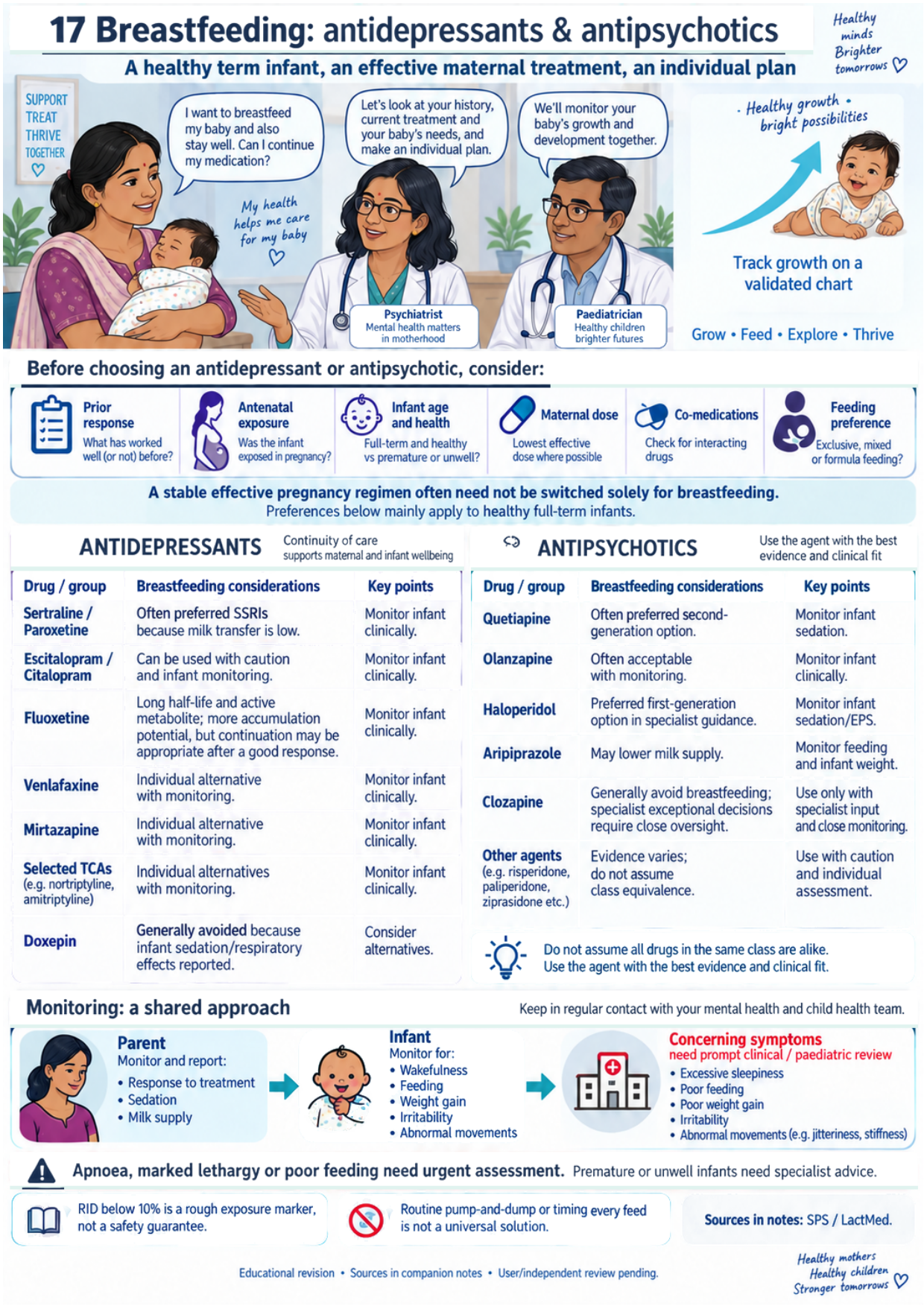
WEAVE 100 · PAPER III · W16



Sedatives anxiolytics and ADHD medicines. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · W17



Breastfeeding antidepressants and antipsychotics. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · W18



Breastfeeding mood stabilisers. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · W19

19 ECT & newer perinatal treatments

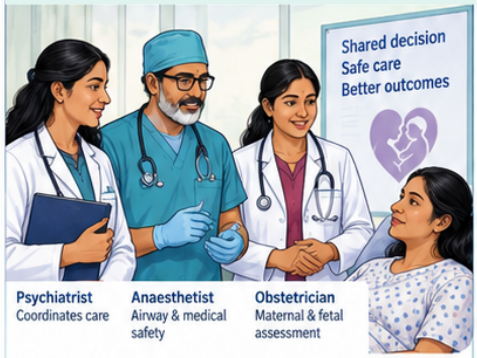
Evidence-informed care for mothers. Brighter tomorrows for families.

Maternal mental health matters. Support changes lives.



ECT IN PREGNANCY / POSTPARTUM

A treatment option in selected severe cases



WHEN TO CONSIDER

Severe depression, catatonia, severe mania/ psychosis or need for rapid response, based on specialist assessment.

KEY POINTS

- Pregnancy is not an absolute contraindication.
- Psychiatry + anaesthesia + obstetrics agree on consent, gestation-specific maternal/fetal assessment, airway/aspiration and hydration plan.
- Left tilt when appropriate.
- Monitor maternal vitals and fetal wellbeing according to gestation/local protocol.
- Ensure obstetric support and post-procedure observation.

EVIDENCE

Largely observational; no claim of zero risk.

Individualised assessment.
Multidisciplinary care.
Mothers and babies first.



ZURANOLONE

Oral GABA-A positive modulator (for postpartum depression)



WHAT IS IT?

Oral GABA-A positive modulator; US-approved for adult postpartum depression.

HOW IT IS TAKEN

14-day evening course with fat-containing food; dosing/interactions need current label.

ACOG 2025

Considers it postpartum for severe depression beginning in third trimester or first four weeks after delivery.

IMPORTANT LIMITATION

Trials do not establish it as emergency treatment for bipolar disorder, psychosis or active suicidality.

SAFETY POINTS

- CNS depression: no driving/hazardous tasks for at least 12 hours after each dose.
- Arrange another alert caregiver; avoid caring for infant alone during this period.
- Avoid pregnancy; effective contraception during treatment and one week after.
- Low milk transfer does not establish infant safety, individual feeding decision.

BREXANOLONE

IV neurosteroid (history and current status)



WHAT IS IT?

IV neurosteroid, historically 60-hour monitored infusion for postpartum depression (PPD).

CURRENT STATUS (US)

- US commercial discontinuation 2025.
- FDA approval withdrawn April 14, 2025 at sponsor request.

Do not present as a routinely available current treatment.

Important context

Its development has expanded understanding of neurosteroid treatments in perinatal mental health.



OTHER CONSIDERATIONS

- rTMS evidence differs; ketamine/esketamine are not established routine perinatal substitutes.
- **Use specialist** assessment and current evidence to guide individual care.

Established psychotherapy and appropriate antidepressant treatment remain central.

Newer agents do not replace safety assessment, ongoing care or relapse prevention.



US status ≠ Indian approval or local access.
Indian availability was not confirmed in this review.

Regulatory review:
20 September 2026.

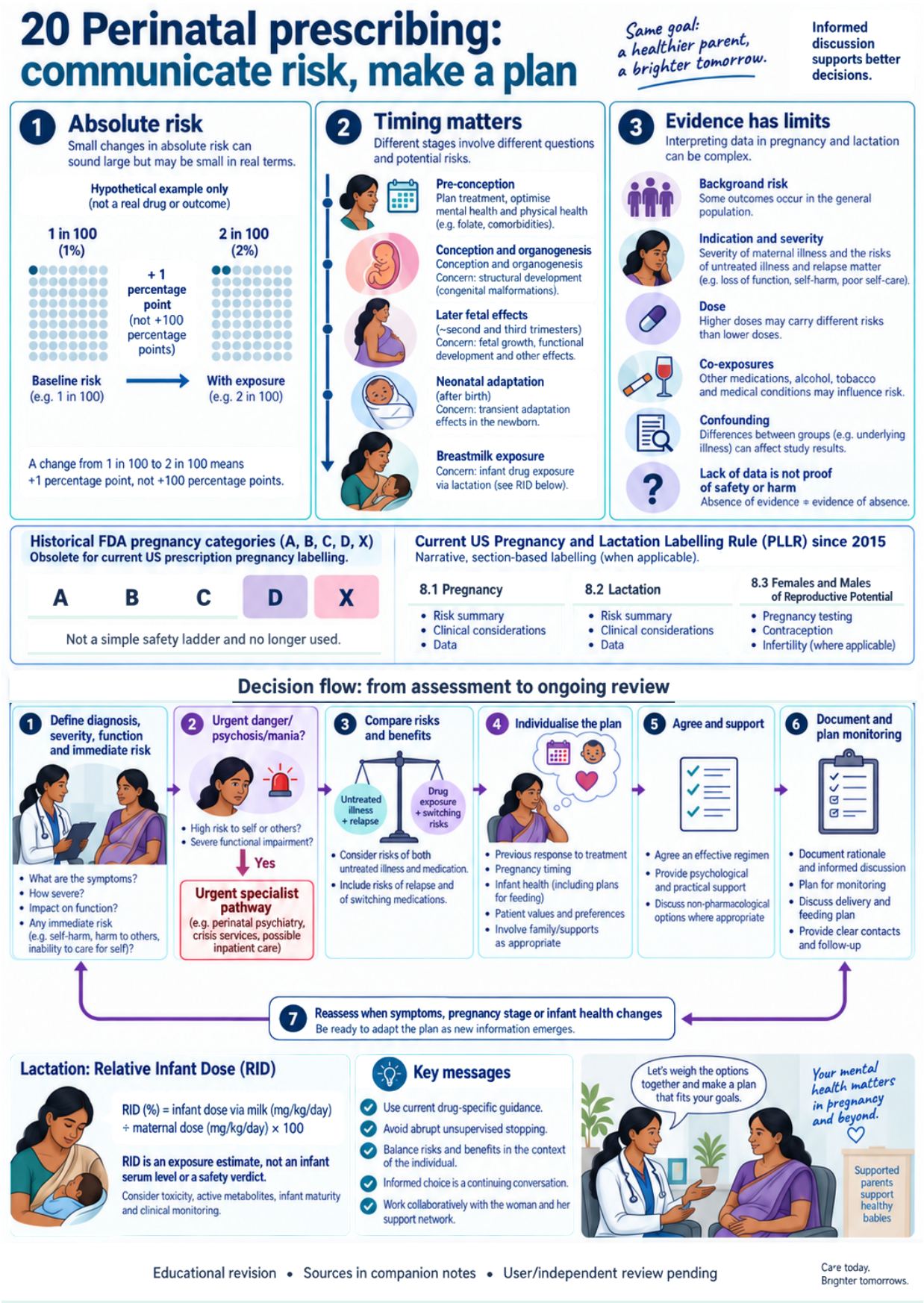
Educational revision • Sources in companion notes • User/independent review pending.

Knowledge today. Better care tomorrow.

ECT and newer perinatal treatments. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

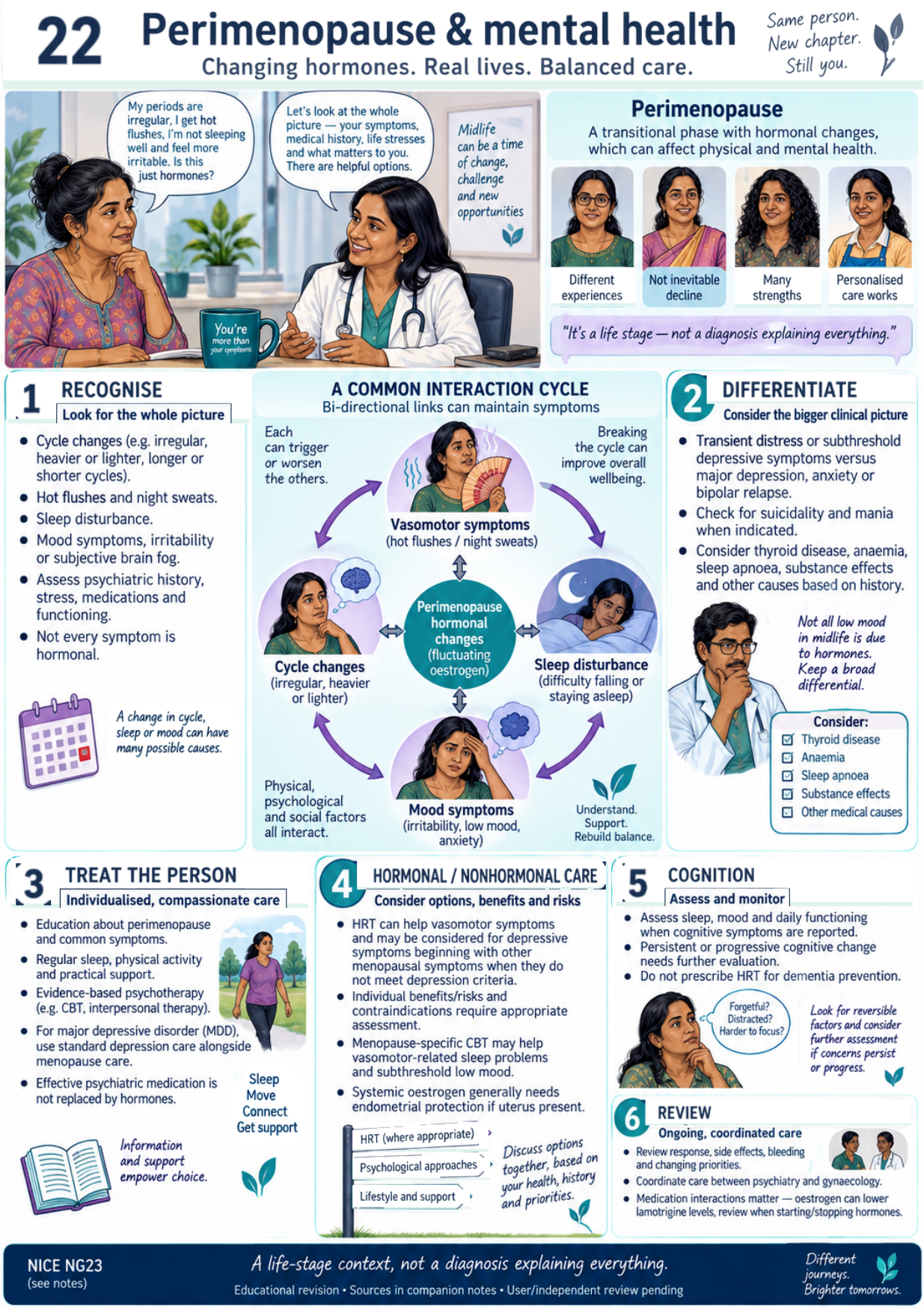
WEAVE 100 · PAPER III · W20



Risk communication and prescribing flow. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

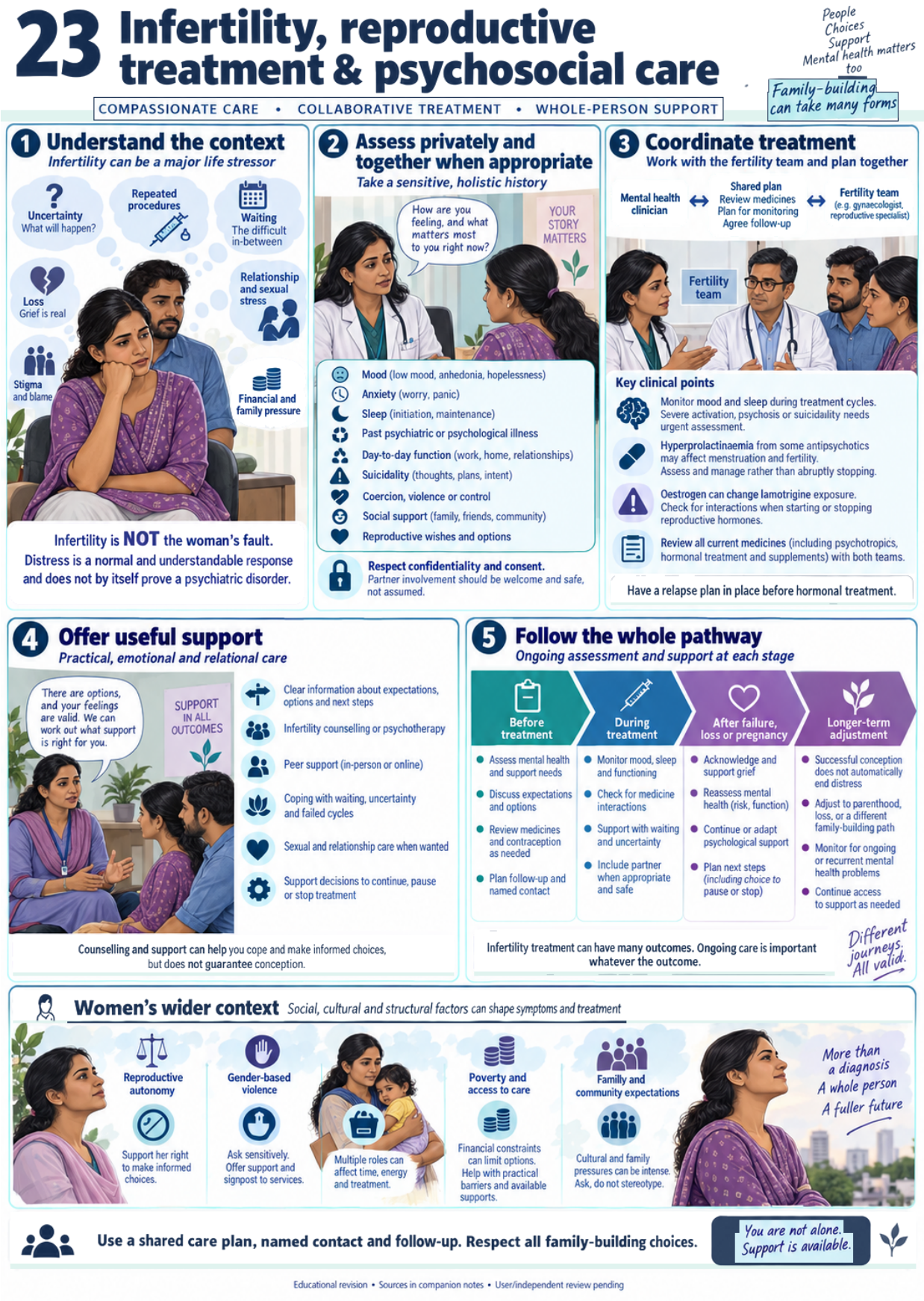
WEAVE 100 · PAPER III · W22



Perimenopause and mental health. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · W23



Infertility and psychosocial care. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · legacy-84.2

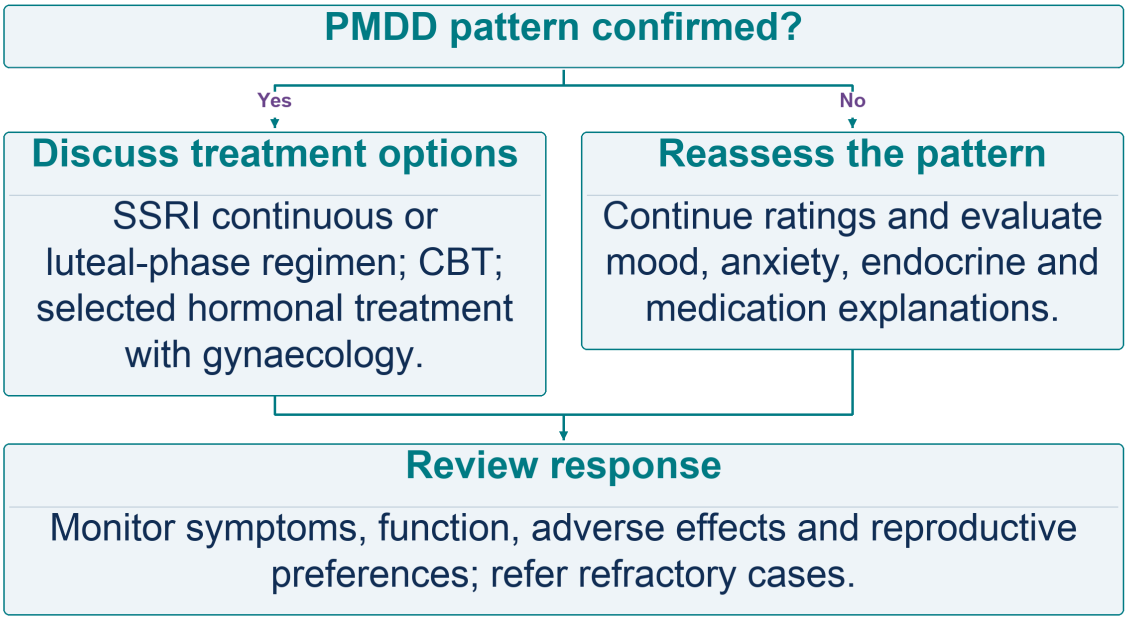
WEAVE 100+ / PAPER III

Premenstrual dysphoric disorder

The cyclical pattern distinguishes PMDD from premenstrual worsening.

Domain	Revision points
Timing	Symptoms arise before menses, improve soon after onset and are minimal after menses.
DSM framework	At least 5 symptoms, including a core mood symptom; clinically significant distress or impairment.
Confirm	Prospective daily ratings across at least 2 symptomatic cycles; exclude substances and medical causes.
Distinguish	Premenstrual exacerbation of an ongoing disorder lacks a clearly symptom-free interval.

DECISION PATHWAY



Weave Sprint day 28; ACOG Clinical Practice Guideline 7 (2023).

III 84.2 • Supplement • Source links and qualifications: SOURCES.md

Premenstrual dysphoric disorder. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

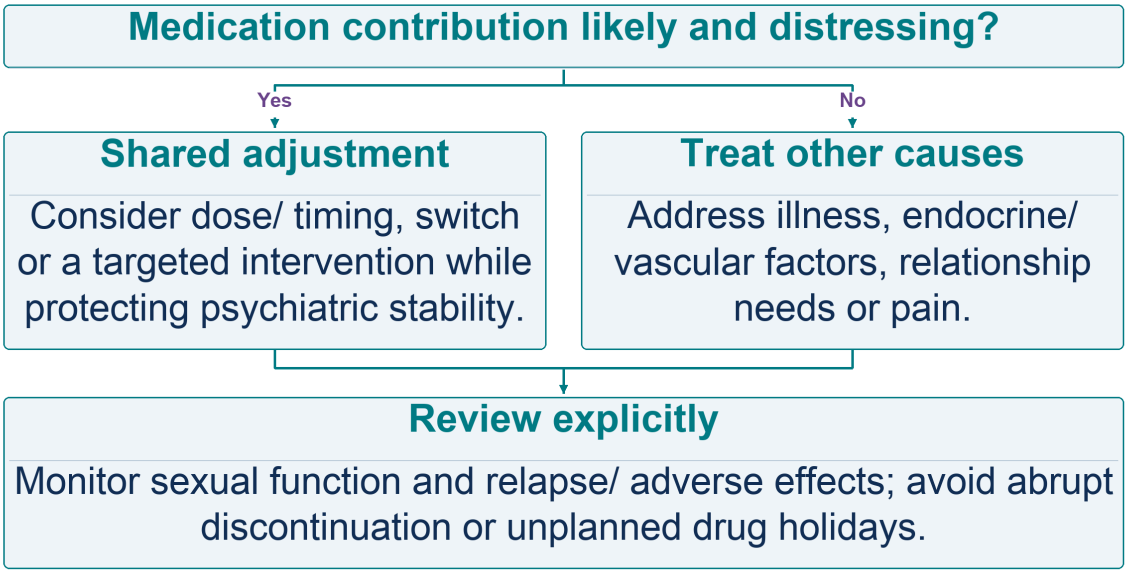
WEAVE 100+ / PAPER III

Psychotropics and sexual dysfunction

Establish timing, domain and competing causes before changing treatment.

Domain	Revision points
Domains	Desire, arousal/ erection, lubrication, orgasm/ ejaculation and pain.
Mechanisms	Serotonergic effects, prolactin elevation, sedation, autonomic effects and metabolic/ vascular burden.
Assessment	Baseline function, medication timeline, mood, relationship context, endocrine/ medical causes and patient priorities.

DECISION PATHWAY



Weave Paper II sexual-function sheets; drug labels and source register.

III 84.3 • Supplement • Source links and qualifications: SOURCES.md

Psychotropics and sexual dysfunction. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Perinatal and women's mental health.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Flibanserin versus bremelanotide

These are selected HSDD treatments, not general sexual-performance drugs.

Domain	Revision points
Target	Acquired, generalised hypoactive sexual desire disorder with distress; exclude medication, medical and relationship explanations.
Flibanserin	Daily oral serotonergic agent; US December 2025 label extends to women younger than 65, regardless of reproductive status.
Bremelanotide	As-needed subcutaneous melanocortin-receptor agonist; US indication remains premenopausal women with acquired, generalised HSDD.
Key risks	Flibanserin: hypotension/ syncope, alcohol timing and CYP3A4/ hepatic restrictions. Bremelanotide: nausea, transient BP rise and hyperpigmentation.
Limitations	Not treatments for sexual dysfunction caused by another medicine; establish diagnosis and follow current label precautions.

DO NOT MISS

Bremelanotide is contraindicated with uncontrolled hypertension or known cardiovascular disease.

JURISDICTION

Indications above are US labels; check Indian authorisation and availability separately.

FDA ADDYI label Dec 2025; DailyMed VYLEESI label.

Flibanserin versus bremelanotide. Read across the labelled contrasts to distinguish the related concepts. Section companion: Perinatal and women's mental health.

AREA 11 OF 13 · P3-A03

Autism spectrum disorder

5	4.6%	III-89	III-93
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

ANCHOR 1 HIGH 1 SINGLE 3

REVISION ORDER

Clinical features first, they carry three of the five slots between them. The pervasive developmental disorder classification next. Rett last, it is a named-syndrome answer.

WHAT IS IN THIS AREA

Clinical features of autism spectrum disorder, the pervasive developmental disorders, high functioning autism, the diagnostic criteria for childhood autism, and Rett syndrome.

III - 89

Describe the clinical features of autism spectrum disorder. [10]

10 AUTISM SPECTRUM DISORDER

KNRUHS, KUHS, TN-MGRMU, WBUHS - 5 APPEARANCES, 5 OF 78 SESSIONS

SKELETON

2	The two domains	Named as a dyad, with the counting rule
4	Features by domain	Each strand, with the early sign to ask for
2	Severity and specifiers	Graded separately for each domain
2	What travels with it	The comorbidity that changes the plan

THE DYAD, IN ONE BLOCK

Persistent deficits in social communication and social interaction across contexts, with restricted, repetitive patterns of behaviour, interests or activities. All three social strands are required and two of the four repetitive strands. Onset is in the early developmental period, though it may be masked until demand exceeds capacity.

STRAND	WHAT IS SEEN	EARLY SIGN TO ASK FOR
Reciprocity	Little sharing of interest or affect, no back and forth conversation	**No bringing an object to show, by eighteen months**
Nonverbal	Reduced eye contact, few gestures, gaze and speech not integrated	**No pointing to share, by twelve months**
Relationships	Cannot adjust to context, no shared pretend play, few friendships	Little interest in other children
Repetitive	Stereotypies, echolalia, lining objects, sameness, narrow intense interests	Distress at a small change of route
Sensory	Over or under reactive; fascination with lights or spinning; pain indifference	Covering ears at ordinary sound

- **Severity and specifiers.** Three levels of support, graded separately for the social and the repetitive domain. Specify with or without intellectual impairment, with or without language impairment, an associated medical or genetic condition, another neurodevelopmental disorder, and catatonia.
- **What travels with it.** Intellectual disability, epilepsy, sleep and feeding problems, attention deficit disorder, anxiety, self injury, and catatonia appearing in adolescence. Indian assessment uses the Indian Scale for Assessment of Autism for certification, and the INCLEN diagnostic tool for case finding.

WHAT EARNS THE MARKS

- **The dyad with its counting rule.** Three of three, and two of four, is what turns a list into criteria.
- **An early sign attached to each strand.** Pointing and showing are the cheapest marks on this page.
- **Severity graded per domain,** not as a single global label.
- **Comorbidity named,** because epilepsy and catatonia change the management answer.

SEE ALSO Slot III - 92 diagnostic criteria enumerated Slot III - 90 high functioning autism **SPRINT**

Day 21, Intellectual disability & autism spectrum disorder

WEAVE 100 · PAPER III · new-89.4



Autism - Explicit DSM-5-TR A-E criteria. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-89.

Credits and references: retained within the illustration.

III - 90

Describe the differential diagnosis, management and prognosis of high functioning autism in a child. [3+4+3]

3 + 4 + 3 | AUTISM SPECTRUM DISORDER | DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

1 What the term means	Autism without intellectual or language impairment
3 Differential diagnosis	Four look-alikes, each with the line that separates it
4 Management	Teach the skill, treat what hurts, prescribe last
2 Prognosis	The predictors, and the adult risks worth naming

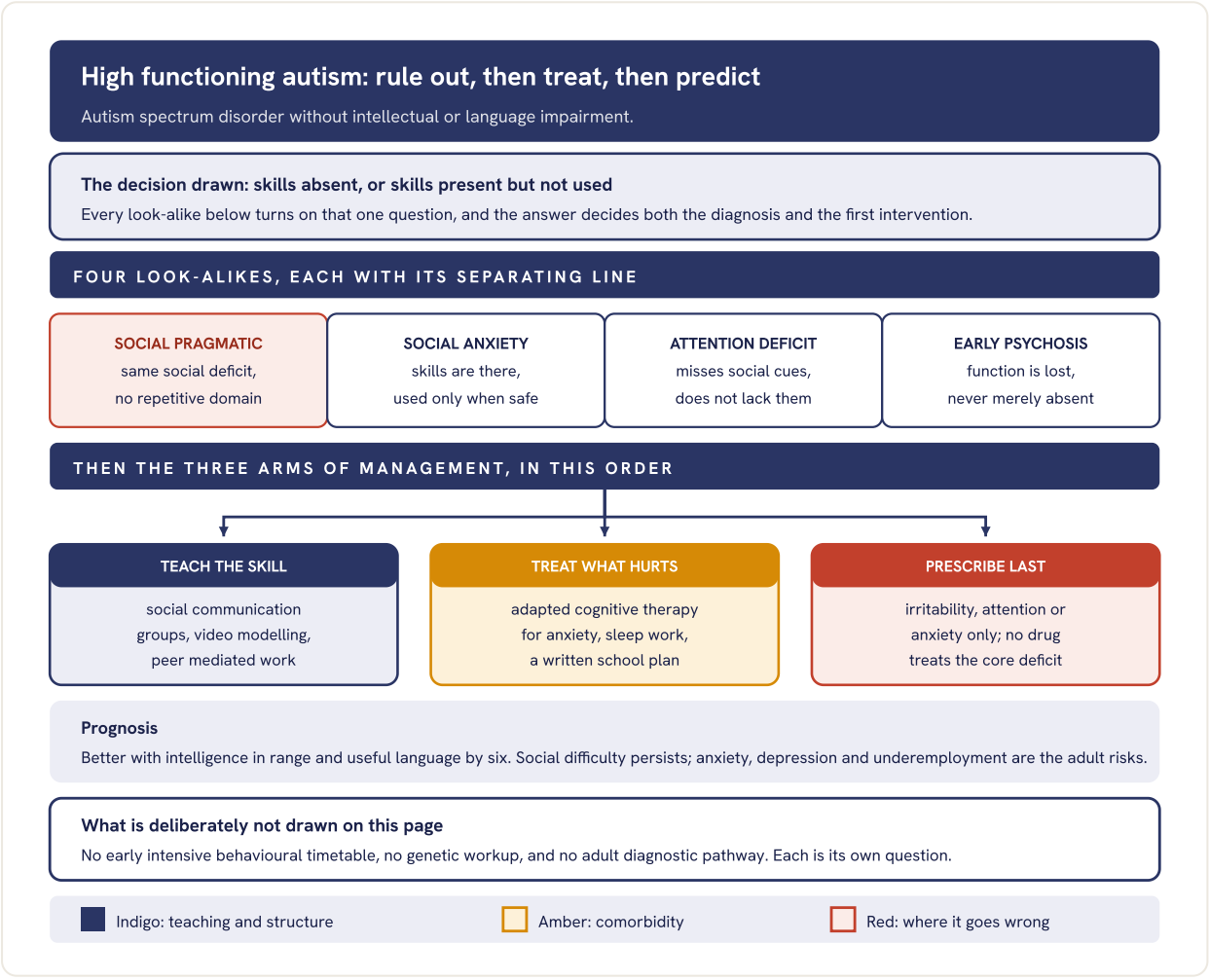


Fig 090.1 Four differentials resolved on one question, then three arms of management in order, with prognosis carried as a strip so the answer ends where the examiner expects it.

- **The rest of the differential.** Developmental language disorder, hearing impairment, obsessive compulsive disorder, reactive attachment disorder, Tourette syndrome, and a gifted child placed badly. Fragile X and the 22q11.2 deletion carry the autism phenotype and are worth testing when dysmorphism or family history points there.
- **Drugs, named honestly.** Risperidone and aripiprazole for irritability and aggression, with metabolic monitoring. Methylphenidate or atomoxetine for attention symptoms, with a lower response rate and more side effects than in attention deficit disorder alone. A serotonin reuptake inhibitor for anxiety, watching for activation.

PITFALL

Adequate speech is not adequate pragmatics. A child with fluent vocabulary who cannot repair a misunderstanding is still in the social communication domain, and calling him shy delays the diagnosis by years.

WHAT EARNS THE MARKS

- **The differential given as separating lines,** not as a list of names.
- **Behavioural and educational work placed before any drug,** with the reason stated.
- **No drug claimed for the core deficit.** Saying so is itself a mark.
- **Prognosis with named predictors,** and the adult mental health risk.

SEE ALSO Slot III - 89 clinical features Slot III - 91 pervasive developmental disorders **SPRINT**

Day 21, Intellectual disability & autism spectrum disorder

WEAVE 100 · PAPER III · legacy-90.1

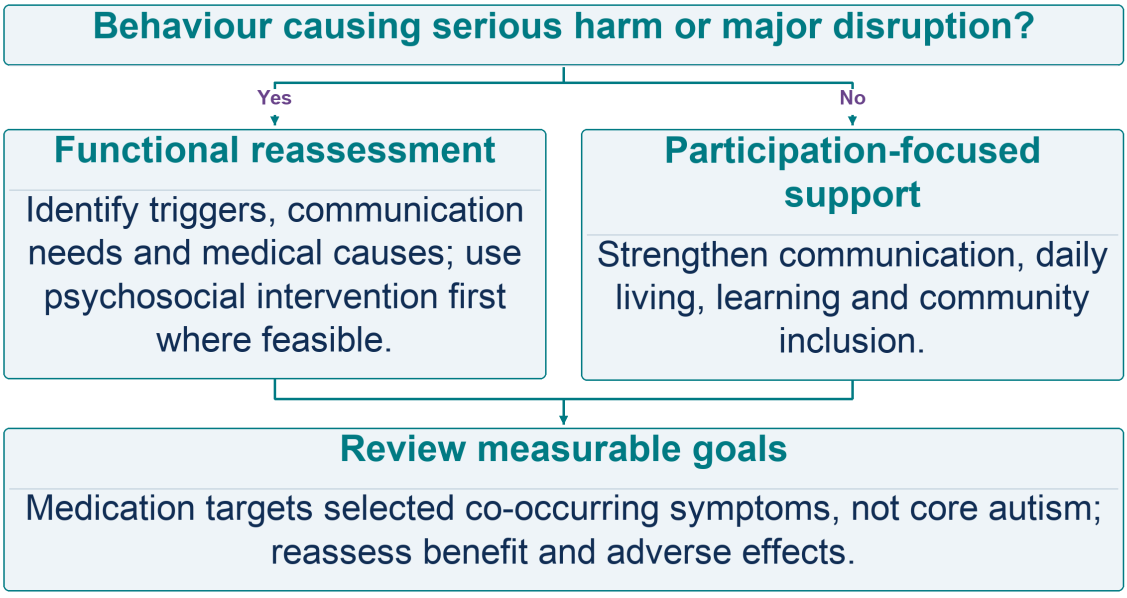
WEAVE 100+ / PAPER III

Autism: management and prognosis

Build support around communication, participation and quality of life.

Domain	Revision points
Individual plan	Shared goals reflecting strengths, preferences, developmental level and family priorities.
Core supports	Developmental/ social-communication interventions, education, environmental adaptation and caregiver support.
Associated needs	Assess sleep, pain, epilepsy, ADHD, anxiety, feeding and sensory difficulties; behaviour may signal unmet needs.
Prognosis	Highly variable; language, cognition, adaptive skills, health and access to support shape outcomes.

DECISION PATHWAY



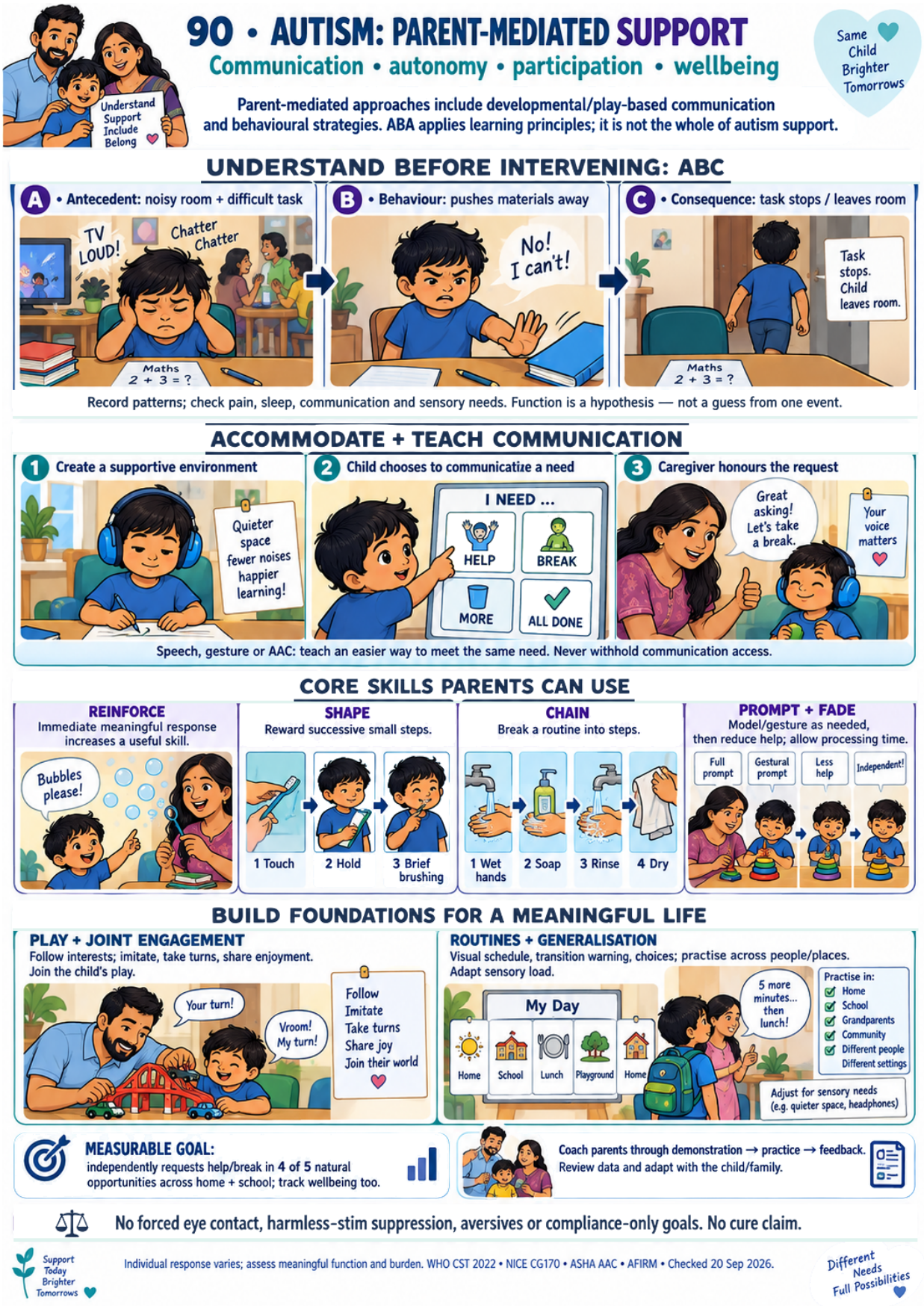
Weave 100 III-90; NICE CG170.

III 90.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Autism: management and prognosis. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-90.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · new-90.2



Autism parent-mediated support. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-90.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · new-90.3

‘HIGH-FUNCTIONING’ AUTISM IN A CHILD

Q90 • Differential diagnosis, management and prognosis

REFRAME THE TERM

- **Older, imprecise label**—not a DSM-5-TR diagnosis. Describe autism with individual intellectual, language and adaptive profiles.
- Fluent speech or high IQ **does not imply low support needs.** Masking may conceal distress.



CONFIRM THE DEVELOPMENTAL PATTERN

- **All 3 social-communication domains + ≥2 restricted/repetitive-pattern domains;** early developmental onset and functional impairment.
- Obtain **developmental history** and information **across settings.**



DIFFERENTIALS: ASK WHAT DRIVES THE DIFFICULTY

Social pragmatic communication disorder



Social-language difficulties without restricted/repetitive-pattern history.

ADHD



Inattention/ impulsivity affects interaction; may coexist with autism.

Social anxiety



Fear of negative evaluation drives avoidance; examine earlier social development.

OCD



Intrusive unwanted thoughts and neutralising compulsions; autistic routines may serve predictability or interest. They can coexist.

Language disorder



Structural language difficulty; assess reciprocity and repetitive patterns separately.

Hearing impairment / selective mutism



Check hearing; distinguish context-specific inability to speak from pervasive developmental differences.

MANAGEMENT: MATCH SUPPORT TO NEED

Agree goals with child and family; identify **strengths** and **communication preferences.**



School: predictable routines, explicit instructions, visual supports, sensory adjustments, anti-bullying plan and transition preparation.



Practise reciprocal communication in **meaningful settings; support friendships** without forcing eye contact or suppressing harmless stimming.



Adapt CBT for anxiety when suitable; assess ADHD, OCD, mood, sleep and learning difficulties and treat individually.



No medication treats core autism **features;** use medicines for defined coexisting problems when indicated.



PROGNOSIS & REVIEW



- **Variable,** not determined by IQ alone. Reassess adaptive skills, wellbeing, participation and support needs as demands change.
- Plan adolescence and adult transitions; support autonomy and family wellbeing.



Sources: CDC DSM criteria • NICE CG128 / CG170

High-functioning autism in a child. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-90.

Credits and references: retained within the illustration.

III - 91

Describe the clinical features and management of Pervasive developmental disorders. [10]

10 | AUTISM SPECTRUM DISORDER | NTRUHS, TN-MGRMU - 2 APPEARANCES, 2 OF 78 SESSIONS

SKELETON

2 What the group is	The older family, the triad, and where it sits now
3 The members	Each with the feature that identifies it
3 Management	The pathway: assess, teach, treat, entitle
2 What changes the plan	Epilepsy, regression, and the family's capacity

- **The triad, described.** Social: no shared attention, no reciprocity, indifference to another child's distress. Communication: speech delayed or absent, echolalia, no compensating gesture, no pretend play. Behaviour: stereotypies, rituals, resistance to change, narrow preoccupations.

MEMBER	THE IDENTIFYING FEATURE	WHERE IT SITS NOW
Childhood autism	Full triad, onset before three years	**Autism spectrum disorder**
Atypical autism	Late onset or an incomplete picture	Autism spectrum disorder
Asperger syndrome	No language or cognitive delay	Autism spectrum disorder
Disintegrative disorder	Normal for two years, then marked loss	Regression, workup first
Rett syndrome	Girls, hand wringing, loss of hand use	**Moved out, a genetic condition**

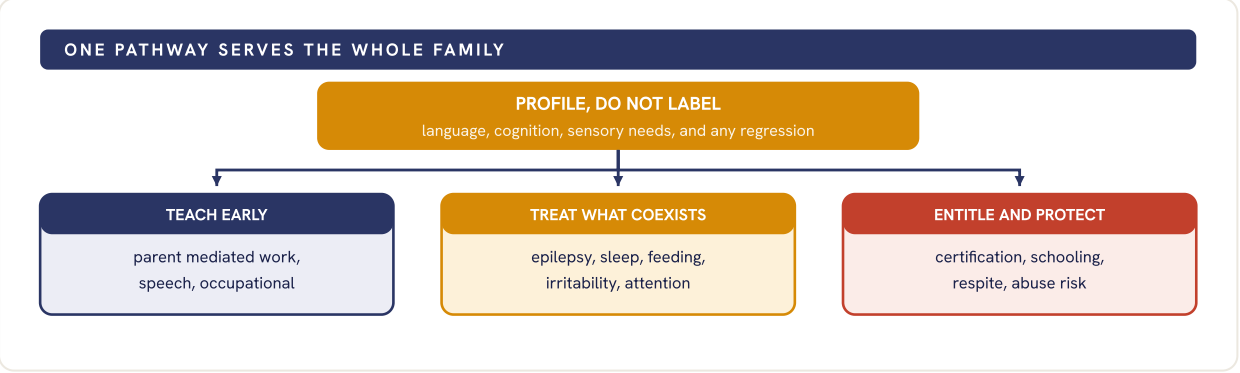


Fig 091.1 The profile decides the plan, and the same three arms serve every member of the family. Regression is the one branch that goes to investigation first.

- **What changes the plan.** Any loss of acquired skill needs electroencephalography and neurological review before a developmental label. Epilepsy appears in a fifth to a third and peaks in adolescence. Certification uses the Indian Scale for Assessment of Autism, and the National Trust covers autism for insurance and guardianship.

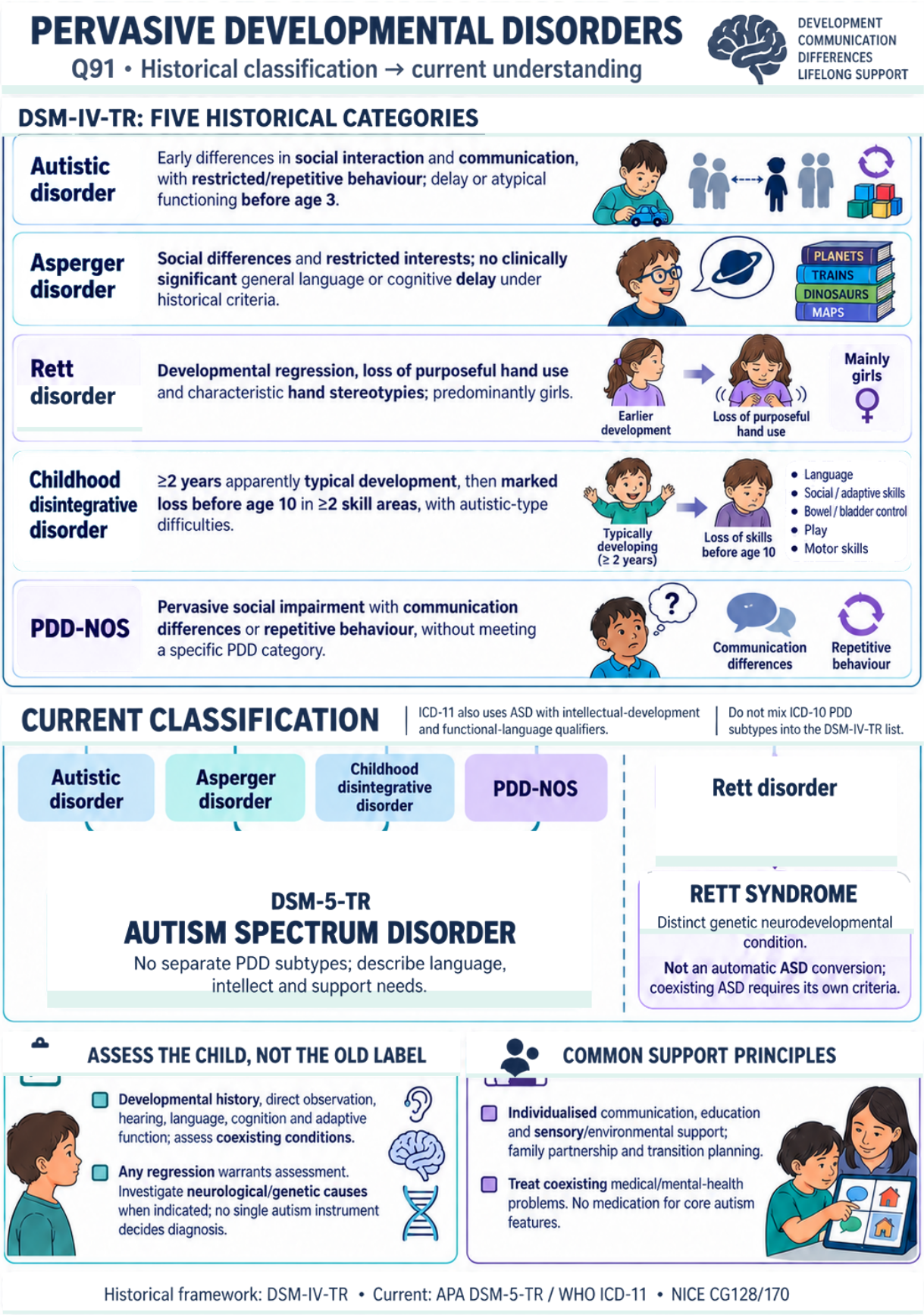
WHAT EARNS THE MARKS

- **The family named with the triad,** and the fact that current systems have collapsed it into one spectrum.
- **One identifying feature per member,** with Rett taken out of the group.
- **Regression routed to investigation,** not to a developmental label.

SEE ALSO Slot III - 89 clinical features Slot III - 93 Rett syndrome SPRINT

Day 21, Intellectual disability & autism spectrum disorder

WEAVE 100 · PAPER III · new-91.1



Pervasive developmental disorders - Historical and current classification. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-91.

Credits and references: retained within the illustration.

III - 92

Mention clinical features common to Autistic Spectrum Disorders. Enumerate diagnostic criteria of Childhood Autism according to DSM. [10]

10 | AUTISM SPECTRUM DISORDER | RGUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

1	The axis	What is common to all of it, before any criterion
3	Common features	Present at every severity, whatever the language level
4	The criteria, enumerated	A to E, with the counting rule on each
2	Severity and specifiers	Graded per domain; and how the older system differed

COMMON TO THE WHOLE SPECTRUM

Whatever the intelligence or the language level: reduced social reciprocity, impoverished nonverbal communication, difficulty forming and keeping relationships, insistence on sameness, narrow intense interests, and atypical sensory reactivity. Severity changes how much support is needed, not which domains are affected.

CRITERION	WHAT MUST BE PRESENT	COUNTING RULE
A. Social	Reciprocity; nonverbal communication; developing and keeping relationships	**All three, across contexts**
B. Repetitive	Stereotyped movement or speech; insistence on sameness; fixated interests; sensory reactivity	**Two of the four**
C. Onset	Present in the early developmental period, possibly masked until demand rises	Required
D. Impairment	Clinically significant, in social, occupational or other important areas	Required
E. Not better explained	By intellectual disability or global developmental delay alone	Required

- **Severity and specifiers.** Three levels of support, graded separately for the social and the repetitive domain. Specify with or without intellectual impairment, with or without language impairment, an associated medical or genetic condition, another neurodevelopmental disorder, and catatonia.
- **How the older system differed.** The earlier manuals used a triad, counted language as a separate strand, and named separate disorders. The current system folds language into a specifier, merges the disorders into one spectrum, and requires the counting rule above.

WHAT EARNS THE MARKS

- **Common features stated before the criteria.** The question asks for both, in that order.
- **All five criteria lettered,** with the counting rule written on A and B.
- **Severity graded per domain,** not as one global label.
- **The triad to dyad change named.** It shows which system the answer is written from.

SEE ALSO Slot III - 89 clinical features described Slot III - 91 pervasive developmental disorders SPRINT
Day 21, Intellectual disability & autism spectrum disorder

III - 93

Rett's syndrome. [10]

10 | AUTISM SPECTRUM DISORDER | KUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	The genetics	Gene, inheritance, and why boys are rarely seen
4	The four stages	Age and the change that defines each one
2	Diagnostic criteria	The four main criteria, and the supportive signs
2	Management	What is treatable, and what is only supported

THE DEFINITION

An X linked dominant neurodevelopmental disorder caused by mutation in the MECP2 gene, almost always arising new rather than inherited, seen almost exclusively in girls because affected boys usually do not survive infancy. Development is normal for the first six months or so, then stalls and regresses.

STAGE	AGE	WHAT DEFINES IT
Stagnation	6 to 18 months	Development slows, head growth decelerates, interest fades
Regression	1 to 4 years	**Purposeful hand use and spoken language are lost; hand wringing appears**
Plateau	2 to 10 years	Some social contact returns; seizures, breathing dysrhythmia, bruxism
Late motor decline	After 10 years	**Scoliosis, rigidity, loss of walking; eye gaze communication survives**

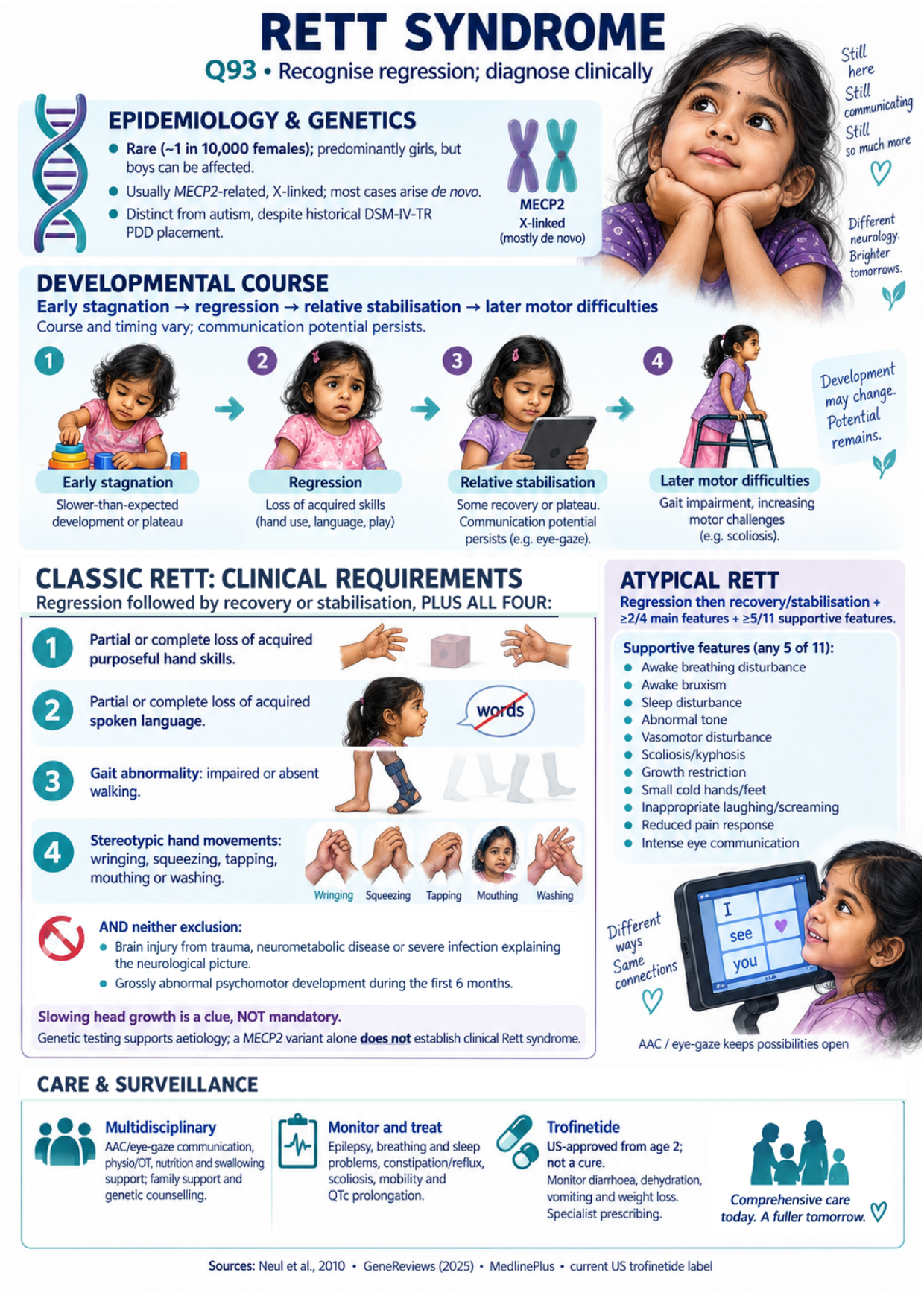
- **The four main criteria.** Partial or complete loss of acquired purposeful hand skills; loss of acquired spoken language; gait abnormality; and stereotyped hand movements such as wringing, washing or mouthing. Supportive signs include awake breathing disturbance, bruxism, cold small hands and feet, scoliosis, and intense eye contact.
- **Differential and variants.** Separate it from autism spectrum disorder, cerebral palsy, Angelman syndrome and a mitochondrial disorder. Atypical forms exist: a preserved speech variant, an early seizure variant, and a congenital variant, each with its own gene.
- **Management, honestly.** No treatment reverses the disorder. Antiepileptic drugs for seizures, screening for prolonged QT, physiotherapy and bracing for scoliosis, nutrition support, sleep and behaviour work, and communication through eye gaze devices. Genetic counselling matters even though most mutations are new.

WHAT EARNS THE MARKS

- **MECP2 named, with the reason boys are rarely seen.**
- **Four stages with ages,** and the regression stage identified as the diagnostic one.
- **Hand stereotypy described,** not merely called stereotypy.
- **The cardiac screen.** Prolonged QT is the line most answers never reach.

SEE ALSO Slot III - 91 pervasive developmental disorders Slot III - 12 aetiology of intellectual disability

WEAVE 100 · PAPER III · new-93.2



Rett syndrome - Diagnostic criteria and care. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-93.

Credits and references: retained within the illustration.

AREA 12 OF 13 · P3-A06

Child assessment, pharmacotherapy and interventions

4	3.2%	III-94	III-97
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SINGLE 4

REVISION ORDER

The two internet addiction slots share nearly all their content, so take them together. Gender dysphoria and the scales slot are independent and short.

WHAT IS IN THIS AREA

Internet addiction in two slots, gender dysphoria in an adolescent, and the rating scales used in child psychiatry.

III - 94

Describe behavioral addiction and how to manage a adolescent with internet addiction. [5+5]

5 + 5 | CHILD ASSESSMENT, PHARMACOTHERAPY AND INTERVENTIONS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	**Definition**	A reward behaviour carrying the dependence criteria
3	**What is recognised**	ICD-11 admits two entities, the rest stay proposed
2	**Assessment first**	Quantify the use, screen for what drives it
3	**Management**	The plate: engage, sort, treat, prevent relapse

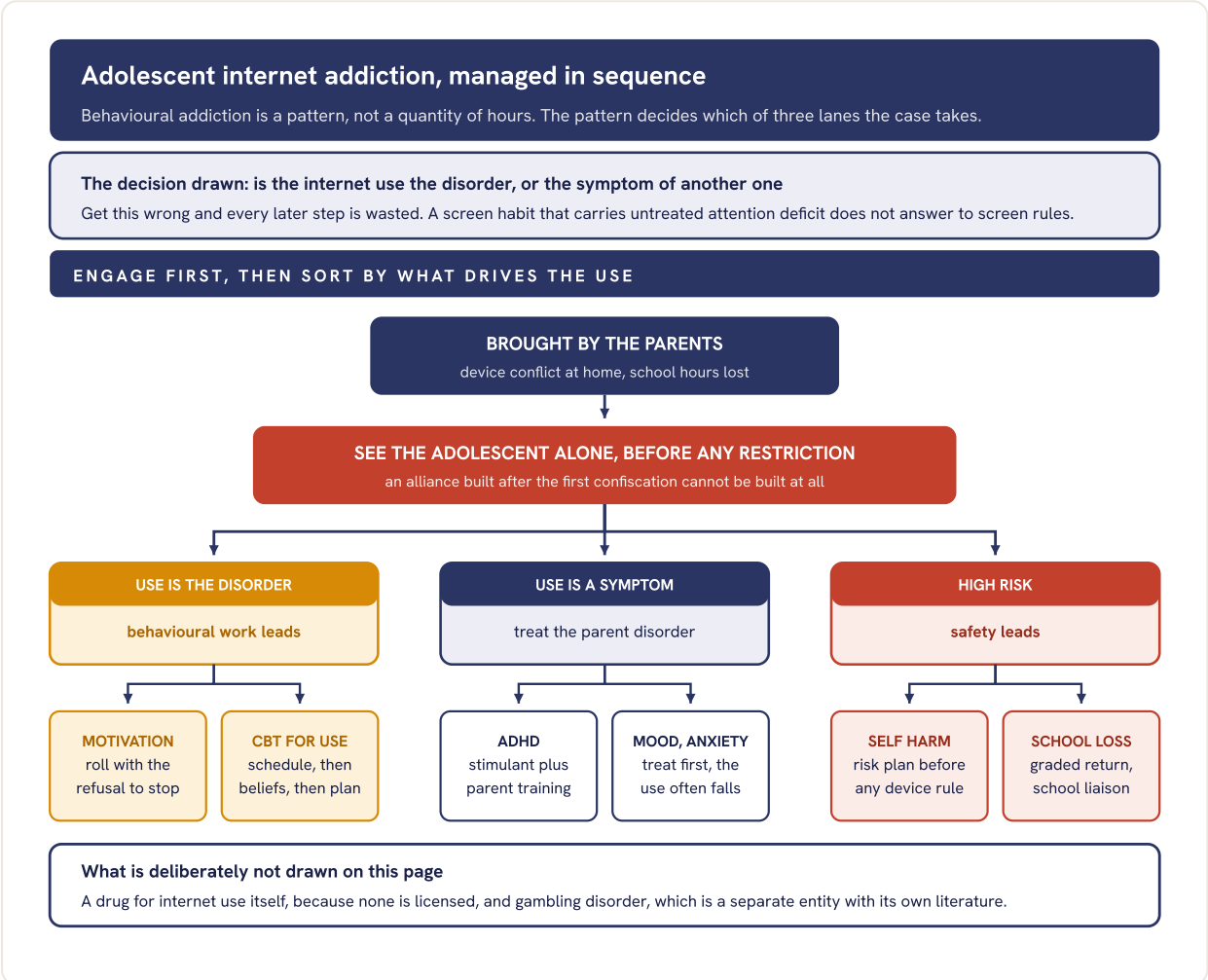


Fig 094.1 The management sequence, with the sorting decision placed above the three lanes so that treating a comorbid disorder is never mistaken for a failure of the behavioural plan.

COLOUR CODE steps and structure · where the marks sit · danger and escalation

- **Behavioural addiction.** A repeated rewarding behaviour that acquires the features of dependence: impaired control, priority over other interests, and continuation despite harm, for at least twelve months.
- **What is recognised.** The ICD-11 grouping of disorders due to addictive behaviours admits exactly two, gambling disorder and gaming disorder. Shopping, exercise and food remain proposed, not classified.

PITFALL

Hours online are not the diagnosis. Six holiday hours without impairment is no disorder; two hours in an adolescent who has stopped eating with the family and stopped attending school may be. Function, not duration.

WHAT EARNS THE MARKS

- **The dependence criteria applied to a behaviour,** not a description of heavy use.
- **Two recognised entities named, and the rest named as proposed.** That distinction is the whole of part one.
- **The sorting decision drawn before treatment,** as the plate does.
- **An engagement step placed ahead of any restriction.** Most answers begin with rules and lose the adolescent.

SEE ALSO Slot III - 96 internet addiction as a disorder Slot III - 97 rating scales in children **SPRINT** Day 24, Child psychiatry

WEAVE 100 · PAPER III · legacy-94.2

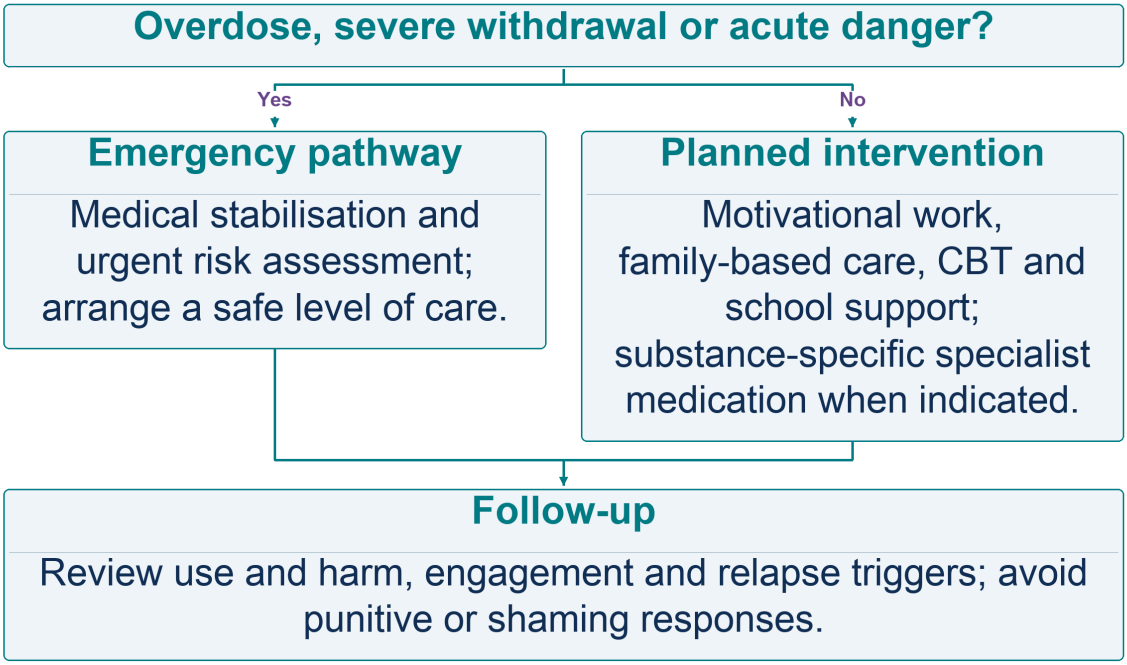
WEAVE 100+ / PAPER III

Adolescent substance use

Separate acute risk, dependence and developmental context.

Domain	Revision points
Engagement	Private adolescent interview plus caregiver information; explain confidentiality and its limits.
Assessment	Substance, route, quantity, context, loss of control, withdrawal and consequences; school, peers and family.
Comorbidity	ADHD, mood symptoms, trauma, conduct problems and suicide risk; check exploitation and safeguarding.

DECISION PATHWAY



Weave Sprint Paper III; see source register

III 94.2 • Supplement • Source links and qualifications: SOURCES.md

Adolescent substance use. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-94.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · new-94.5



Internet gaming disorder - DSM and ICD criteria. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-94.

Credits and references: retained within the illustration.

III - 95

What is gender dysphoria? Discuss its clinical presentation and management in a young adolescent. [2+3+5]

2 + 3 + 5 | CHILD ASSESSMENT, PHARMACOTHERAPY AND INTERVENTIONS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	Definition	Incongruence plus distress, and where each system puts it
3	Presentation	Onset, the adolescent picture, what travels with it
3	The staged pathway	Assess, social, suppression, hormones, in that order
2	Law and ethics	Self-identification, and the prohibition on conversion

- **Gender dysphoria.** Distress from a marked incongruence between experienced gender and assigned sex, for at least six months. ICD-11 moved the construct out of mental disorders as gender incongruence; DSM-5 keeps gender dysphoria.
- **Presentation at this age.** Insistence rather than preference, distress at pubertal change, binding or tucking, avoidance of changing rooms, and a request for a new name and pronoun.
- **What travels with it.** Depression, self-harm, anxiety, autism co-occurrence, and family rejection, the strongest predictor of poor outcome.

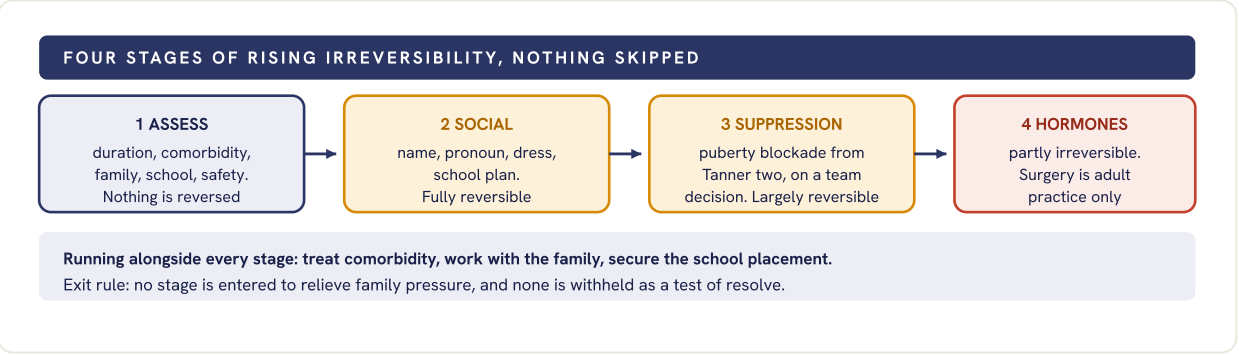


Fig 095.1 The pathway drawn as four stages of rising irreversibility, with the supports that run through all four kept on the foot strip so they are not read as a later phase.

PITFALL

Any attempt to change the young person's gender identity is prohibited. Conversion practice was held unlawful by the Madras High Court in 2021 and notified as professional misconduct by the National Medical Commission in 2022. Self-identification is protected by NALSA, 2014.

WHAT EARNS THE MARKS

- **Incongruence and distress named as two separate requirements,** with the ICD-11 relocation stated.
- **The four stages in order of irreversibility,** as the figure sets them out.
- **Comorbidity and family work placed alongside, not after.** Suicidality is the exam-critical line.
- **Self-identification named to NALSA, 2014,** and the conversion prohibition to an Indian authority.

SEE ALSO Slot III - 97 assessment instruments in children **SPRINT** Day 24, Child psychiatry

WEAVE 100+ / PAPER III

Adolescent gender-related distress

Provide respectful, developmentally informed assessment.

Domain	Revision points
Engagement	Use the young person’s stated name/ pronouns; explain confidentiality and its limits.
Assessment	Explore identity, distress, development, mental health, autism/ ADHD when relevant, family/ peer context and safeguarding.
Support	Address bullying, rejection, isolation and co-occurring difficulties; involve family when appropriate and safe.
Specialist care	Medical interventions require specialist assessment, informed consent processes and current jurisdiction-specific standards.
Classification	Gender diversity itself is not a mental disorder; distinguish identity from clinically significant distress.

SAFETY

Assess self-harm and suicidality without assuming them from identity alone.

BOUNDARY

Do not use coercive identity-change practices; avoid presuming any one developmental outcome.

Weave Sprint Paper III; see source register

III 95.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Adolescent gender-related distress. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-95.

Credits and references: retained within the illustration.

III - 96

a) Is internet addiction a mental disorder? b) What are the psychological and social problem faced by them? c) How to treat an adolescent patient of internet addiction? [2+2+2+4]

2 + 2 + 2 + 4 | CHILD ASSESSMENT, PHARMACOTHERAPY AND INTERVENTIONS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 The status	Answer yes and no, and say who says which
2 Psychological harm	Sleep, mood, attention, self-worth
2 Social harm	School, family, peers, money, safety online
4 Treatment	Three tiers, none of them a device ban

- **The honest answer is qualified.** Gaming disorder is a recognised ICD-11 diagnosis, so a specified form of internet use is a mental disorder. Generalised internet addiction is not: DSM-5 lists internet gaming disorder only as a condition for further study.

DOMAIN	WHAT IS SEEN	WHAT IT IS MISTAKEN FOR
Sleep and mood	Delayed sleep phase, morning unrousability, irritability on interruption, low mood offline	Laziness, or an independent depressive episode
Attention	Poor sustained attention offline, falling grades	**Attention deficit disorder, which may equally be the cause**
Family and school	Escalating conflict, deceit about hours, aggression on device removal, absence, offline friendships dropped	Conduct disorder, or social anxiety, which is often genuinely present
Money and safety	In-game spending, loot box gambling, grooming and cyberbullying exposure	Ordinary adolescent spending

The amber cell is the discriminator: attention deficit predating the heavy use is treated first, and the use often settles behind it.

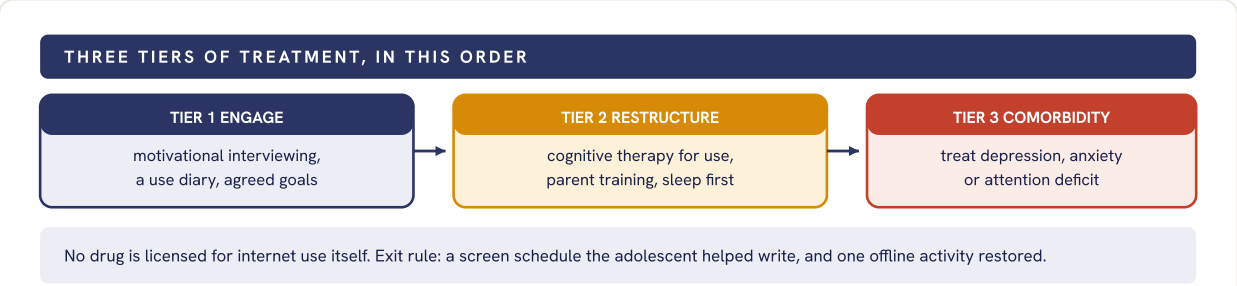


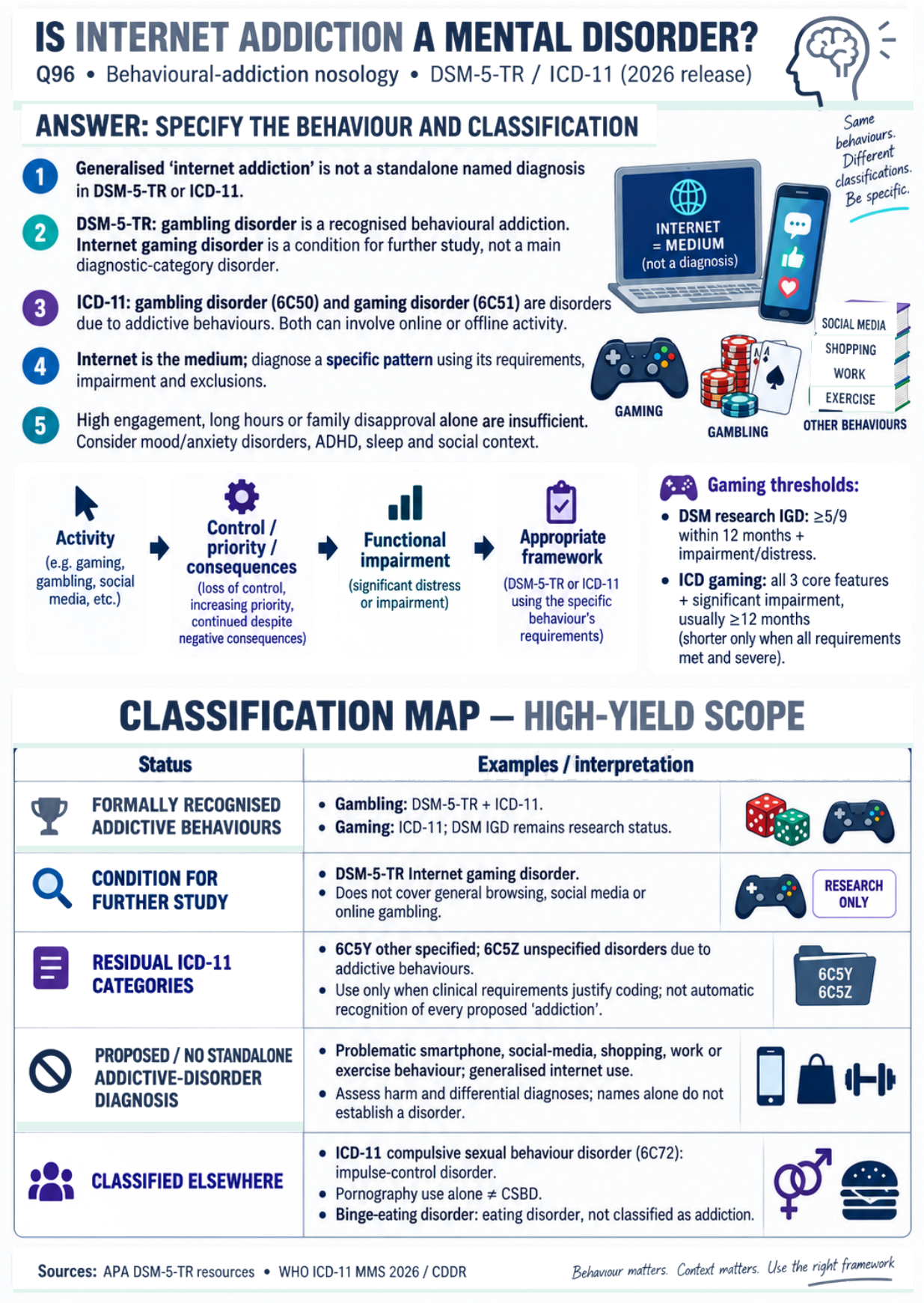
Fig 096.1 The treatment tiers, with the absence of any licensed pharmacotherapy stated on the figure so that medication is not read as a fourth tier.

WHAT EARNS THE MARKS

- **Part a answered both ways, with the classification named.** A flat yes or a flat no both lose marks.
- **Psychological and social harms kept apart,** because the question asks for two things.
- **Treatment tiered rather than listed,** with engagement placed before restriction.
- **The line that no drug is licensed for the behaviour itself.**

SEE ALSO Slot III - 94 behavioural addiction and its management **SPRINT** Day 24, Child psychiatry

WEAVE 100 · PAPER III · new-96.1



Internet addiction and behavioural addiction nosology. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-96.

Credits and references: retained within the illustration.

III - 97

a) What is Behavioural and Emotional Rating Scale? b) Enumerate the rating scale for ADHD? Describe any one such. c) How to assess autism in a 4 year old child? [2+2+2+4]

2 + 2 + 2 + 4 | CHILD ASSESSMENT, PHARMACOTHERAPY AND INTERVENTIONS

DNB - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	The strength scale	What BERS measures, and why that is unusual
2	The ADHD set	Grouped by informant, not listed at random
2	One described	Items, informants, scoring, what it cannot do
4	Autism at four	History, observation, instrument, certification

THE DEFINITION

A standardised, strength-based measure of a child's emotional and behavioural competence, against a field of problem-based instruments. Five domains: interpersonal strength, family involvement, intrapersonal strength, school functioning and affective strength, on parent, teacher and youth forms.

INSTRUMENT	INFORMANT	SHAPE	BEST USED FOR
Conners scales	Parent, teacher, self	Broad, normed, long and short forms	Diagnosis and severity together
Vanderbilt scales	Parent, teacher	Symptom items plus performance and comorbidity screens	Free clinic and school use
ADHD Rating Scale	Parent, teacher	Eighteen criterion items, nought to three	Direct criterion mapping
Child Behaviour Checklist	Parent, teacher, self	Broad-band, with an attention problems scale	Screening across disorders

The axis is the informant, because ADHD requires symptoms in more than one setting and no single rater can supply that.

- **One described.** The Vanderbilt parent form carries the eighteen criterion items rated nought to three, plus screens for oppositional, conduct and anxious-depressive symptoms and separate performance items. A domain counts only when six of nine items score two or three and performance is impaired. It supports a diagnosis; it never makes one.
- **Autism at four, in sequence.** History with regression enquiry, hearing and vision testing, examination for dysmorphology; then the autism diagnostic observation schedule at the child's language level with the parent interview; then severity, adaptive and cognitive measures, since intellectual disability is the commonest co-occurrence.
- **Keep certification separate.** The Indian Scale for Assessment of Autism is the instrument notified for disability certification, and it is scored for that purpose, not for diagnosis.

WHAT EARNS THE MARKS

- **The strength-based framing of BERS, named as its distinguishing feature.**
- **ADHD scales grouped by informant,** which is the axis the table divides on.
- **One instrument described with items, scoring and its limit.**
- **Autism given as a sequence,** certification instrument kept apart from diagnostic ones.

SEE ALSO Slot III - 48 domains and scoring of IDEAS **SPRINT** Day 24, Child psychiatry

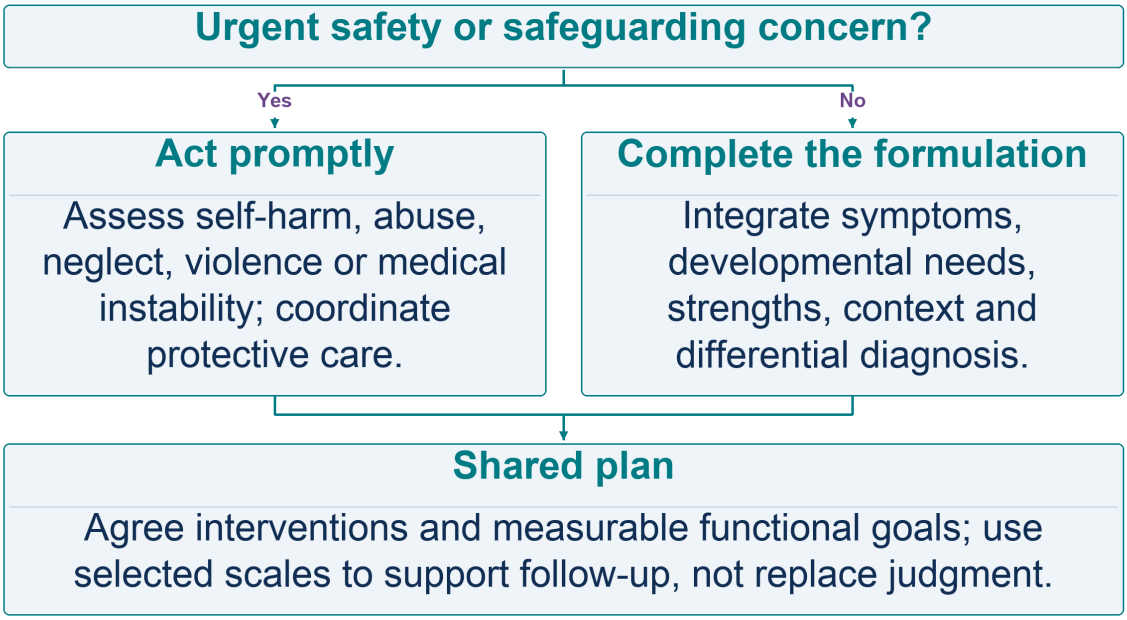
WEAVE 100+ / PAPER III

Child and adolescent psychiatric assessment

Integrate development, multiple informants and an explicit formulation.

Domain	Revision points
Engagement	Explain confidentiality and limits; offer age-appropriate private discussion and caregiver history.
History	Presenting problem, development, family, medical history, school, peers, sleep, substances and digital context.
Examination	Mental state, observation/ play and indicated physical/ neurological examination; interpret against developmental level.
Information sources	Child, caregivers, teacher/ school and records; explore discrepancies rather than averaging them away.

DECISION PATHWAY



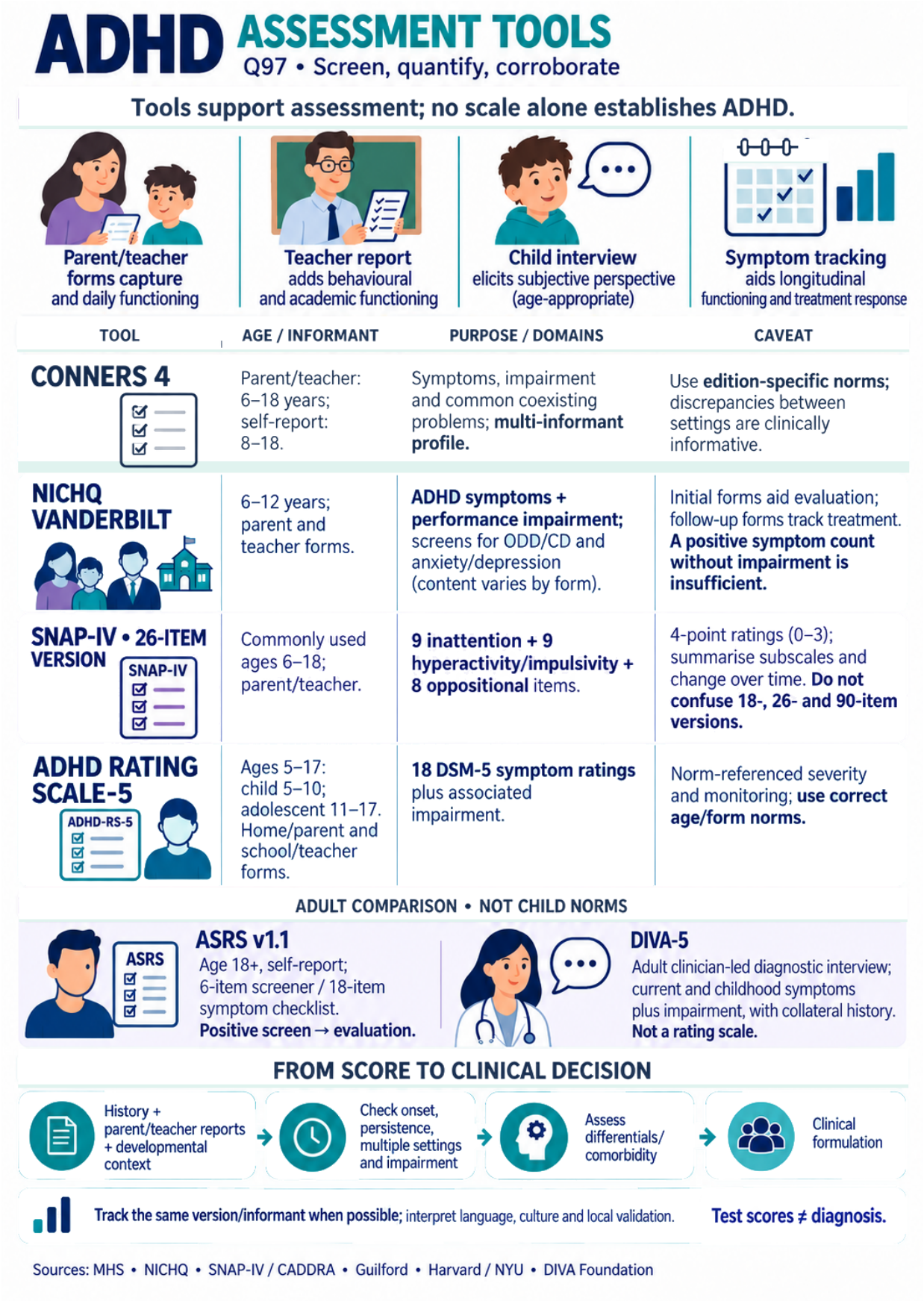
Weave Sprint Paper III; see source register

III 97.4 • Supplement • Source links and qualifications: SOURCES.md

Child and adolescent psychiatric assessment. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-97.

Credits and references: retained within the illustration.

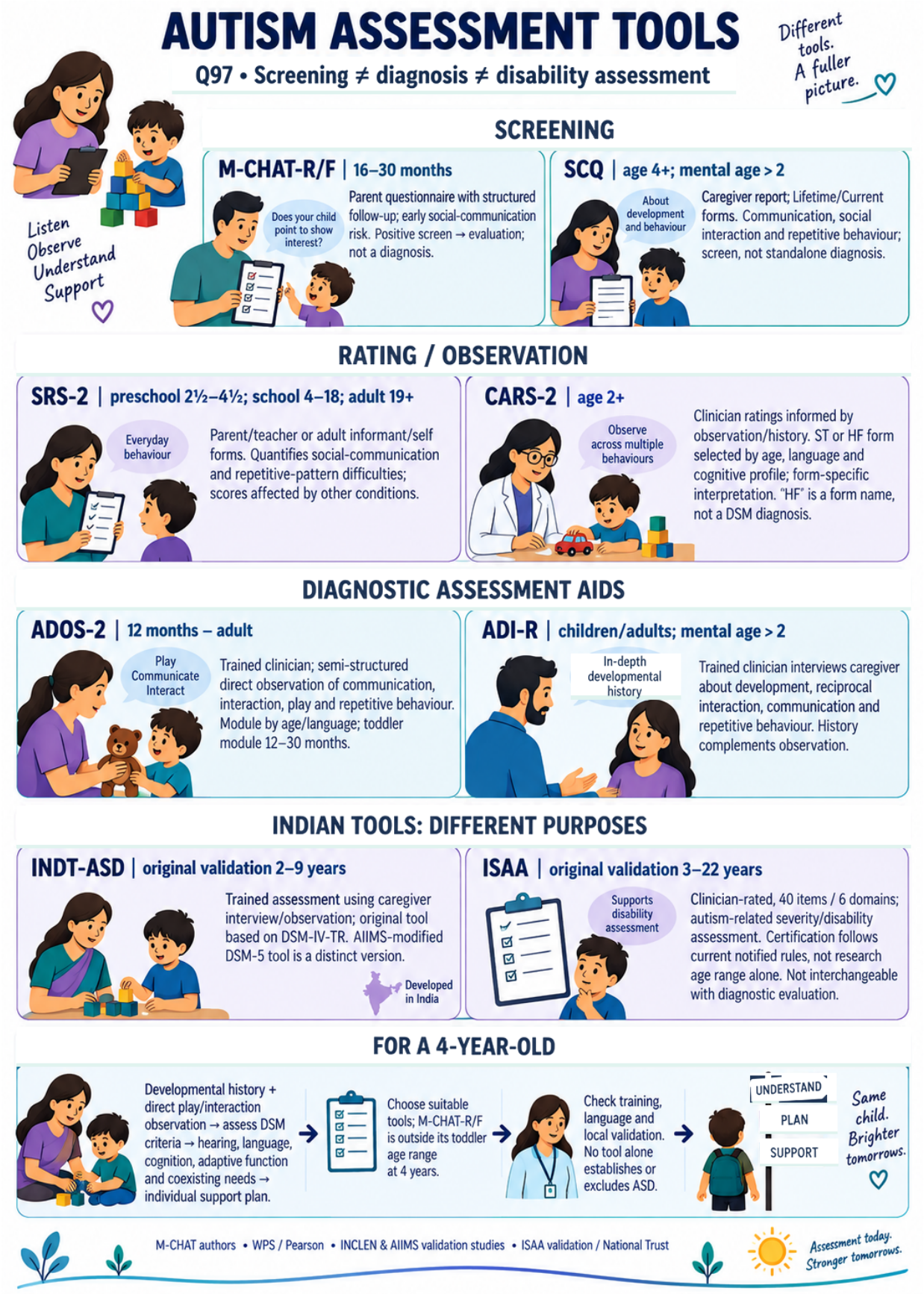
WEAVE 100 · PAPER III · new-97.6



ADHD assessment tools. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-97.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · new-97.7



Autism assessment tools. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-97.

Credits and references: retained within the illustration.

Adaptive Functioning and Developmental Assessment

Adaptive functioning: everyday performance in context

Conceptual
language, literacy, numbers, time and money



Social
relationships, social judgement, understanding rules and vulnerability



Practical
self-care, health, travel, safety and work routines



Judge skills relative to age, sociocultural expectations, opportunities and support.

Three different questions

Intelligence assessment:
how does the person reason and solve problems under standard conditions?



Adaptive assessment:
what does the person usually do in daily life?



Developmental assessment:
which abilities and milestones has the young child acquired across domains?



History + Direct assessment + Caregiver/teacher information → Integrated formulation

Main instruments

Instrument	Role and method	Output or key distinction
Vineland Adaptive Behavior Scales, Third Edition	caregiver interview or parent/caregiver and teacher forms; adaptive functioning	Adaptive Behavior Composite uses Communication, Daily Living Skills and Socialization. Motor skills are separate, not part of this composite.
Vineland Social Maturity Scale, Indian adaptation	informant-based social maturity	social age and Social Quotient; distinct from Vineland-3.
Developmental Screening Test, Bharat Raj	Indian developmental screen	developmental age and Developmental Quotient; identifies need for further assessment.
Denver II	developmental screen, birth to 6 years	personal-social, fine motor-adaptive, language and gross motor; screen, not intelligence quotient.
Bayley Scales of Infant and Toddler Development, Fourth Edition	comprehensive assessment, 16 days to 42 months	cognitive, language and motor direct assessment; social-emotional/adaptive caregiver information; norm-referenced scores.
Gesell Developmental Schedules	milestone-based developmental evaluation	interpret the specific edition and its norms.
Seguin Form Board	timed visuomotor performance task	limited estimate of nonverbal performance; not a complete adaptive or intelligence assessment.

Illustrative age-ratio calculations

Social Quotient = social age ÷ chronological age × 100.
Example: 3 years ÷ 5 years × 100 = 60.

Developmental Quotient = developmental age ÷ chronological age × 100.
Example: 18 months ÷ 24 months × 100 = 75.

These are age ratios, not disability percentages. Bayley-4 and Vineland-3 standard scores are not calculated by these formulas.

Key points for examination and clinical practice



Intellectual disability requires impaired intellectual AND adaptive functioning with developmental onset.



Clinical severity emphasises adaptive functioning.



A screening result alone does not diagnose intellectual disability.



Consider hearing, vision, language, motor ability, educational opportunity and informant bias.



Clinical assessment and statutory certification follow different rules.

Adaptive functioning and developmental assessment. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Child assessment, pharmacotherapy and interventions.

Credits and references: retained within the illustration.

WEAVE 100+ / PAPER III

Hamilton Anxiety Rating Scale

A clinician-rated severity scale, not a stand-alone diagnosis.

Domain	Revision points
Structure	14 items, each scored 0– 4; total 0– 56. Higher scores indicate greater symptom severity.
Content	Anxious mood, tension, fears, sleep, cognition, depressed mood, somatic/ autonomic symptoms and interview behaviour.
Administration	Use the relevant anchored interview/ scoring guidance; record the timeframe and clinical context.
Interpretation	Compare change with baseline and function; somatic illness and depression can increase scores.
Limitations	Does not establish a particular anxiety disorder; thresholds differ across settings and studies.

EXAM USE

State the author, item count, scoring range, psychic/ somatic coverage and limitations.

FOLLOW-UP

Use the same version and method over time; symptom reduction and functional recovery are separate outcomes.

Hamilton (1959), assessment of anxiety states; Weave scale notes.

Credits and references: retained within the illustration.

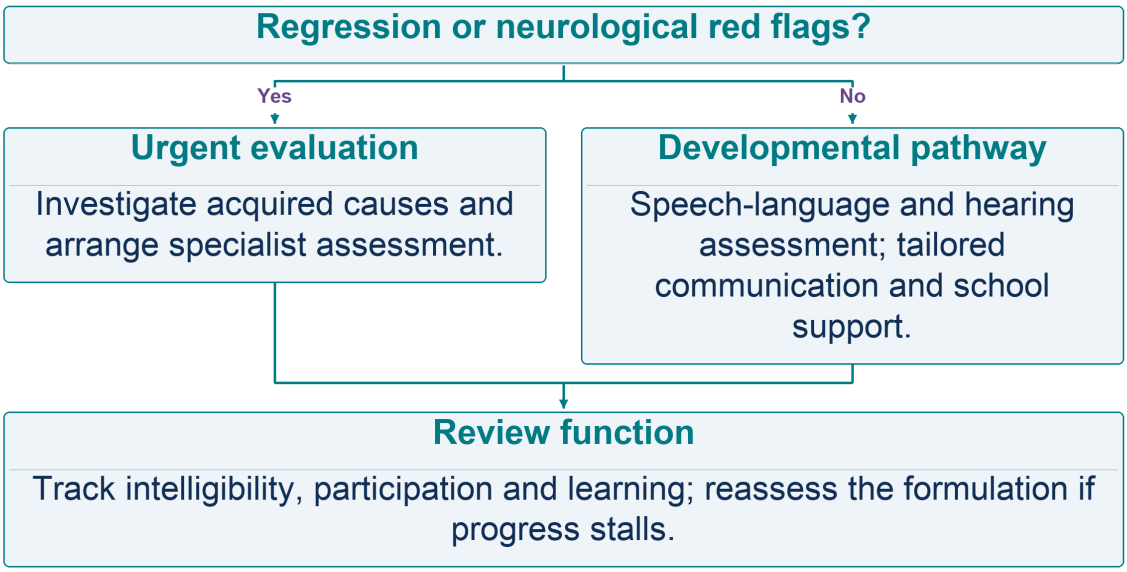
WEAVE 100+ / PAPER III

Communication disorders

Separate language content, speech production and social use.

Domain	Revision points
Language disorder	Persistent difficulty learning and using language; vocabulary, sentence structure or discourse.
Speech-sound disorder	Speech production reduces intelligibility; assess sound patterns, oral structures and hearing.
Social communication	Difficulty using communication socially; distinguish from autism by developmental history, including restricted/ repetitive patterns.
Assessment	History across languages, hearing, cognition, adaptive skills, school function and direct speech-language assessment.

DECISION PATHWAY



EXAM TRAP

Bilingual exposure alone is not a language disorder.

Weave Sprint day 22; ASHA Practice Portal: language, speech sound and social communication.

III 97.2 • Supplement • Source links and qualifications: SOURCES.md

Communication disorders. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Child assessment, pharmacotherapy and interventions.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · legacy-97.3

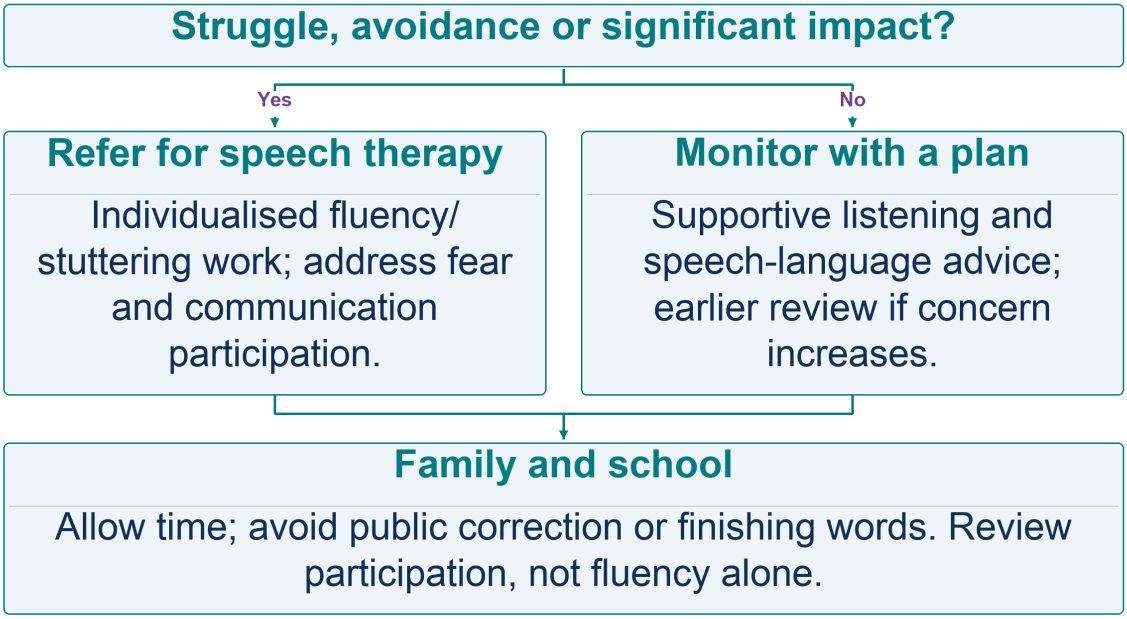
WEAVE 100+ / PAPER III

Stuttering

Describe the speaking experience as well as the audible dysfluency.

Domain	Revision points
Core features	Sound/ syllable repetitions, prolongations and blocks; may include tension and avoidance.
Assessment	Onset, persistence, family history, speech samples, distress, participation and listener responses.
Differential	Typical developmental dysfluency, cluttering, vocal tics and acquired neurological/ functional dysfluency.

DECISION PATHWAY



KEEP DISTINCT

Anxiety may worsen the experience; it is not a sufficient explanation for developmental stuttering.

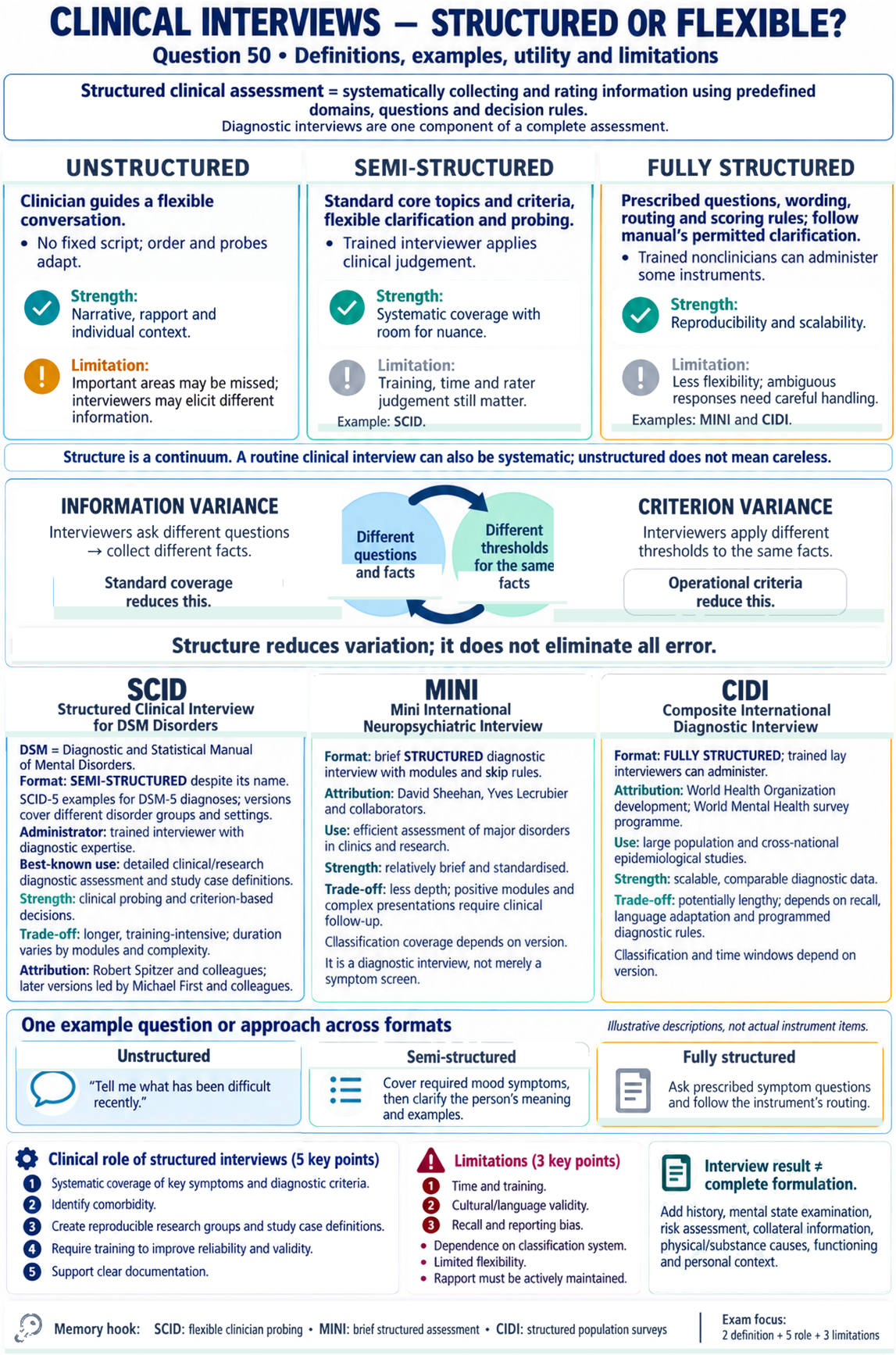
Weave Sprint day 22; ASHA: Stuttering, Cluttering, and Fluency.

III 97.3 • Supplement • Source links and qualifications: SOURCES.md

Stuttering. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Child assessment, pharmacotherapy and interventions.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · legacy-97.5



Structured clinical assessment. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Child assessment, pharmacotherapy and interventions.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · new-94.4

UNDERSTAND SUPPORT FIND A WAY FORWARD

PROBLEMATIC SCREEN USE

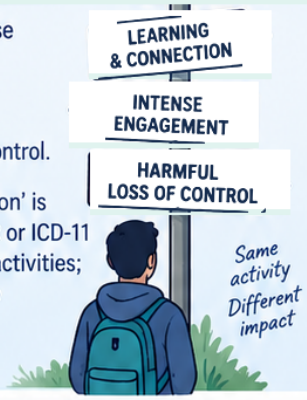
Q94 / Q96 • Assess harm, context and developmental needs

People Context Balance Brighter futures

USE ≠ DISORDER

Hours alone do not diagnose addiction. Distinguish educational/social use, intense engagement and persistent harmful loss of control.

Generalised 'screen addiction' is not a standalone DSM-5-TR or ICD-11 diagnosis. Assess specific activities; gaming and gambling have distinct frameworks.



DEVELOPMENTAL FORMULATION

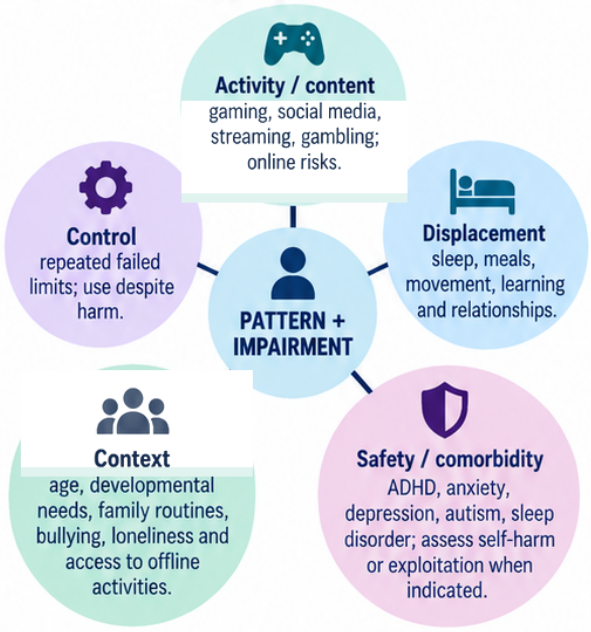
Rewards, social reinforcement and escape from distress can sustain use. Difficulties regulating attention/emotion and stressful environments may increase vulnerability; associations can run both ways.

Protective: supportive relationships, predictable routines, appealing offline opportunities and age-appropriate supervision.



ASSESS PATTERN + IMPAIRMENT

Explore the following areas:



MANAGEMENT: A SHARED PLAN

Use AAP 5 Cs: Child • Content • Calm • Crowding out • Communication.

Engage without blame; agree functional goals and review a brief use/sleep diary.



Younger children: co-use age-appropriate content, support play and interaction; teach calming beyond screens.



School-age: predictable boundaries, device-free sleep routines, movement/play, parental modelling and school coordination.



Adolescents: collaborative goals, privacy and online safety, peer/offline connection; CBT/motivational and family approaches when impairment persists.

Reduce cues and notifications; plan alternatives and relapse responses. Treat coexisting conditions.

No established medication for general screen-use problems. Escalate for major impairment or safety concerns.

THE BIGGER PICTURE

Aim for a balanced life:



TRACK RECOVERY

Sleep, attendance, relationships, wellbeing and regained control—not time alone.

Progress matters

Sources: AAP Digital Ecosystems policy (2026) / 5 Cs • APA • WHO

Healthier childhoods Brighter adult lives

Problematic screen use. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Child assessment, pharmacotherapy and interventions.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · new-97.8



Other childhood assessment measures. Use the visual organisation to recall the key distinctions and structure your answer. Section companion: Child assessment, pharmacotherapy and interventions.

Credits and references: retained within the illustration.

AREA 13 OF 13 · P3-A01

Normal child development

3	0.7%	III-98	III-100
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SINGLE 3

REVISION ORDER

Three unrelated slots, three unrelated answers. None of them is long. This is the area to read on the night before, not the week before.

WHAT IS IN THIS AREA

Temperament and its implications, Piaget, and adverse childhood experiences. Three slots, the smallest area in the book.

III - 98

What is temperament and its implication in the development of behavioral and emotional problems in child? [10]

10 | ASKED AT 15 MARKS | NORMAL CHILD DEVELOPMENT

TN-MGRMU - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 Definition	Style of behaviour, constitutional, early, measurable
2 The nine dimensions	Named, then clustered into the three constellations
4 Implications	Fit first, then the externalising and internalising routes
2 Qualifiers	Stability, cultural loading, and what it cannot predict

THE DEFINITION

Temperament is the constitutionally based, early appearing style of behaviour: the how of behaviour rather than the what or the why. Thomas and Chess described nine dimensions in the New York Longitudinal Study. Moderately heritable, moderately stable from the second year, rated by parent report.

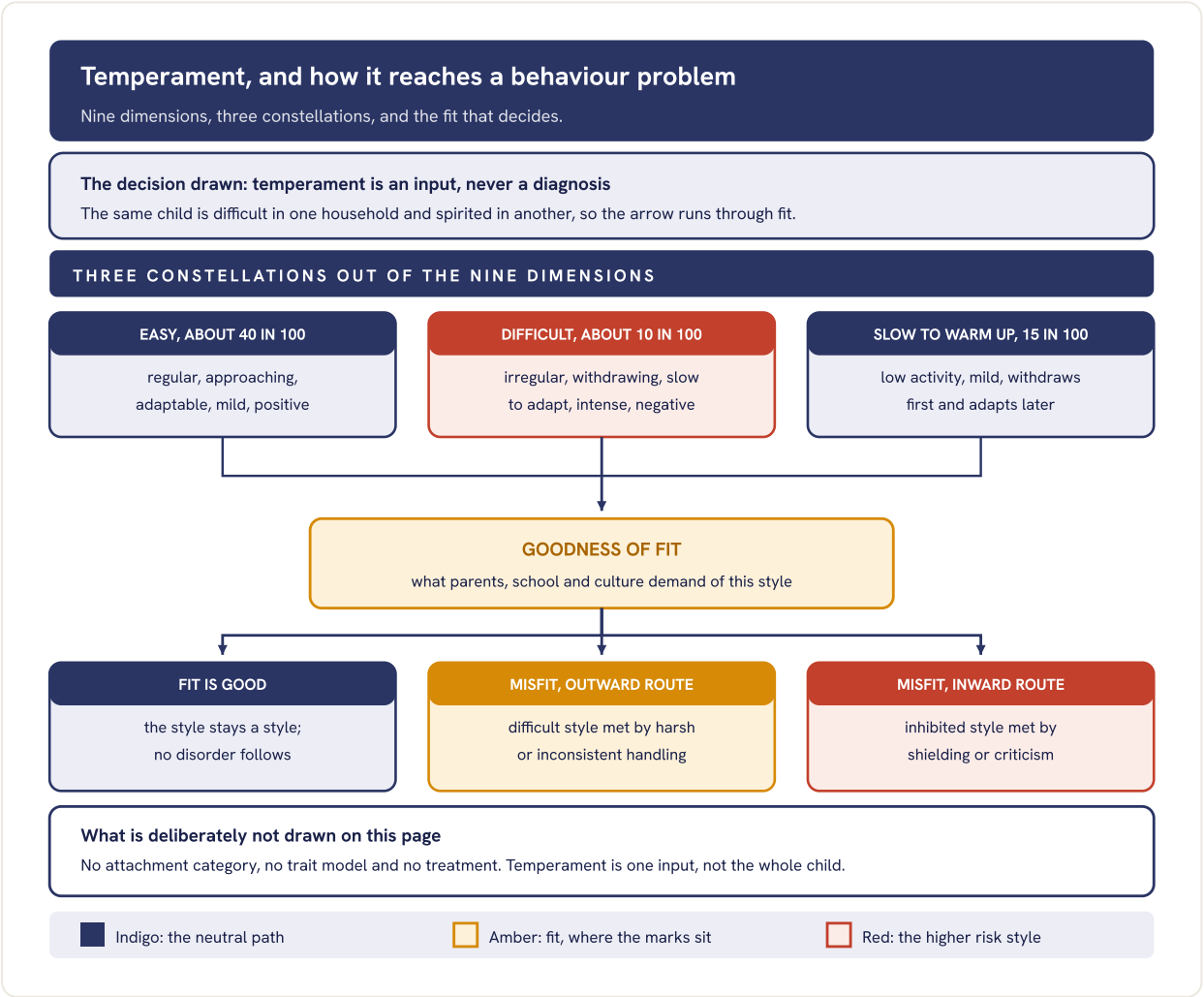


Fig 098.1 The nine dimensions clustered into three constellations, routed through goodness of fit, and the three outcomes that follow.

- **The nine dimensions.** Activity, rhythmicity, approach or withdrawal, adaptability, intensity, threshold, mood, distractibility, persistence. About a third of the original cohort fitted none of the three clusters.
- **Why fit carries the marks.** Difficult temperament predicts oppositional and conduct problems mainly where handling is harsh or inconsistent. Behavioural inhibition, described by Kagan, predicts social anxiety mainly where novelty is repeatedly avoided for the child.
- **The honest limit.** Effects are small and probabilistic. Indian ratings load differently on rhythmicity and approach, so use an Indian instrument such as the Malhotra Temperament Measurement Schedule.

WHAT EARNS THE MARKS

- **Definition as a style, then the nine dimensions named.** Naming three clusters without the dimensions is half the definition.
- **The fit arrow.** An answer that runs temperament straight to disorder cannot earn the four implication marks.
- **The outward and inward routes kept apart.** Different temperaments, different handling, different outcomes.
- **One honest limit.** Small effect, culture-bound ratings, no prediction for an individual child.

SEE ALSO Slot III - 100 adverse childhood experiences Slot III - 51 oppositional defiant disorder **SPRINT** Day 20, Normal child development & milestones

WEAVE 100 · PAPER III · new-98.2

Different ways of being Bright futures together ♡

TEMPERAMENT

Q98 • Dimensions, models and goodness of fit

Children grow in relationship with their environment



UNDERSTAND • SUPPORT • HELP THEM THRIVE

DEFINITION

Early-emerging individual differences in **emotional, attentional** and **motor reactivity** and **self-regulation**: the **HOW** of behaviour.
Biologically influenced, shaped by experience; **not fixed** personality or a diagnosis.

THOMAS & CHESS: NINE DIMENSIONS

Activity level
amount of movement



Rhythmicity
regularity of routines



Approach / withdrawal
initial response to novelty



Adaptability
adjustment over time



Threshold
stimulation needed for response



Intensity
strength of response



Mood
positive / negative emotional tone



Distractibility
response to competing stimuli



Attention span / persistence
staying with a task



THREE HISTORICAL PROFILES

Easy



- regular rhythms
- adaptable
- generally positive.

Difficult



- irregular rhythms
- intense negative reactions
- slower adaptation.

Slow-to-warm-up



- cautious withdrawal
- low activity
- gradual adaptation.

Descriptive clusters, not diagnoses or moral labels.
Many children fit none; dimensions are more informative.

GOODNESS / POORNESS OF FIT

Child characteristics × caregiver / school demands

Good fit



- gradual familiarisation for a cautious child
- movement breaks for an active child
- → **supported adaptation.**

Poor fit



- repeated pressure, overload or inflexible demands
- → **distress/conflict.**

Adapt expectations and environment; teach skills without blame.

Same child brighter possibilities ♡

TWO OTHER ESTABLISHED MODELS

ROTHBART

Reactivity + regulation.

- Childhood broad factors: **surgency/extraversion; negative affectivity; effortful control.**
- Regulation develops with age; infant and older-child structures differ.
- Age-specific measures: **IBQ-R** (infancy), **ECBQ** (toddler), **CBQ** (3–7 years).

BUSS & PLOMIN: EAS

- **Emotionality** — tendency to distress
- **Activity** — energy / tempo
- **Sociability** — preference for company
- Early-developing, partly heritable traits; use age-appropriate informant measures.
- Some child forms also score shyness.

DEVELOPMENTAL & CLINICAL USE

Risk is probabilistic: negative emotionality/weak regulation may relate to later problems; context and protective relationships modify trajectories.

Assess across situations using caregiver history, observation and appropriate tools. Consider culture, development and informant effects.

Parenting: predictable routines, co-regulation, graded novelty, flexible supports and realistic expectations.

Support today • More possibilities tomorrow ♡

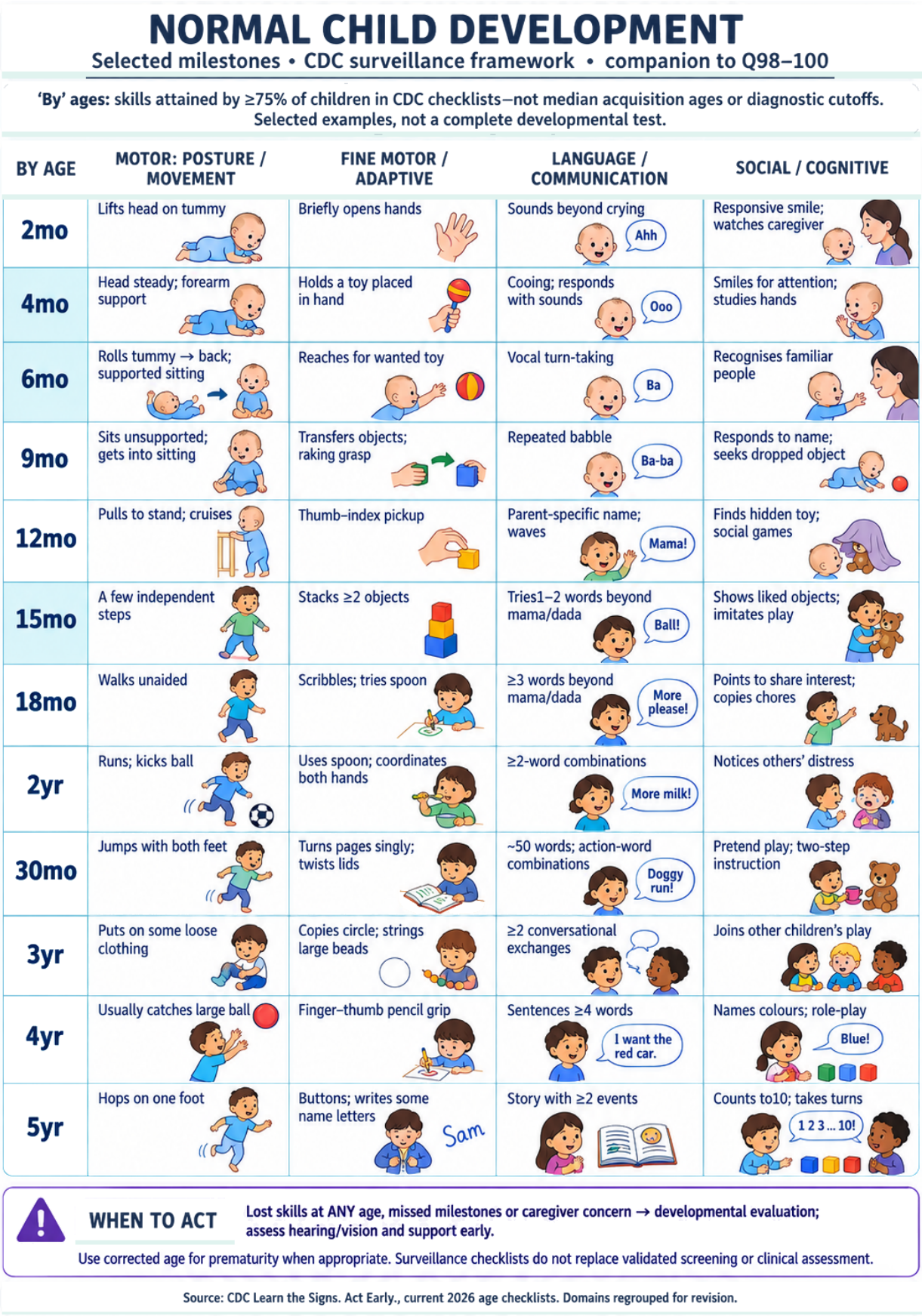
Thomas & Chess • AAP • Rothbart / Bowdoin questionnaires • Buss & Plomin

Children are more than a single dimension ♡

Temperament - Models and goodness of fit. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-98.

Credits and references: retained within the illustration.

WEAVE 100 · PAPER III · new-98.3



Normal child development milestones. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-98.

Credits and references: retained within the illustration.

III - 99

Jean Piaget. [10]

10 NORMAL CHILD DEVELOPMENT KUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2	The framework	Constructivism, and the four process words
4	The four stages	Age, what is gained, one bedside test each
2	Clinical use	Explaining illness, consent, choosing a therapy
2	Criticism	What later work overturned, and who answered him

THE FRAMEWORK IN ONE BLOCK

A constructivist stage theory: the child builds knowledge by acting on the world. Four process words carry the theory. A schema is a unit of knowledge; assimilation fits new experience into an existing schema; accommodation alters the schema to fit the experience; equilibration is the drive that moves the child from one stage to the next. Stages are invariant in order and qualitative, not a matter of knowing more.

STAGE	AGE	WHAT IS GAINED	TEST AT THE BEDSIDE
Sensorimotor	0 to 2	Circular reactions, means and ends, object permanence, deferred imitation	Hide a toy under a cloth and watch for the search
Preoperational	2 to 7	Symbols, language, pretend play; still egocentric, animistic, centred, irreversible	Pour water into a taller glass and ask which has more
Concrete operational	7 to 11	Conservation, reversibility, seriation, classification, transitivity	Conservation now passes, but only for present objects
Formal operational	11 upward	Abstract and hypothetical reasoning, systematic testing of possibilities	Give a pendulum problem and watch for one change at a time

Amber cells are the two tests an examiner expects by name: object permanence and conservation.

- **Why a psychiatrist uses it.** It sets the level at which illness is explained, the age at which assent becomes meaningful, and the readiness for a therapy: thought records need concrete operations, so younger children get play, drawing and story instead.
- **Where he was wrong.** Infants show numerical and physical expectations far earlier than the theory allows, transitions are gradual rather than stage-like, and formal operations are neither universal nor reached by every adult. Vygotsky placed the same development in the social zone between child and helper.

WHAT EARNS THE MARKS

- **The four process words, defined.** Assimilation and accommodation as a pair is the commonest place marks are lost.
- **All four stages with ages and one gain each.** A stage list with no age band reads as recall.
- **Object permanence and conservation named as the markers,** with the test each is shown by.
- **One clinical use and one criticism.** They are what separate a top answer from a textbook summary.

SEE ALSO Slot III - 98 temperament Slot III - 100 adverse childhood experiences SPRINT

Day 20, Normal child development & milestones

WEAVE 100+ / PAPER III

Piaget: cognitive development

Stages describe a theoretical sequence; ages are approximate.

Domain	Revision points
Sensorimotor · 0– 2 years	Learning through action and perception; object permanence develops.
Preoperational · 2– 7 years	Symbolic play and language; centration and difficulty with conservation are characteristic.
Concrete operational · 7– 11 years	Conservation, reversibility and logical operations with concrete material.
Formal operational · from ~11 years	Abstract and hypothetical reasoning becomes possible; performance varies with experience/ context.
Clinical relevance	Adapt explanations, play, consent discussions and therapy tasks to demonstrated understanding.

TRAP

Stage ages are not diagnostic milestones or rigid tests of intelligence.

CRITIQUE

Development is more variable and task/ context dependent than a strict stage model suggests.

Weave Sprint Paper III; see source register

III 99.1 • Question-linked revision • Source links and qualifications: SOURCES.md

Piaget: cognitive development. Use the visual organisation to recall the key distinctions and structure your answer.
Read with III-99.

Credits and references: retained within the illustration.

III - 100

Adverse childhood experiences. [10]

10 NORMAL CHILD DEVELOPMENT KUHS - 1 APPEARANCES, 1 OF 78 SESSIONS

SKELETON

2 Definition and origin	The construct, the study it came from, the score
3 The three domains	Ten categories, grouped, with the dose relation
3 Mechanism	Toxic stress to biology to behaviour, in that order
2 What follows clinically	Enquiry, the Indian legal duty, trauma-informed care

THE DEFINITION

Adverse childhood experiences are potentially traumatic events and chronic stressors occurring before the age of eighteen, counted as a simple score of exposure categories rather than weighted by severity. The construct comes from the Kaiser study reported by Felitti and Anda, which found a graded dose relation between the number of categories endorsed and adult disease and death.

DOMAIN	CATEGORIES COUNTED	WHAT RISES WITH THE SCORE
Abuse	Physical, emotional, sexual	Depression, suicide attempt, post-traumatic stress
Neglect	Physical, emotional	Attachment difficulty, poor emotion regulation
Household adversity	Parental mental illness, substance use, incarceration, violence between adults, separation or divorce	Substance use disorder, psychosis, personality difficulty
Dose relation	Score of four or more against a score of zero	Risk rises across most adult health outcomes, not one

Amber cells are the three findings the question is testing. The score counts categories, so it treats one episode and years of exposure alike.

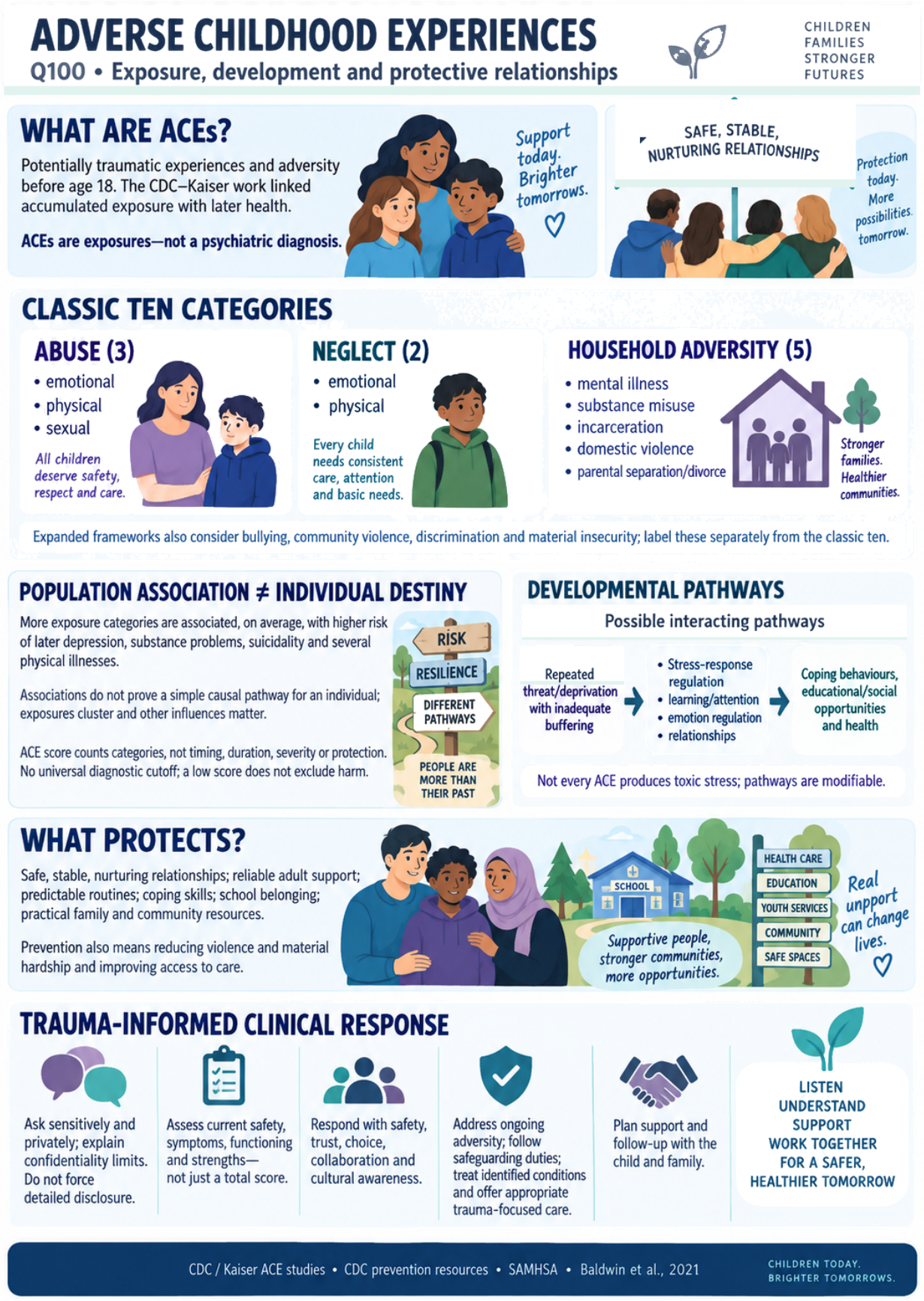
- **Mechanism, in order.** Prolonged activation without a buffering adult is toxic stress: altered hypothalamic pituitary adrenal reactivity, low grade inflammation, epigenetic change at stress-response genes, and altered amygdala and prefrontal development. Health risk behaviour follows as coping, not as cause.
- **Indian frame.** Sexual abuse of a minor carries a mandatory reporting duty under the Protection of Children from Sexual Offences Act 2012. A neglected or abused child is a child in need of care and protection under the Juvenile Justice Act 2015, referred to the child welfare committee.
- **The trap.** The score is a population risk marker, not a diagnosis and not a prediction for the child in front of you. Enquire routinely, never in a first interview with the parent present, and never repeat the history for teaching.

WHAT EARNS THE MARKS

- **The definition with the age boundary and the counting rule.** A list of adversities with no score is half the construct.
- **Three domains, then the dose relation stated as graded.**
- **Mechanism written as a chain,** from buffering failure to biology to behaviour.
- **The two Indian statutes named.** Mandatory reporting is the line most answers never reach.

SEE ALSO Slot III - 98 temperament Slot III - 37 mother infant relationship disorders

WEAVE 100 · PAPER III · new-100.1



Adverse childhood experiences. Use the visual organisation to recall the key distinctions and structure your answer. Read with III-100.

Credits and references: retained within the illustration.

APPENDIX, PAGE ONE OF TWO

Ten sets, ten sittings

The same hundred questions, dealt into ten papers of ten. Each cell gives the slot and the page it is answered on.

Read down a row to sit a paper. The deal is not random: the hundred are ranked by score and dealt one question from each rank decile into each set, so every set holds one of the ten strongest, one of the ten weakest, and one from each band between. That is why the sets are comparable to each other and why none of them is an easy paper.

SET	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
III-S1	III-50 p 139	III-33 p 96	III-54 p 147	III-06 p 21	III-43 p 118	III-96 p 295	III-30 p 79	III-85 p 253	III-86 p 255	III-98 p 309
III-S2	III-89 p 276	III-68 p 202	III-13 p 39	III-05 p 19	III-64 p 180	III-16 p 44	III-20 p 54	III-84 p 246	III-80 p 236	III-93 p 286
III-S3	III-31 p 91	III-52 p 143	III-35 p 99	III-04 p 17	III-69 p 203	III-29 p 77	III-45 p 122	III-37 p 103	III-81 p 237	III-92 p 285
III-S4	III-11 p 33	III-22 p 62	III-94 p 289	III-03 p 16	III-65 p 181	III-36 p 102	III-10 p 29	III-70 p 204	III-57 p 152	III-91 p 283
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III-S6	III-51 p 141	III-02 p 14	III-76 p 226	III-61 p 171	III-55 p 149	III-15 p 43	III-97 p 297	III-71 p 206	III-87 p 257	III-88 p 259
III-S7	III-75 p 225	III-90 p 278	III-53 p 145	III-26 p 72	III-44 p 120	III-83 p 244	III-18 p 50	III-56 p 151	III-78 p 231	III-58 p 153
III-S8	III-67 p 200	III-34 p 97	III-23 p 64	III-25 p 69	III-07 p 23	III-09 p 27	III-77 p 230	III-49 p 128	III-39 p 108	III-73 p 210
III-S9	III-59 p 167	III-21 p 61	III-24 p 66	III-42 p 115	III-14 p 41	III-27 p 74	III-46 p 124	III-48 p 127	III-79 p 234	III-100 p 315
III-S10	III-32 p 94	III-82 p 242	III-60 p 170	III-63 p 178	III-95 p 293	III-08 p 25	III-19 p 52	III-47 p 126	III-40 p 110	III-99 p 313

No set repeats a question, a merged variant of a question, or a near-duplicate, and no set takes more than three questions from any one area.

APPENDIX, PAGE TWO OF TWO

How to sit one of these

SET	MARKS	MEAN SCORE	AREAS	ANCHOR OR HIGH	HEAVIEST AREAS IN THE SET
III-S1	100	0.387	8	2	ADHD 2; Perinatal 2; Childhood emotional 1
III-S2	100	0.379	7	2	Intellectual disability 3; Autism spectrum disorder 2; ECT 1
III-S3	100	0.374	8	2	Childhood emotional 3; ADHD 1; Criminal 1
III-S4	100	0.363	9	4	Criminal 2; Intellectual disability 1; Ethics 1
III-S5	100	0.361	7	2	Intellectual disability 2; Geriatric 2; ECT 2
III-S6	100	0.358	8	0	ADHD 2; Perinatal 2; Criminal 1
III-S7	100	0.353	7	3	ADHD 3; Emergency psychiatry 2; Autism spectrum disorder 1
III-S8	100	0.353	6	3	ECT 2; Childhood emotional 2; Ethics 2
III-S9	100	0.346	6	0	Ethics 3; Mental health legislation 3; Geriatric 1
III-S10	100	0.348	8	1	Childhood emotional 2; Geriatric 2; Perinatal 1

Mean score is the selection score of the ten questions in that set, on the same scale used across all four books. The spread between the strongest and the weakest set is small by construction.

Three hours, ten questions, one hundred marks. That is the shape of the real paper, so it is the shape of these. Eighteen minutes a question leaves you twenty minutes at the end, which is roughly what you will have and roughly what you will need.

Write the skeleton first, for all ten. Spend the first twenty minutes writing nothing but mark splits and section headings across all ten answers. The map on each page shows what that skeleton should look like, so you can mark your own against it before you have written a line of content. Most marks lost in this examination are lost to allocation, not to ignorance.

Then mark yourself against the anchors. Every map ends with three or four things an examiner ticks. Those are the marking scheme, as close as this book can get to one. Count how many you hit before you read the rest of the page, because reading the page first will convince you that you knew it.

Sit them in order, or sit them backwards. Set one holds the strongest question in the book and set ten the weakest, but the decile deal means the difference in mean score across all ten sets is small. Any set is a fair paper. Sitting them in order simply means the first one you sit is the one most like the paper you will get.

What a set is not. It is not a mock paper from any board, it is not a leak, and it is not a prediction. It is ten questions that have been set, arranged so that ten of them together look like a paper. Sit five of them and you will have written a hundred answers in the shape the examination wants, which is the only preparation that has ever reliably worked.

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Every entry points at the map that answers it. A subject asked in several places carries up to three pages, and the one in bold is the map whose question is about it.

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CREDITS

Who made this, and from what

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The record. Every question in this book was read off a paper set by DNB, KNRUHS, KUHS, MUHS, NTRUHS, RGUHS, TN Dr. MGR Medical University or WBUHS. Where a paper reached us as a mirror, an archive or a transcription rather than an official file, that session carries a lower weight in the count, and the weightage chapter says by how much.

The residents. Papers, corrections and photographs of question papers came from residents across several states who had no reason to send them except that somebody else would need them. This book is mostly their work.

The tools. The counting, weighting, selection and typesetting all run as code in this repository, so any number in this book can be traced back to the row it came from.

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